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Feminisation of the South African medical profession – not yet nirvana for gender equity

The notion of feminisation of a profession signifies a variety of meanings. In much of the literature, a profession is feminised when women constitute the majority of its practitioners. However, Menkel-Meadow[1] identifies two other meanings: those who recognise certain attributes as uniquely feminine regard the profession as feminised 'when traits such as empathy, relatedness, nurturance and collectiveness are recognised, valued and expressed in the performance of professional tasks and functions'. Women purportedly impart these traits when they join a profession. Then there is the feminist premise that a profession is feminised not by stereotypic attribution of gender qualities, but when its practice and substantive rules adapt and change in such a manner that women who enter the profession do not have to conform to a male model of what it means to be a professional. This editorial considers feminisation of the South African medical profession from all three perspectives.

The increasing presence of women in the medical profession in South Africa has been confirmed in several studies. According to the 2007 figures (the latest available) on medical school enrolments, females now form 56.2% of overall enrolments, up from a minority of 49.7% in 1999, and the proportion of women graduating from medical school has increased from 46.6% to 55.1% during the same period.[2] In this regard South Africa is in line with global trends. In the USA, for example, women make up more than 50% of matriculating medical students and 25% of practising doctors.[3]

The foreseeable eventuality of women becoming a majority in the profession is generating angst in some quarters. Globally, women doctors work fewer hours in all age groups than their male counterparts, and take time off for child rearing. McKinstry *et al.*[4] fret that 'the rapidly increasing proportion of women in general practice [in Scotland] may lead to an increasing shortfall of medical availability in the future if current work patterns are maintained'. The feminist response might be that such work patterns should not be maintained, but should rather be adapted to be in harmony with the changing professional demographics, taking into account *inter alia* that women generally stay in the workforce longer and retire later in life.

Some worry about the impact of feminisation on the status of medicine. Citing the experience in former Soviet Union countries where medicine has long been dominated by women, and where the profession is generally regarded as a low-status occupation, some speculate that feminisation will lead to the erosion of the profession's prestige. Others, however, counter that medicine is feminising precisely because, for a complex set of reasons, the profession has already lost some of its gloss and has consequently become less attractive to men.

There is some evidence that the growing participation of women in the medical profession has a favourable transformative impact on medical practice. A much-cited paper by Levinson and Lurie[3] predicts notable changes in four domains: the patient-physician relationship, the local delivery of care, the societal delivery of care, and the medical profession itself. Studies show that female doctors are more likely than their male counterparts to engage patients as active partners in their care and to be sensitive not only to patients' biomedical concerns but also to their emotional and social concerns. Women are generally more likely to practise in primary care settings and to serve less advantaged populations. Women are changing the profession itself by forging new pathways to allow doctors – women as well as men – to balance career and family responsibilities.

Internal segregation

Yet gender equity within the profession remains elusive. Women have not achieved leadership positions in academia and professional societies, nor have they attained representation within the medical specialties, in numbers that are commensurate with their growing numerical strength. The proportion of women graduates entering specialist training remains much lower than that for men, with women trainees largely gravitating towards the less well-remunerated, so-called 'soft' primary care specialties such as family medicine, paediatrics and public health. In what has been called 'internal segregation', women remain under-represented in the male-gendered so-called 'hard' surgical disciplines.

Opinions differ as to why this is so. One view holds that 'the choice of a specialty depends on a variety of considerations that may be different for women, who often take family responsibilities and social roles into account, than for men'.[5] Such a choice is not necessarily free, but more likely reflects the human tendency to adjust one's desires to what is attainable. For the profession to become gender-neutral will require fundamental transformation in society and the profession.

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