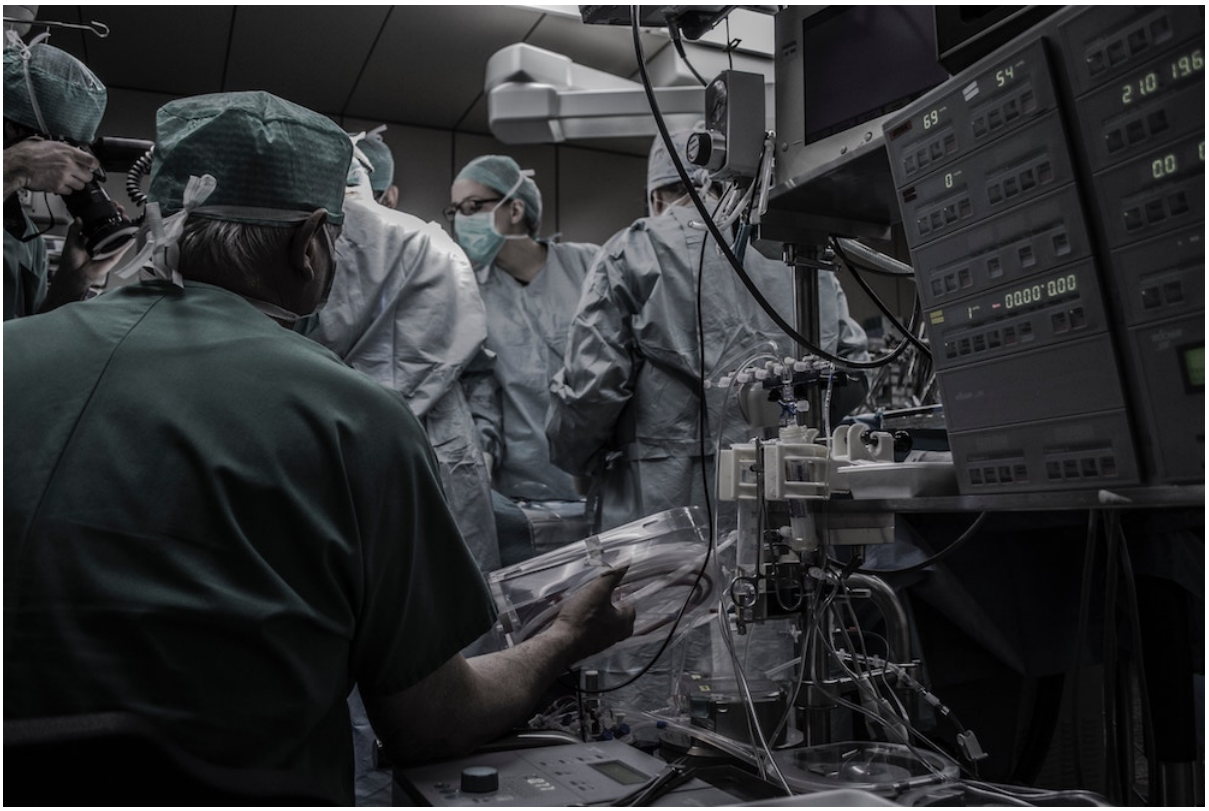
How Gender Discrimination Against Women Physicians Handicaps Value and Patient Care

written by Theresa Hush | February 28, 2019



We need to get women's health care right. This is not a parochial issue, important only to women, and disconnected from Value-Based Health Care. Gender disparity in health care is real, with significant ramifications for outcomes—for the patients, certainly, as well as for providers' ability to succeed under risk. Just as quality measurement is necessary to improving quality, achieving the triple aim of quality, cost and patient experience must include both measurement and elimination of gender and gender-race impediments.

ACOs and providers accept that they must help patients overcome social attributes of health if those patients are to improve. Yet gender and race are even more basic; genetic attributes determine risk for disease, its biology and appropriate therapies. Gender and race should be part of VBHC quality measurements and specifically tested in interventions for outcomes improvements.

The experience of women patients is one side of the issue. Interventions to improve women's health care must involve providers and be grounded in clinical research. Just as significant,

women physicians and researchers are dealing with inequities. Creating a physician-focused effort to resolve gender disparity can't be totally effective in an environment where those physicians are struggling with similar unmet needs.

Women Physicians are Undervalued, with Leadership Out of Reach

In theory, diversity in the workforce will reduce discrimination against the consumer—in this case, the patient. If so, shouldn't the higher number women physicians help improve care for women patients? Regrettably, there is no cause for immediate optimism, for a number of reasons.

First, only about a third of practicing physicians are now women, and they work fewer total hours, and predominate in only a few specialties—OB/GYN, pediatrics and plastic surgery, where half or more of the total volume of specialty physicians are women. Also, 23 per cent of women physicians work part-time, compared to 15 per cent of men.

Second, women are underrepresented in high-volume specialties outside primary care and specialties historically favored by women—such as cardiology, orthopedics, radiology and gastroenterology—among the highest income specialties. Depending on specialty, women earn 25 to 42 per cent less than male physicians after controlling for other factors, yet have higher expenses.

Third, women rarely make it to the leadership level in health care. In a special issue of *The Lancet* devoted to multi-faceted issues of gender inequity among women in health care, many women physicians cited the reality of family responsibility and childbearing decisions, along with sexual harassment and gender discrimination, as challenges to career advancement. In the larger context, states the journal, "the disparity in global health leadership negatively affects outcomes for women and children worldwide."

Those factors work to make women a less powerful minority in their workplaces and less able to wield influence over systems of care. But it also distances them from patient care in critical areas with significant gender disparities in disease presentation and outcomes: cardiac care, specialties focused on conditions with high levels of pain, and emergency medicine where women may first present for life-threatening or painful events.

Studies Indicate Women Deliver Higher Quality Care, with More Research Needed

Dismissal of symptoms, especially pain and other symptoms that are particular to women, is one of the biggest problems that women patients face. It is associated with misdiagnoses of heart attacks, delays in diagnoses for other conditions and even with the high maternal mortality rate in the U.S.

Numerous studies of pain dismissal highlight gender distinctions in the biology of pain and providers' failure to adequately and accurately perceive it. Providers generally perceive men to be in worse pain than women, even as women's pain is often a significant precursor to serious medical conditions. It's important to note that gender of "providers" is all-inclusive, and the distinct contributions of physician gender are not adequately studied. Review of physician gender by specialty raises questions about whether the composition of the workforce itself can contribute to gender disparities in care.

Aside from examining responses to pain, other studies have taken a stab at evaluating attitudes and gauging the influence of physician gender in patient care. One caveat: randomized trials have yet to be conducted that validate observational and retrospective data analysis about care and outcomes for women physicians. The surveys and other studies presented here represent the best information, to date; however, just as for gender-disparate outcomes in patients, rigorous research on the provider side is critically needed.

A significant pro-male bias towards taking risks with treatment was indicated in one survey of cardiologists. Several separate studies of women physicians delivering care for heart attack victims revealed better long-term results for women patients, regardless of higher risk profiles and poorer self-management of their conditions.

Additional studies reveal that women patients of women physicians may be more likely to receive preventive services, such as pap smears and mammography, than women patients of male doctors. According to another review of outcomes, female patients with Type 2 diabetes receive higher quality care from women physicians, including management of hypertension and cardiac risk.

Comparisons of hospital outcomes for patients (both men and women) seen by men and women physicians show lower mortality and lower readmission rates for patients of women physicians, regardless of disease severity. More evidence favoring patients of women physicians was revealed by data in other studies, including 580,000 heart patients admitted to Florida emergency rooms with better outcomes, and a John Hopkins study identifying women

as better communicators.

Finally, responses of women physicians to a Medscape survey indicated that women physicians spend more time individually with patients, and they put more emphasis on patient relationships and making a difference than male physicians. If representative, this could explain why women are assessed as having better communication with patients that contribute to improved outcomes.

Studies notwithstanding, results associated with women physicians are not without limitations. Physician selection by patient, quality of communication skills, workflow and many other factors go into physician-patient conversation and medical decision-making. Given the evidence of disparate outcomes for women physicians, however, there is a compelling case for serious research.

The Work Environment for Women Physicians Is Too Often Unsafe or Unhealthy

A recent survey of women physicians found that 10 per cent were harassed in the work settings, compared to 4 per cent of men. Nearly half of women physicians and a higher proportion of residents said that they were harassed by another physician, 97 percent of whom were men.

Most women who were harassed believed that the instance was trivialized by their employers. More than a third of harassed women physicians and residents considered quitting, and 14 per cent did. Even a large number of women medical students reported significant levels of harassment.

Beyond harassment, women physicians face higher levels of stress on many levels. The American Women's Medical Association reports that in a study at Kansas State University, 22 per cent of women physicians demonstrated emotional exhaustion, compared to 9 per cent of male physicians. Thirty per cent of women physicians, compared to 15 per cent of male physicians, met criteria for burnout. Issues that women associated with stress included interpersonal interactions, experiencing an "imposter syndrome" as a physician or feeling stereotyped, meeting gender expectations and sexual harassment.

Four Essential VBHC Strategies for Boosting Women Physicians

In many articles on VBHC, we have emphasized that key physician-related activities are the foundation for achieving VBHC: physician education, participation in a learning environment for data sharing and cost-quality improvement, and involvement in management of the change process. If the work environment is toxic or disadvantageous to women physicians, however, that is a major impediment to successfully implementing Value-Based Health Care and must be resolved as a priority. ACOs and providers must address fundamental issues of gender equity in order to create the ability to have agency with a large component of the workforce. Here's what to do first:

1. Demonstrate value for women physicians through better compensation and cultivating leadership potential.

Under financial risk, the incentives will change associated with physician skills. Communication, motivational conversation, data and relationships will be assets for better decision-making, patient outcomes and patient loyalty. Systematic wage discrimination only exacerbates the looming physician shortage and cannot continue. The investment in women physicians will have far-reaching effects on workforce morale as well as health system-physician partnerships.

2. Create a safe workplace.

Sexual harassment exists in all kinds of work environments, but surveys in health care environments clarify both the extent of the problem and the fact that it is not being taken seriously. Many businesses have been able to establish policies that safeguard the safety of the environment through training programs and leadership. Health care should be no exception.

3. Enable women to advance their careers by evaluating work flexibility, child care and other supports.

Attestations that women physicians will be equal partners are not believable without measures that improve the ability of women to work at full steam. While there will always be work-home balance issues for both men and women, employers must recognize that most women have a heavier burden for childbearing and childrearing, and help them manage it through needed flexibility and other options.

4. Work with physicians to eliminate gender disparities in patient care.

Help both men and women physicians improve their ability to elicit accurate and relevant information from patients. Providers can benefit from women physicians' experiences as patients and as physicians. Involve them in efforts to create better protocols for evaluating women's symptoms and biology of disease, and to develop physician education to implement those protocols.

Women in medicine can be powerful allies for change and a channel to improve gender disparity in patient care. ACOs and health care systems will achieve better VBHC results by creating a workforce that is equipped to identify and take on gender disparity in the delivery of care. Population health and improvement efforts should be designed to address recent findings related to disparate care. But in building trust with their own physicians, ACOs' and health care systems' first goal must be to remove the same kind of discrimination in the work environment.

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