

WORKING DOCUMENT FOR STRATEGIC PLANNING

AND

**EXECUTIVE SUMMARY OF
MONOGRAPH**

**WONCA WORKING PARTY ON
WOMEN AND FAMILY MEDICINE**

**“WOMEN WORKING THROUGH WONCA
TO BE THE BEST WE CAN”**

November 2004

**Prepared for the Working Party on Women and Family Medicine
Includes Pre-conference Strategic Planning Workshop
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INTRODUCTION

Increasing numbers of women are entering family medicine and general practice around the world. They bring a variety of life experiences, work in many different practice settings, both urban and rural, and participate in both academic and medical organizations. Although they play an important role in both developing and developed countries they universally face societal, cultural and institutional barriers. Women have consistently pointed out the need for medicine to address concerns about power in medical practice and organizations and have highlighted the importance of balance in physicians' lives. Increasingly women physicians have joined together in medical organizations to share experiences and consider strategies to address personal, cultural and structural barriers to their full professional development and to raise awareness about discrimination experienced by women patients in clinical practice and research.

Vision of the Working Party on Women and Family Medicine (Orlando '04)

To promote the role of women family doctors working in WONCA, to highlight their special contributions and reduce the barriers facing them, thereby enabling them to reach their full potential and enhance the contribution of family physicians/GPs around the world to clinical care, women's health, education, research and leadership in family medicine.

Objectives of the Working Party on Women and Family Medicine (Orlando '04)

- To identify key issues for women doctors working in family medicine in all WONCA member countries, including developed and developing countries, and rural and remote areas, and to seek solutions to common problems.
- To review WONCA policies and procedures on representation, programs, training, research, management, leadership and support structure, and ensure that these policies are equitably, transparently and effectively implemented.
- To provide opportunities for international exchange of knowledge and expertise on women and family medicine at regional and international WONCA meetings, and through electronic means, such as the WWPWFM listserv and WWPWFM website.
- To reduce linguistic, cultural and economic barriers to women family physicians/GPs participating in WONCA initiatives.
- To evaluate the effectiveness of the WWPWFM.

Purpose of this Executive Summary and Working Document

In preparation for the pre-conference of the WONCA Working Party on Women and Family Medicine in Orlando Florida in October 2004, a steering committee has prepared the Working document to:

- Develop a framework to consider the issues facing women physicians in family medicine;
- Delineate the principles to guide WONCA in supporting and promoting women in family medicine/general practice; and
- Outline short-term and long-term goals.

Role of WONCA and the Working Party on Women in Family Medicine

As the World Organization of Family Doctors, WONCA through the WONCA Working Party on Women and Family Medicine can play a leadership role in advocating for the concerns raised by women in family medicine/general practice.

ACTION PLAN

Why an Action Plan for the Working Party on Women and Family Medicine?

The Action Plan will outline short-term and long-term goals developed at the pre-conference. WONCA is an international organization made up of member organizations from various regions around the world. The policy of WONCA is set by a governing board, which meets every year and makes recommendations about policy to the member organizations. Decisions adopted by the WONCA governing council have a large symbolic and potentially practical influence on family medicine and general practice in all parts of the world. Up until the present, women's concerns within family medicine have not been a major focus for WONCA. With the official formation and recognition of the of the WONCA Working Party on Women and Family Medicine at the 16th International Conference of WONCA in Durban in 2001 comes the potential for the Working Party to influence WONCA's language, policy, and program. With the growing importance of women in family medicine around the world, the Council will be listening hard to our recommendations because we represent more and more of the family doctors of the future.

PRINCIPLES

Preamble to the principles (Orlando '04)

The contributions of women to family medicine reflect not just the influence of their numbers in training and practice settings, but also their ability to integrate an understanding of women's lives into their professional work. Women physicians have highlighted the need for enhanced interpersonal skills for all practitioners, including non-hierarchical relationships with patients and peers.

Recognizing the increasing role of women in medicine in general and in family medicine in particular;

Recognizing that furthering of women's issues within family medicine will improve the discipline for all practitioners and patients;

Recognizing the importance of the specific contributions of women to family medicine;

Recognizing in highlighting girls' and women's vulnerabilities in society;

Recognizing the challenges facing women in family medicine owing to socialization and social conditions around the world;

Recognizing the need for organizational representation and leadership to promote women's contributions and to persistently address the barriers facing women both in organizations and in practice settings and training programs;

Recognizing the vulnerability of women patients to repeated discrimination based on gender in clinical practice and research;

Recognizing the inadequacy of information about women in family medicine/general practice in certain parts of the world;

Recognizing the diversity of cultures represented in which women practice family medicine

Principles (Orlando '04)

Administration

WONCA's governance structure, policies and procedures, and conference programs should reflect the increasing numbers of women in family medicine

WONCA's internal organization should be free from discrimination and harassment

Healthy Practice

WONCA should promote nonhierarchical, caring and collaborative skills at all levels of training, practice, research and organization

WONCA should promote the recognition of the importance of balance in physicians' lives, for both women and men, to maintain healthy, resilient personal and professional lives

WONCA should celebrate the richness of experiences of gender and culture brought by women family physicians from many countries

WONCA should collaborate with national colleges and academic departments of family medicine to celebrate the relationship as fundamental to the provision of optimal patient care (e.g. doctor-patient relationship, other provider – patient relationship, etc.).

Education and Leadership

WONCA should collaborate with national colleges and academic departments of family medicine to promote educational initiatives that enable girls and women to enter medical training and ultimately achieve their full potential as family doctors

WONCA should promote initiatives that enable women family physicians to become leaders in regional, national and international organizations

WONCA should collaborate with national colleges and academic departments of family medicine to promote professional development of women as academics and leaders

Human Rights and Social Justice

WONCA should provide a platform to confront societal discrimination against women through prioritizing their health needs in practice, education and research

WONCA should take a stand against violence and victimization against women and girls in families and society

WONCA should support the Beijing Platform of Action on human rights issues as they affect women

Monitoring

WONCA should provide a database about the demographics of WONCA members and a mechanism for the collection and dissemination of data about women in family medicine/general practice in all member countries

HISTORY

Women family physicians have worked within WONCA member organizations to develop remedies for the systematic discrimination against women physicians and patients. Initially informally, and later formally, women have organized working parties, standing committees, and separate women's organizations nationally and internationally. At the 15th International Conference of WONCA in Dublin in 1998, a group of 50-100 women met regularly and proposed a Women in Family Medicine Special Interest Group (SIG). This

was accepted at the next WONCA Executive meeting in April 1999. The proposed aims and objectives of the SIG were seen to be worthy of a WONCA working party and the new Working Party for Women and Family Medicine was named at the 16th International Conference of WONCA in Durban, in 2001.

Members of the SIG attended a WONCA workshop in Christchurch in June 2000 and developed Strategic Objectives from the Beijing Platform for Action for promoting and protecting the health of women. (see pg. 7) These objectives were supported by the Working Party on Women and Family Medicine and were endorsed by the WONCA Executive in Durban, 2001, Singapore in 2001 and London in 2002, in the Strategic Action Plan (Singapore 2001, London 2002). Attendees at the 4th World Rural Health Conference in Calgary, Canada, in August 2000 recognized the special contributions of women physicians to rural practice. At the Durban congress a Women-in-Leadership Symposium developed a series of recommendations for WONCA to promote leadership skills and opportunities for both junior and experienced women in family medicine. (see pg 10). A Needs Assessment Questionnaire of women in family medicine has been circulated and the responses collated (see pg. 15). Finally a review of the literature has been undertaken and a literature review/ monograph prepared (see pg. 20). Copies of the documents are available for review at the following website: www.womenandfamilymedicine.com.

A WORKING DOCUMENT

We are offering the Working Document as a framework to guide strategic planning and to initiate further discussion. This Working Document is a *work-in-progress*, and will continue to be informed by members of WONCA, by emerging international literature and by the ongoing research being undertaken by the WONCA Working Party on Women and Family Medicine, such as the needs assessment questionnaire and the survey of the member organizations of WONCA.

EXECUTIVE SUMMARY

This Working Document includes:

- The Beijing Platform for Action

- The WONCA Women's Leadership Symposium

- The International Women in Family Medicine Survey - needs assessment questionnaire with preliminary results from 13 countries

- The executive summary of the Literature Review/Monograph that covers six separate topic areas. Each chapter contains a summary of the literature on the topic area and an inventory of each of the research articles reviewed.

The purpose of the monograph and ongoing research undertaken by the working party is to provide evidence to support initiatives and strategies undertaken by WONCA and by the working party itself. All these documents will inform our planning process.

STRATEGIC OBJECTIVES FROM THE BEIJING PLATFORM OF ACTION

Women and poverty

Review, adopt and maintain macro-economic policies and development strategies that address the needs and efforts of women in poverty;

Revise laws and administrative practices to ensure women's equal rights and access to economic resources;

Provide women with access to savings and credit mechanisms and institutions;

Develop gender-based methodologies and conduct research to address the feminization of poverty.

Education and training of women

Ensure equal access to education;

Eradicate illiteracy among women;

Improve women's access to vocational training, science and technology, and continuing education;

Develop non-discriminatory education and training;

Allocate sufficient resources for and monitor the implementation of educational reforms;

Promote lifelong education and training for girls and women.

Women and health

- Increase women's access throughout the life cycle to appropriate affordable and quality health care, information and related services;
- Strengthen preventive programmes that promote women's health;
- Undertake gender-sensitive initiative that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues;
- Promote research and disseminate information on women's health;
- Increase resources and monitor follow-up for women's health

Violence against women

- Take integrated measures to prevent and eliminate violence against women;
- Study the causes and consequences of violence against women and the effectiveness of preventive measures;
- Eliminate trafficking in women and assist victims of violence due to prostitution and trafficking

Women and armed conflict

Increase the participation of women in conflict resolution at decision making levels and protect women living in situations of armed conflicts or under foreign occupation;

Reduce excessive military expenditures and control the availability of armaments ;

Promote non-violent forms of conflict resolution and reduce the incidence of human rights abuse in conflict situations;

Promote women's contribution to fostering a culture of peace;

Provide protection, assistance and training to refugee women in need of international protection and internally displaced women;

Provide assistance to the women of the colonies and non-self-governing territories;

Women and the economy

Promote women's economic rights and independence, including access to employment and appropriate working conditions and control over economic resources;
Facilitate women's equal access to resources, employment, markets and trade;
Provide business services, training and access to markets, information and technology, particularly to low-income women;
Strengthen women's economic capacity and commercial networks;
Eliminate occupational and all forms of employment discrimination;
Promote harmonization of work and family responsibilities for women and men;

Women in power and decision making

Take measures to ensure women's equal access to and full participation in power structures and decision making;
Increase women's capacity to participate in decision making and leadership;

Institutional mechanisms for the advancement of women

Create or strengthen national machineries and other governmental bodies;
Integrate gender perspectives in legislation, public policies, programmes and projects;
Generate and disseminate gender-disaggregated data and information for planning and evaluation;

Human rights of women

Promote and protect the human rights of women, through the full implementation of all human rights instruments, especially the Convention on the Elimination of All Forms of Discrimination against Women;
Ensure equality and non-discrimination under the law and in practice;
Achieve legal literacy;

Women and the media

Increase the participation and access of women to expression and decision making in and through the media and new technologies of communication;
Promote a balanced and non-stereotypes portrayal of women in the media;

Women and the environment

Involve women actively in environmental decision making at all levels;
Integrate gender concerns and perspectives in policies and programmes for sustainable development;
Strengthen or establish mechanisms at the national, regional and international levels to assess the impact of development and environmental policies on women.

The girl child

Eliminate all forms of discrimination against the girl child ;

Eliminate negative cultural attitudes and practices against girls;

Promote and protect the rights of the girl child and increase awareness of her needs and potential;

Eliminate discrimination against girls in education, skills development and training;

Eliminate discrimination against girls in health and nutrition;

Eliminate the economic exploitation of child labour and protect young girls at work;

Eradicate violence against the girl child ;

Promote the girl child's awareness of and participation in social, economic and political life;

Strengthen the role of the family in improving status of the girl child.

SUMMARY OF LEADERSHIP SYMPOSIUM DURBAN 2001

Abstract

This workshop was part of the "Women's Track" and provided a forum to discuss women and leadership in family medicine from an international perspective. The objectives were:

- To share the particular challenges, difficulties and opportunities of women in leadership in FM in different countries;
- To discuss the leadership challenges facing women in family medicine in international organizations; and
- To invite audience participation and to develop a strategy on how to effectively develop women in FM for leadership positions.

In the first part an international selection of four panelists Dr. Marietjie de Villiers (South Africa), Dr. Zorayda Leopando (Asia), Dr. Thembi Maleka (South Africa) and Dr. Barbara Lent described the leadership challenges facing women in their experiences in family medicine, and in national and international organizations.

A summary of key elements of their presentation formed the basis for small group round table discussions in the second part of the workshop.

Moderators were Dr. Cheryl Levitt (Canada), Dr. Sarah Strasser (Aus) and Dr. Lucy Candib (USA). Key concepts are summarized below and will be reported to the WONCA executive. List of participants attached in Appendix 2.

Summaries

What key recommendations would you make to the WONCA Board

Group 1

- Plenaries should have equal representation of women and men
- WONCA council should have a balance of gender
- WONCA should invite themes in regional and world congresses that focus on needs of women patients and women doctors
- Encourage the WONCA council to continue and improve on the development of women's issues at the next triennial meeting, building on the successes of the women's track at the WONCA 2001 at Durban

Group 2

- Start leadership skills early in the undergraduate program
- WONCA should encourage/facilitate networking among women leaders
- International policies must encourage leadership positions
- Support is needed from women to women to take on leadership skills
- Create a positive image for leadership

Group 3

WONCA should assure adequate funding resources for Working Party of Women in Family Medicine

WONCA should maintain the women's track as demonstrated in Durban

Women should take on more leadership positions in WONCA

List of participants

Name	Address and Email	Leadership in Family Medicine	Area of Interest
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Ylva Tomson	S:t Eriksg.73 S-11332 Stockholm Sweden ylva.bo@chello.sa	Clinical manager of a health centre, senior lecturer at mist of Family Medicine- Karolinska Institute Stockholm	Leadership development, caring for patients
Sherine Nasr EL DIN	Egypt. Cairo Maadi. Ol-hman Towers Nis Flat 172 Shero81@hotmail.com	Lecturer of Family Medicine, Central supervisor in the Egyptian Family Medicine project in the Ministry of health & population.	Leadership Skills, Training& Education public health
Gertraud Rothe	Sternwartestrasse 6 A-1180 Vienna Austria gertroud.rothe@univie.ac.at	Lecturer at the University of Vienna (Family Medicine) President of the Viennese society of general practice/ family medicine	Teaching, personal development
Lisbeth Errebo-Knudsen	Nordlundevg50A. 4913 Horslunde Denmark Lek@dadlnet.dk	CME facilitator in Storstroems County, DK	Research Training
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Barbara Doty	bdoty@alaska.net Alaska, USA	Ass. Director of Rural Affairs Alaska Family Practice Residency	Women in Rural practice Need for input for WONCA, Working party- Rural re: Policy on women Physicians in Rural practice
Miriam MogoHhong	PIBagx24 Vryburg 8613 Fax 0539270009	Assistant Director PHC Nurse Training	Women in leadership position
Sonia V. Roache-Barker M.B.B.S.	Svr.ccfp@trinidad.net or alacab@trinidad.net	1) Executive director and post president Caribbean college in family physicians (CCFP) 2) Medical director/Superintendent waterfront clinic @ Trinidad and robaro port authority	-Domestic violence -Gender Related -Health Behaviour Changes -Choices -Spirituality and gender -Women in leadership but members of TEAM -Gender- Equality
Margareta Larsson	margareta.k.larsson@lvn.se	Used to be chief of general practice	Education
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Naomi Arnheim	77 Craighall Rd. Victory Park Johannesburg 2195, R.S.A. pblieden@iafrica.com	Chairman, Johanneburg branch Academy of Family Practice. 1 st Woman council member and 1 st executive member	

Bitty Muller	170 Main St. Alrewas, Staffs, UK. DE137ED bitty_shake@compuserve.com		Women in medicine
Sarah Shrasser	S.Shrasse@acrrm.org.au	Nat. Med. Advisor to Acrrm (1 st) Nat. Dir of Rural Training (2 nd) Aching E.D. rural (1 st) prev. Sen lec Monesh Uni- rural aboriginal and gender curriculum	Leadership and managerial especially leading charge rural, aboriginal, human rights/gender
Ineke Dolmans	dr.dolmans@dufrasres.com	Member of regional committee owning my private practice being a trainer for g.p.	Being a member of the council
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Modupe Ladipo	GOPD, UCH, Ibadan, Nigeria mladipo@skannet.com	Head of Dept. of Fam. Medicine Faculty secretary Post Graduate Studies in Fam. Medicine	Medical Education Women in Medicine and Academics
Barbara Lent	Victoria Family Medical Centre 60 Chesley Ave London, ON N5Z 2C1 (519) 433-8424 blent@uwo.ca	Associate Professor, Dept. Family Medicine, University of Western Ontario	Women's health, gender issues
Khaleda Islam	Centre for Medical Education Mohakhali, Dhaka-1212 Bangladesh khaleda@bdcom.com	Assistant Prof. Centre for Medical Education Trying to introduce F.M. in undergraduate and Post graduate Med. Education in Bangladesh	Reproductive Health and Prevention of Violence Against Woman in F.M.
Zorayda E. Leopanda	dada.wonca@pacific.net.ph	Asst. Prof and Chair Dept. of Family and Comm Medicine, PGH-UP college of Medicine Founding president- PSTFM Past president, PSFP RVP for Assistant Pacific Woman 1995-2001	F.M. Education Quality Assurance in F.M.
Thembi Maleka	themnim@mhs.co.za	Council Member in S.A. Academy of Family Physicians Head of Women's Health Task Group Academy of Family Physicians	-Women's health and woman doctor issues -Leadership development
Marietjie de Villiers	mrdv@gorga.skin.ac.za	Chair SAA Academy of Family Practice/Primary Care	Leadership development, role model development.
Cheryl Levitt	clevitt@mcmaster.ca	Professor and Chair Department of Family Medicine McMaster University Hamilton Ontario CANADA	Leadership development, mentoring

Sylvie Lo Fo Wong	slofowong@chello.nl	Wolphaerrtsbocht 109 3082 AG Rotterdam Netherlands	FP Researcher Dept Women's Studies Medicine Education: Gender Health Issues -Intimate Partner Abuse and the role of the Family Physician -Gender specific approach in medicine -Women's Health Issues - Training of family Physicians
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INTERNATIONAL SURVEY OF WOMEN AND FAMILY MEDICINE

INTERIM RESULTS, OCTOBER 2004

INTERNATIONAL SURVEY OF WOMEN
AND FAMILY MEDICINE
Interim Results, October 2004

Objectives

To survey women in many countries about the main challenges in their countries to training and practicing in family medicine, women's participation in academic family medicine, leadership in family medicine, and their feelings about the helpfulness of family medicine organizations.

Methods

The method used was a semi-quantitative self-administered survey of a convenience sample of groups of women in various family medicine departments and organizations. Women were physicians,

registrars, non-physician researchers, medical students, and residents.

Setting: Women in the following countries have been surveyed to date: Canada, United States, Australia, England, Ecuador, Philippines, Nigeria, Latvia, Ireland, Netherlands, Norway, and Argentina.

Survey Administration: Groups of women collectively completed the surveys, as the intent was for answers to emerge from group discussions. They were surveyed at national family medicine conferences and international regional WONCA meetings. In addition, women completed the survey at other meetings and individually. The survey is posted on the WONCA website.

Respondents were asked to identify the three major barriers they believe to be

facing women in family medicine in 1) practicing, 2) training, 3) academic careers in family medicine, 4) leadership in family medicine, and three ways in which their national organization has been helpful, or have hindered addressing the challenges.

Results

Fourteen groups of women were surveyed, with the number of respondents ranging from one (one group) to 15 per group.

Overall Themes (early and preliminary summary of findings)

Challenges that were mentioned in all settings (practice, training, academics, leadership) were family responsibilities, male domination in the profession, discrimination and intimidation by men and sexual harassment.

Women *in practice* noted the general issue of lack of recognition of family medicine by other specialties. They reported feeling that their gender was related to changing practice styles towards more psychosocial and preventive issues in family medicine, suggesting that women perceived themselves as having strengths in these areas. Women reported that that these needed changes in the emphasis of practice are not recognized by the male-dominated profession.

Additional specific challenges mentioned for *women in training* in family medicine were lack of resource materials, training being focused on men, the rigidity of training schedules, and difficulty in completing training in rural areas due to responsibilities at home and safety and accommodation concerns.

Specific challenges noted for *academics* were different than those mentioned for

practice and training. They included lack of financing, lack of an academic department entirely, a shortage of women teachers and mentors, financial disincentive, and the location of academic institutions normally being in larger urban centers which are not easily accessible to everyone. Additional, more personal challenges were mentioned such as women's lack of confidence in academic activity, feelings of being 'invisible' leading to assumptions that women do not do research, expectations that women will only work in areas of women's health, and pervading gender roles. One respondent group noted that in academics women must be "Margaret Thatcher with a stethoscope".

Leadership for women in Family Medicine appeared to be a much less developed area. Challenges included lack of exposure or opportunity, critical numbers and identity, and the perception that current male dominated leadership models are not based on skills or competency. It was noted that women felt lack of interest in leadership, possibly because they are not taught the "power skills" that are more often associated with male leadership.

Institutional factors mentioned included lack of institutional respect for women, lack of female role models or mentors, the presence of an established hierarchy that is not based on skill. Problems with Family Medicine *organizations* in addressing these challenges were noted and included lack of representation for women in organizations, organizational politics, lack of funding, and lack of linkages between women to support and promote each other. On the other hand, there were some positive reports of Family Medicine organizations; some respondent groups reported that women had been accepted into associations of

Family Medicine, support for research in women's issues was present (note that assumptions that women only do women's health was seen as a barrier), explicit policies on gender equity are in place in some organizations, recruitment appears in some organizations to be based on quality rather than gender, lobbying by women's groups has been successful, and there has been support from organizations such as AAMC and STFM.

The following section summarizes the themes found in the surveys.

Major challenges facing women in medicine

- Conflicting family commitments
- Absence of institutional respect, support (ie. child care, maternity leaves, high cost of child-care) and rights for women physicians, some specifically in rural areas
- Inequitable financial resources and compensation for men and women and between specialties
- Competition and lack of acceptance from men colleagues
- Lack of recognition and respect from patients and society
- Changes in practice styles and structure of health care system
- Recognition of specialty by other disciplines
- Lack of part-time opportunities for women with children/household responsibilities
- Perception of lack of prestige in family medicine, fewer skills required, therefore "perfect" specialty for women
- More complex problems presented to women doctors (Netherlands)

Major challenges facing women in training

- Gender bias, intimidation, discrimination and sexual harassment
- Conflicting family commitments or child rearing
- Absence of institutional respect, support (ie. child care, maternity leaves) and rights for women in training
- Limited women mentors and role models
- Accessibility of training in rural locations
- Financial and resource constraints, insufficient funding for flexible training
- Time constraints and rigid schedules
- Lack of part-time posts

In some cultures, expectation that women will leave training and career when children are born

Lack of ambition/drive- societal shifts towards focus on 'rights' away from 'responsibilities'

***Latvian women feel they have a very flexible program on the whole*

Major challenges facing women in academic medicine

- Male dominance in field
- Time restraints from balancing multiple responsibilities. ie. research, teaching, clinical, etc.
- Rural locations
- Lack of part-time appointments
- Financial and resource constraints, poor pay
- Gender role stereotypes and sexual harassment
- No academic department of family medicine
- Lack of teachers/professors
- Lack of confidence
- Emphasis on publication productivity
- Inequitable pay
- Assumption that women work in women's health
- Assumption that women "don't do research"

***Latvian women feel they have equal or better opportunities than men*

Major Challenges Facing Women in Leadership

- Culture not accepting of female leadership
- Male dominance in field resulting in a lack of women at higher ranks
- Traditional concept of leadership role
- Men not open to being under direction of women
- Less opportunity for leadership training and development of skills and women not chosen for this training
- Lack of identity and autonomy
- Lack of interest of women for being "in power"
- Tokenism
- Low financial compensation

***Latvian women feel they have equal or better opportunities than male counterparts*

Helpfulness of national family medicine organizations

Yes = 3

- recruitment and acceptance into institutions and faculties as equals
- establishment of policies for gender equity
- advocate issues important to women physicians

function as support system
 support of organizations (AAMC,
 STFM)
 concerns are being listened to
 No = 5
 insufficient numbers and
 cohesiveness to address issues
 lack of funding
 no organization specifically for
 women family physicians
 national organization gender
 neutral and male dominated
 Yes and No = 3

Familiarity with WONCA

Yes = 4
 Somewhat = 5
 No = 2

Variation in Themes by Country

An exception to the general response themes was the Latvian group of respondents who did not indicate as many barriers as the other groups. These respondents noted that women have equal or better opportunities compared to men in academic family medicine, and that training was very flexible to allow for childbearing, although this may interrupt and prolong training.

Responses from groups of women in Nigeria were compared to those from the developed countries. Challenges common to all countries were family responsibilities, male domination and gender discrimination, and lack of mentors. The status of women in society was much more an issue in Nigeria than in the developed countries. Issues of lack of confidence, alienation, and tokenism in leadership mentioned by women in developed countries were not even mentioned by Nigerian women, since their biggest challenge was to overcome the cultural expectation that women should not be in leadership. This was similar for challenges in academic family medicine. In practice and training, women in developed countries mentioned lack of flexibility and differences in

earnings, whereas Nigerian women noted lack of female family physicians, lack of acceptance of women as doctors by society, and training focused on male patients. Only women in Nigeria mentioned the issues of safety and travel difficulties for training in rural areas. This may be due to the religious and cultural views towards women traveling away from home without their husbands or family members. Most of the problems of Family Medicine organizations in addressing challenges were noted only by Nigerian women, specifically lack of organizations, organizational politics, and lack of encouragement and recognition of women. However the Nigerian women also noted some acceptance as equals in associations (see Table).

Working Group Questionnaire: Working Party on Women and WONCA Preliminary Analysis – Regional Themes from Questionnaires 1-14

SURVEY RESPONSE:	NIGERIA	OTHERS	LATVIA	ALL
Practicing Family Medicine				
Family responsibility	X	X		
Domination by men	X			
Lack of women family physicians	X			
Lack of acceptance by society/patients	X			
Lack of flexibility		X		
Lack of valuing women's work practices		X		
Differential in compensation		X	X	
Difficult work hours			X	
Training in Family Medicine	NIGERIA	OTHERS	LATVIA	ALL
Family responsibilities	X	X		X
Gender bias/discrimination	X	X		
Outside/rural postings	X			
Difficult hours/rigid time schedules				
Training focused on male patients	X			
Lack of women role models		X		
Hostility to family medicine in institution		X		
Academic Family Medicine	NIGERIA	OTHERS	LATVIA	ALL
Male domination/harassment/ discrimination	X	X		
Multiple responsibility/family gender roles	X	X		
Financial shortage/resources	X			
Lack of teachers/mentors	X	X		
Pay less than clinical		X		
Lack of voice for women		X		
No academic Dept of Family medicine	X			
Culture/discrimination against women	X			
No challenges			X	
Leadership in Family Medicine	NIGERIA	OTHERS	LATVIA	ALL
Culture/women should not be in leadership role	X			
Family demand	X	X		
Lack of mentorship		X		
Women lack confidence		X		
Tokenism/alienation		X		
Role limitations "old school" views of women		X		
Financial disincentive		X		
No challenges			X	
Family Medicine Organizations Helpful?	NIGERIA	OTHERS	LATVIA	ALL
NO	(4 no, 1 yes)	(4 yes, 3 no)	(0 no, 1 yes)	
Lack of organizations, do not address women's concerns, academic policies, do not encourage women	X			
Hostile to women's health issues like abortion		X		
Male dominated		X		
Lack of gender equity policies		X		
Lack of communication/recognition- absence of forum	X			
YES				
Been accepted as equals in associations	X			
Funding support		X		
Women's health issues funded in research		X		
Policies on gender equity/flexible training etc		X		
Efforts being made by organizations			X	
NB: The "others" category includes Australia, Austria, Philippines, USA, South Africa, England and Canada , Ecuador, Ireland, Netherlands, Norway, and Argentina the "both" category includes Australia, Austria, Philippines, USA, South Africa, England, Canada, Ecuador, Ireland, Netherlands, Norway, and Argentina, and Nigeria * Not all groups answered all questions				

EXECUTIVE SUMMARY OF LITERATURE REVIEW/MONOGRAPH

OPPORTUNITIES AND CHALLENGES FACING WOMEN IN FAMILY MEDICINE: A FRAMEWORK FOR FUTURE PLANNING

The following summary was developed as a framework for review of the literature on the challenges and opportunities facing women physicians in family medicine. The principal authors developed it after the 16th WONCA International Conference in Durban, the Women's Leadership Workshop at the Women's Track at WONCA 2001, extensive informal and formal discussion with experts, as well as with members of the Working Party on Women and Family Medicine and their list serve. Each topic has been further developed into a monograph/literature review after examining the relevant international English-language literature. The literature review/monograph is limited by the authors' cultural backgrounds and by the geographic and language bias of the literature; in addition, some of the articles may be somewhat outdated.

Introduction

Across the life span, across professional development, across national boundaries, women in family medicine have demonstrated remarkable resilience in facing the enormous challenges involved in this career choice. In many settings, the persisting social image of a physician is a male, even among physicians themselves. Nevertheless, women increasingly choose to become family physicians and report great satisfaction in their career choice.

I. Women In Training (Medical School And Post-Graduate Training)

A. Gender Bias in Medical Education and Research

Medical training focuses on male examples and values, and tends to over-emphasize the reproductive aspect of women's health to the exclusion of other aspects of health

Much research in previous decades has excluded female participants and has assumed that results of studies in men can be universally applied to women

B. Factors in Choosing Family Medicine

Presence of role modeling- women may choose family medicine where there is more role modeling by women compared to other specialties

Stereotyping in every culture may limit the career choices and scope of practice considered by women trainees and offered to them

Family medicine is regarded as less prestigious than other specialties

Potential ability to focus on maternal and child care and the underserved may attract women towards certain career choices

Women consider their spouse's career when making their career choices

It is believed, although there is no empirical evidence, that difficulties of coverage and call may discourage women planning to have families from practicing comprehensive primary care

Potential income: women family physicians earn less money than male family physicians, yet work more hours when counting professional, household and parenting chores
Shorter training period in family medicine is appealing to women

C. Training for Rural Medicine

Rural physicians perform a greater breadth of activities because of the lack of specialists in rural areas.
Rural physicians work longer hours than those in urban areas
Flexible training is required to ensure that adequate skills in a wide variety of areas can be obtained by rural physicians, particularly women rural physicians

Harassment in training

Occurs in a variety of different training settings from a variety of different sources, including patients, peers, supervisors, attending physicians
Harassment is present in family medicine as in all other training programs
Females are much more aware of the existence of sexual harassment in medical training than their male colleagues
Sexual orientation is a target for sexual harassment and discrimination

E. Medical marriages offer unique challenges and opportunities to women in family medicine

Possibility of shared practice
Possibility women may become the part-time practitioner in future
Women in dual physician marriages may take on more stereotypically feminine roles in the home, compared to women physicians married to other professionals

F. Parenting during training

Varying flexibility of schools to accommodate maternity leave, breast feeding, child care
Varying flexibility for delaying training in some countries, varying medical insurance and maternity benefits, varying child care in undergraduate and postgraduate training programs
Potential for shared training positions for trainees who are parents.
High degree of stress while pregnant during demanding rotations, faced with an unsupportive environment from peers and supervisors if unable to fulfill all usual training obligations.
Increased risk of obstetrical complications for the resident in countries with minimal flexibility in their medical training

G. Cultural and class issues for women of racial, ethnic or class origins different from majority physicians

Discrimination towards women of minority groups lead to increased pressure and stress for these women who are working in a predominantly white medical establishment
In US, affirmative action policies have been implemented in order to enhance diversity. Suggestions for community education, targeting young women in math and science and implementing strategies for more open communication within medical schools are discussed.
Training requirements may not be compatible with cultural restrictions on women's mobility
Cultural restrictions may not support un-chaperoned exposure to male patients

II. Women In Practice

A. General Overview

Women in family medicine practice experience stereotyping and practice in a variety of settings in developing and developed nations.

B. Sexual Stereotypes

In most countries professional choices are influenced by traditional, cultural and religious attitudes and stereotypes.

Women in medicine are turning the profession into a 'pink collar profession'

C. Attitudes, Policies and Practices

Most literature from North America, UK, Australia, but some from Iran, Philippines, Mexico, South Africa, Israel, Egypt and some countries in Central and Eastern Europe (the former Soviet Union)

The numbers of women physicians entering the field of medicine in many countries is increasing

Low prestige of medicine in countries where majority of physicians are women

In some settings women's health is regarded as a gender based activity, and women in family medicine are relegated to doing only women's health

Discrimination of women physicians and cultural restrictions on practice opportunities

Cultural restrictions on women's mobility and activity may limit practice opportunities and scope of practice

Practice characteristics between men and women differ

Women choose different medical specialties for careers

Women choose more flexible working conditions and more options are needed

D. Marriage and Parenting

Women shoulder double responsibility for home, children, and professional work;

Women married to other doctors work fewer professional hours (Canada)

Part-time women feel excluded from decision-making (UK)

Part-time women feel financially penalized, excessive workload (UK)

Maternity leave options are helpful but cause special challenges: loss of income, interruption of careers, locums etc.

E. Lesbian Women Physicians

Lesbian physicians must make difficult choices between facing discrimination on one hand, and alienating patients and colleagues on the other, when deciding to reveal their sexual identity

Homosexual discrimination remains a large problem in the medical community

Lesbian and gay health professionals have formed organizations to support one another and influence policy and attitudes

F. Rural Medicine

Shortage of physicians

More challenging working environment

Isolation, lack of social network

Lack of options for work for women's spouses- women graduates more likely to choose urban sites to accommodate spouses' career choices and job options as well as family responsibilities

Attitudes of rural communities can be hostile to women physicians
Need for strategies to address recruitment of women physicians to rural settings

G. Complex Hierarchical Relationships with Nurses

Women physicians often felt that they obtained less assistance from nurses than their men colleagues

Women physicians often felt that they obtained less assistance from nurses than their men colleagues

III. Women In Academia

A. General Overview

There are many women entering academic family medicine
However, most are located at the lower rungs of the academic ladder

B. Status, Promotion and Tenure of Women Faculty

Women more frequently have lower academic rankings compared to men
Many women faculty are part-time, leading to complex issues surrounding promotion

Tenure difficulties for faculty with family responsibilities or part-time status

Increased attrition rates of women faculty compared to men

Lower publication productivity of women academicians

C. Gender differences in compensation

Women earn less on average than men, even at the same level of productivity

Women may not value a high income to the same extent as men, and be less aggressive in demanding higher remuneration

Even small salary increases can result in significant increases in morale

D. Gender Bias in competitive evaluations

There is some evidence that women must be more productive than men to be perceived as equally successful

Some studies show that women reviewers of manuscripts tend to favor women authors

Women fellowship applicants were shown to be less successful in one study compared to men, however their background of fewer high impact publications may have accounted for this

Women clinical supervisors may be seen as less competent by residents than men supervisors

E. Role models and mentorship

Importance of mentorship is well accepted

Women report difficulties finding a suitable mentor- female or male

Women may be better able to relate personally to a woman mentor who has experience with dual career/family roles

Women report dissatisfaction with mentorship relationship more often than men

Qualities of kindness and approachability in a mentor may be more important for women than for men, and this may affect the relationship

F. Research career

Academic women spend more time on teaching and clinical work, and less on research and administration compared to men

This may be due to less grant support, institutional funding, and protected time among women faculty
The topics that often are of interest to women researchers (e.g. issues of women's health) are often marginalized
Grants have specific time frames and are not flexible for parental leave or part-time work

G. Lack of Institutional Support

Academic medical institutions created to support men with full time help at home.
After hours meetings and weekend obligations exclude some women from important information and networking

H. Women in academic administrative leadership

Lack of women in academic medicine leads to small number for academic leadership
Women leaders may experience isolation
Women in junior ranks feel that women leaders are 'superhuman' and may be discouraged from seeking leadership
Men may be reluctant to be supervised by a woman
Work may be devalued if a woman is granted a leadership position to fill an 'affirmative action' quota

I. Family Responsibilities

Academic career often requires long and variable hours of work
The implicit expectation that after-hours work is routine, conflicts with women's family and personal priorities
Women physicians are often married to other physicians or professionals with busy careers
Women experience slower career progression compared to men due to family priorities
Women choose part-time status in academia to accommodate family responsibilities, but part-time status is perceived with less respect
Like all working mothers, academic women physicians require maternity leave provisions and child care

J. Sexual harassment, gender discrimination and stereotyping

Gender bias, discrimination and harassment in academia may set a poor example for trainees
Women in academic medicine report experiencing more sexual harassment and discrimination than men
Although institutional policies have led to declines in harassment in some settings, there are still higher levels of sexual harassment and gender discrimination reported in academia than in the community
Women more often than men report informal networking that excludes them
Women are expected to exhibit traditionally feminine qualities such as kindness and nurturing, yet by being so, they are seen as less assertive and ambitious
Women often feel unwelcome in their relationships with men in academia
Harassment, discrimination, and stereotyping are counter-productive to women's careers and can negatively impact on productivity and costs to the profession

K. Culture and class discrimination

Women minority physician are drastically under-represented, leading to lack of representation of these groups

Minority faculty are less likely than white faculty to be promoted, even after controlling for tenure and productivity
Minority women faculty may experience isolation and have difficulty finding a mentor
Minority women faculty may face difficulties in research productivity

L. Tokenism

Over-burdening of women asked to participate in multiple tasks to justify political needs for representation

IV. Women in Organizational Medicine

A. Why women are under-represented in organizational medicine

- Balancing career and family - women with families often take on the majority of work in child-rearing, resulting in the inability to devote the extended hours to organizational commitments, especially when meetings take place outside regular work hours
- Women may not have the opportunity to develop leadership skills and may lack assertiveness in competing for these positions- in specialties with large numbers of women, there are more women leaders and vice versa
- Lifestyle choices and financial issues such as dues for organizations and lower pay for women compared to men, have been reported to be barriers for some women
- The lack of representation of women results in lack of role models and mentoring
- Women experience harassment and discrimination and opposition from the “old boys’ club” mentality

Importance of Women’s Contributions to Organized Medicine

- Women have different practice and communication styles than men that can benefit organizational medicine
- The presence of women in positions of power in public office brings more attention to the issues of women and children
- When women are well represented in high positions, women medical students are more likely to see that career as an option

Need for equal gender representation

- By increasing the representation of young women physicians, the organizations hope to significantly increase the level of gender sensitivity throughout their organization
- Recently women physicians in the UK have been calling for more recognition of the need to balance work and family, more flexibility in work hours and more women representation on committees
- Many organizations in North America are beginning to systematically include more women in organizational positions
- Many organizations are developing policies for harassment, equity, maternity leaves, and child-care
- Women need to be educated about the importance of belonging to organized medicine, and fully integrated and encouraged once they express interest
- Gender equality cannot be achieved solely by a focus on the problems of women, but must also change the attitudes of men and the public, with respect to assumptions that professional leadership leads to long hours, sacrifice of personal life and stereotypes of managerial style

Development of women's caucuses and projects

- The International Medical Women's Association has been in existence since 1919 and has 70 member countries from 5 continents
- A few country specific examples: Women in Medicine project of American Medical Association (AMA); Women Physicians' Congress of AMA; annual leadership conference for women in medicine, Canadian Medical Association; American Academy of Family Physicians (AAFP) committee on Women in Family Medicine; Committee to increase women's leadership in academic medicine (Association of American Medical Colleges); Medical Women's International Association
- Also several specialty-specific associations for women physicians (e.g., radiology, surgery, ophthalmology, dermatology, endocrinology, urology)

Conclusions

- There is reason to be optimistic about the increasing role of women in organizational medicine, as their strengths have the potential to bring positive changes for the profession and for women's health
- Substantial changes in the current ideology may be required for women's contributions to be fully realized

V. Women Family Doctors Caring For Themselves And Their Families

Physical health

Women report high health status compared to the general population

Women report healthier lifestyles as compared to men physicians; decreased use of alcohol and tobacco, better exercise and sleeping habits among women physicians compared to men physicians in some countries

In some studies, women physicians report more chronic health problems and increased use of health care system compared to men

Mental health

Women physicians might experience a higher level of psychological distress than men, for example, they might react to events such as divorce or illness in the family with greater distress than men physicians

Sources of occupational stress

Despite many stresses women experience high work and life satisfaction – “paradox of the contented worker”

Women's personality traits are a source of stress (for example, a strong sense of guilt, chronic self doubt and an excessive sense of responsibility)

Workplace politics (competitiveness, power politics, loss of autonomy, workplace hours, drive to out-perform men, lack of role models, discrimination, etc) are a source of stress

Marriage and childrearing are both a source of stress and of support for women physicians

85% of women physicians marry other professionals; 50% to 60% marry other physicians

Women physicians are more likely than male physicians to be single or divorced when compared with their male colleagues

Disagreement as to whether dual-physician marriages are successes or failures, although some studies show a lower divorce rates in physician marriages

Many challenges face married partners in physician marriages (i.e. competition); but studies have shown that a supportive relationship with one's spouse contributes to the female physician's well-being

In spite of challenges, women physicians report higher levels of satisfaction with work and life; possibly due to different career expectations and values, greater interest in intrinsic versus extrinsic rewards, etc.

Burnout, depression, substance abuse and suicide

Increased risk of burnout among women physicians as compared with men physicians, often resulting in negative coping mechanisms
Higher frequency of depression among women physicians when compared with men physicians and the general female population
Higher suicide rates among women physicians as compared with the general female population
Lower likelihood of substance abuse problems when compared to men colleagues
Knowledge of elevated rates of depression and suicide may increase awareness and assistance, but may also lead to more discrimination against women physicians
The atmosphere encountered during medical training and practice (lack of flexibility, competitiveness, power politics, discrimination, etc.) can pose a special challenge to women physicians; becoming a physician requires overcoming many systemic social barriers (harassment, discrimination)

Implications for health care

Women physicians' personal lives appear to determine the organization of their professional lives, and may have consequences on the planning and distribution of medical resources and services
Health care administrators must allow for flexible work schedules, part-time practice, and non-traditional on-call arrangements

VI. Women Family Physicians In The Doctor-Patient Relationship.

General Overview:

Women's professional attitudes, conduct and practice patterns differ from those of men physicians in some countries

Practice Patterns: Prevention and counseling

Prevention

Studies suggest women physician place greater emphasis on preventive care

Counseling

Studies suggest women physicians place a greater emphasis on counselling and health education

Relationship with specialty

Some studies suggest that female physicians in other specialties have similar practice patterns to those in family medicine

Social attitudes

Some studies report more liberal social attitudes and more awareness of social determinants of health among women physicians

Patient population

Women physicians attract more women patients to their practices
Women physicians provide more gynecological, obstetrical, and other women's health care than men physicians; in some cases even in spite of working fewer hours

Women patients tend to prefer women physicians for female-specific health concerns

Women physicians see different kinds of children for different visit purposes
A consequence of this may be that women physicians may have limited exposure to men's health issues

The Medical Encounter

Communication and practice style

Women physicians are more likely to spend more time in consultations and offer more support to their patients

Women physicians have been found in research to be more sympathetic to women

Women may be more comfortable with domestic violence issues

Women have been shown to perform fewer technical interventions and write fewer prescriptions

Studies suggest women physicians take a broader more interactive approach to patient care

There are other studies showing no difference between men and women physicians on these issues

Patient satisfaction

Studies show higher satisfaction with women physicians, especially for women patients

Women may self-select women physicians because they prefer more interaction and discussion

Sexualization of the medical encounter

Women physicians may be at greater risk of sexual harassment in the medical encounter with male patients

This may be more difficult to diffuse for women physicians since they often have women staff members

Activity levels

Studies of family physicians and general practitioners found that women billed more per patient encounter but provided fewer services compared to men

Providing counseling and health education may seem costly at the time but may prevent costly health problems in the long run

A feminist perspective on the medical encounter

The power imbalance between patient and physician may be exacerbated when the patient is female and the physician a man

Traditionally women's health and bodily functions have been medicalized and the male body has been seen as the norm

Women's health complaints are sometimes not taken as seriously

Women physicians can play an important role in addressing the power imbalance by providing understanding, counseling, information and tools for women to maintain their own health