Feminisation of the Workforce

Phillippa Poole BSc MBChB MD FRACP
Assoc Prof. in Medicine
General Physician, Auckland City Hospital

NORTH
Northern Regional Training Hub Ltd

a+ AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

The Royal Australasian College of Physicians

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Outline

Overview of trends

What are the issues?

Positives and negatives of a more feminised workforce

Future directions

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♀ medical students over time

Emily Siedeberg
1896

10% rule
1940s

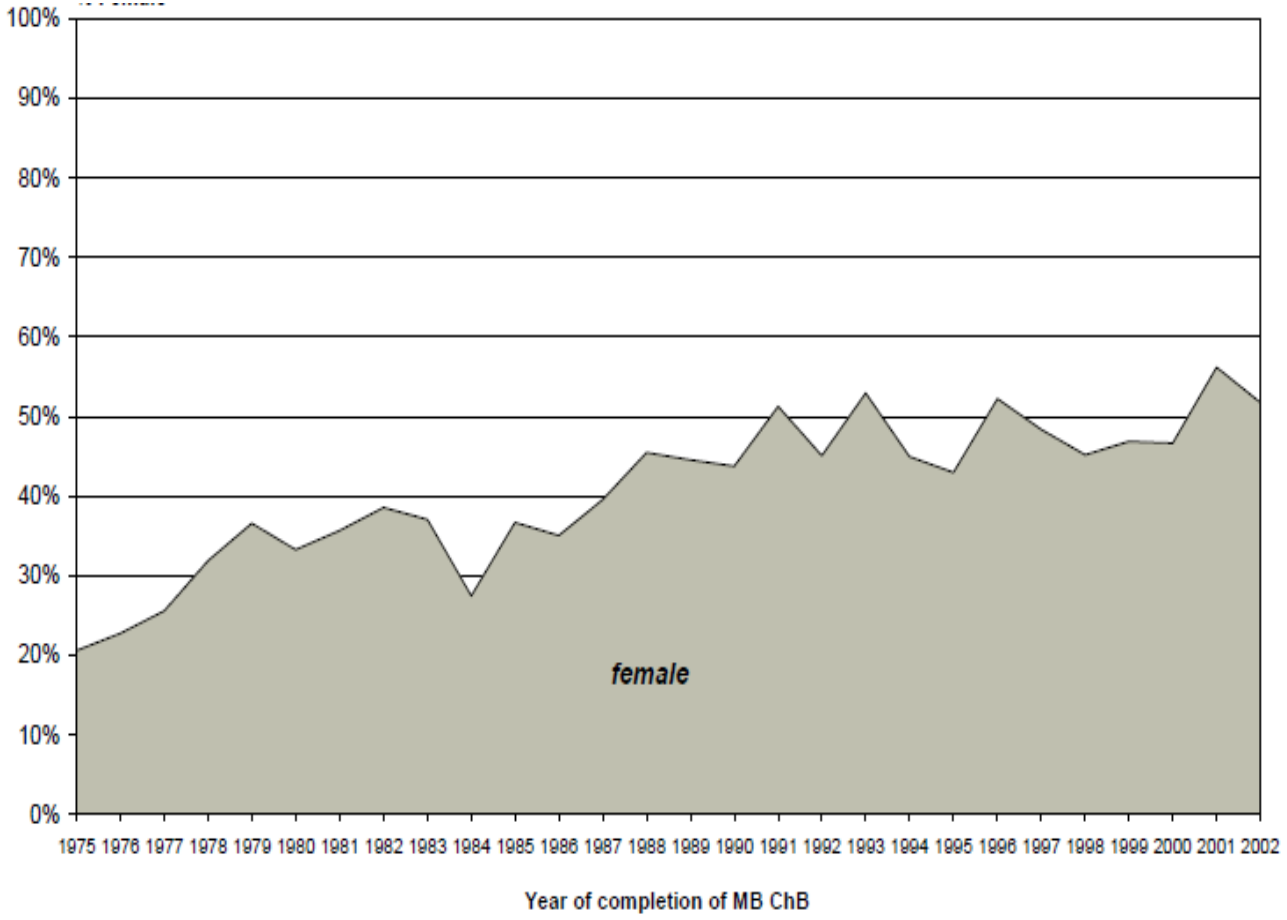

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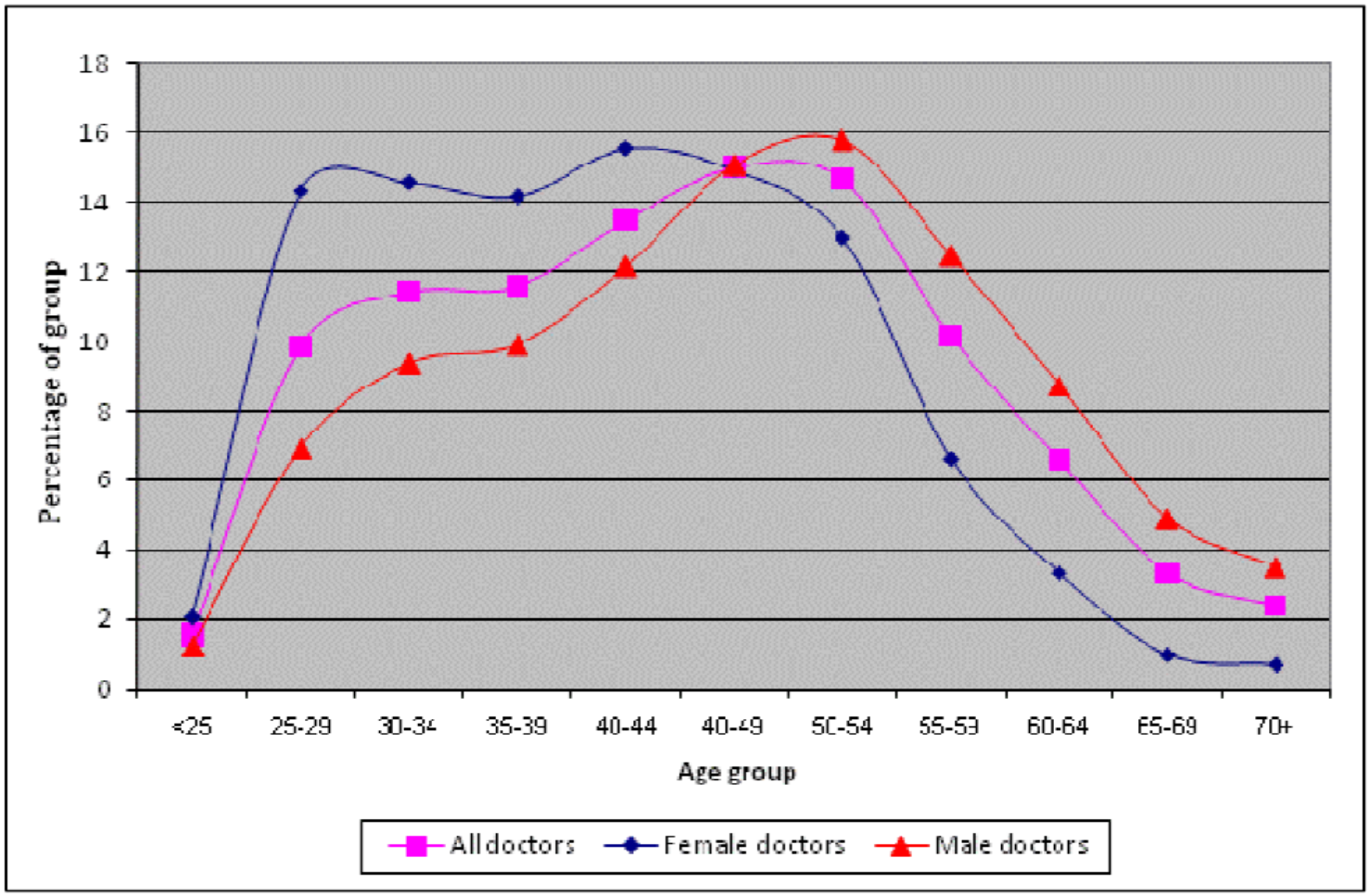
Figure 3: Age distribution of the active workforce by gender



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Reality of lives of medical women

- 75% of women doctors will have children
- child raising ~ training
- Most are primary caregivers
- Most parents work flexibly at some stage
- Practise fewer hours per week than men
- 25% live alone (c.f. 10% men)

Angell 1981
Poole and Lawrence 2001
Durham 1989
Dennerstein 1989
Sewell 2002

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Hours of work by age and gender

Gender	Age group											All ages, average hours
	<=24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69	70+	
Women	54.4	50.5	44.5	36.4	34.6	35.3	37.8	38.0	39.6	33.0	28.3	39.8
Men	54.7	52.6	50.6	48.4	47.5	47.2	47.5	46.1	43.8	37.8	27.5	46.6
Total	54.5	51.4	47.5	42.6	41.6	42.5	44.1	44.0	43.0	37.3	27.6	43.9

Women work about 7 fewer hours per week than men – gap is closing

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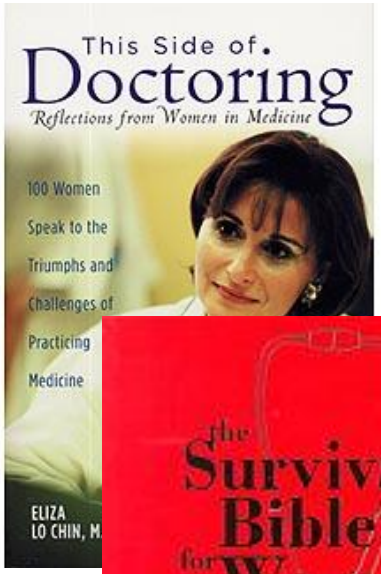
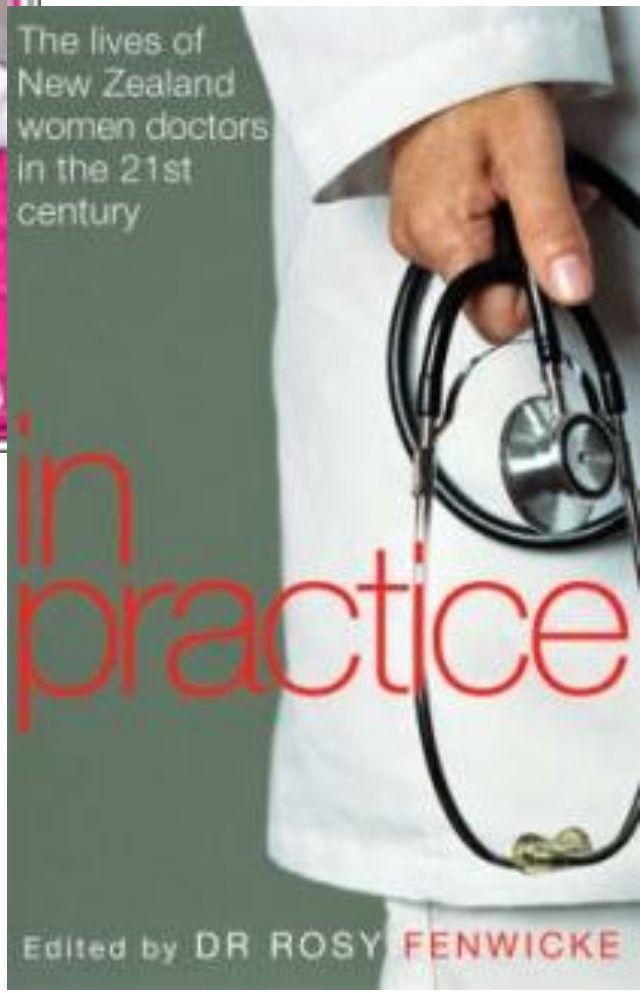
What's the issue?

Depends on perspective

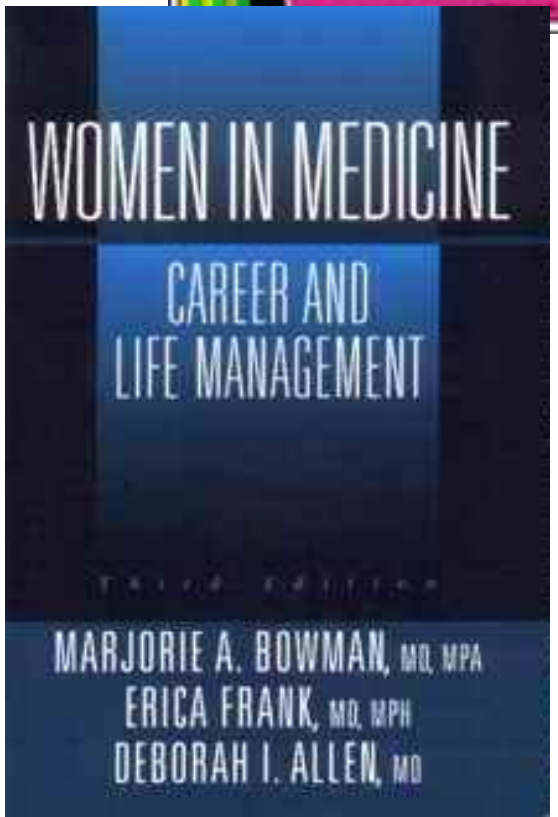
- Patient (access to a good doctor that suits them)
- Employer (filling jobs reliably)
- HWNZ (numbers of doctors and training pipeline)
- Treasury (cost-effectiveness)
- Woman doctor (no undue barriers to fulfilling career)

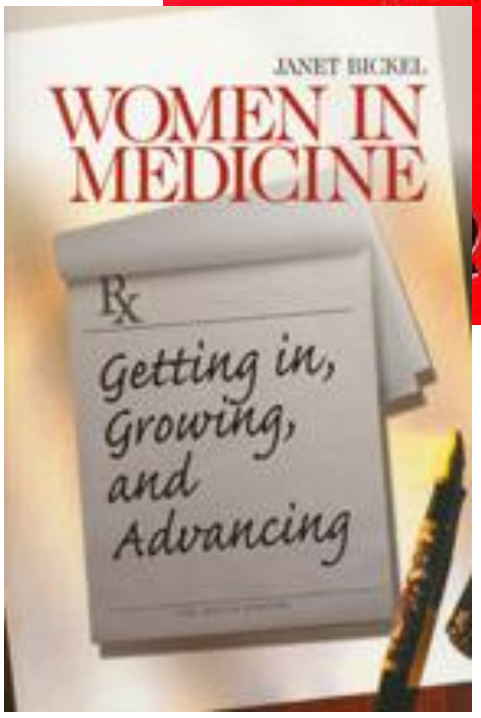

Leadership Skills for Women in Medicine


This Side of Doctoring
Reflections from Women in Medicine
100 Women Speak to the Triumphs and Challenges of Practicing Medicine
ELIZA LO CHIN, M


The lives of New Zealand women doctors in the 21st century
in practice
Edited by DR ROSY FENWICKE


the Survival Bible for Women in Medicine


WOMEN IN MEDICINE
CAREER AND LIFE MANAGEMENT
MARJORIE A. BOWMAN, MD, MPA
ERICA FRANK, MD, MPH
DEBORAH I. ALLEN, MD


JANET BICKEL
WOMEN IN MEDICINE
Rx
Getting in, Growing, and Advancing

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Influencing Factor	Mean	95% CI
Interest and enjoyment	7.7	7.57 , 7.83
Variety within job	7.1	6.92 , 7.28
Flexible working hours	6.6	6.31 , 6.89
Intellectual challenge	6.5	6.30 , 6.70
Compatibility with family responsibilities	6.5	6.20 , 6.80
Regular working hours	5.7	5.40 , 6.00
Opportunities to take time off	5.6	5.27 , 5.93
Encouragement from others to enter field	5.3	5.03 , 5.57
Ease of re-entry after taking time off	5.3	4.99 , 5.61
Positive experiences during undergrad training	5.1	4.81 , 5.39
Lack of ‘on call’ duties	5.1	4.76 , 5.44
Role models in general	5.1	4.83 , 5.37
Job security	5.0	4.73 , 5.27
Mentors	4.9	4.61 , 5.19
Women role models	4.3	4.02 , 4.58
Compatibility with partner’s job	4.9	4.59 , 5.21
Option of part time training	4.8	4.46 , 5.14
Lack of sexual harassment	4.5	4.21 , 4.79
Financial reasons	3.6	3.33 , 3.87

Lawrence and Poole 2003

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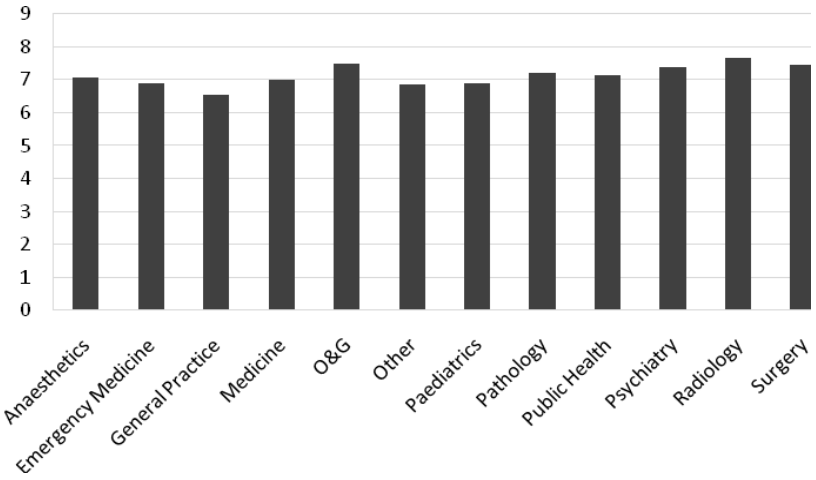
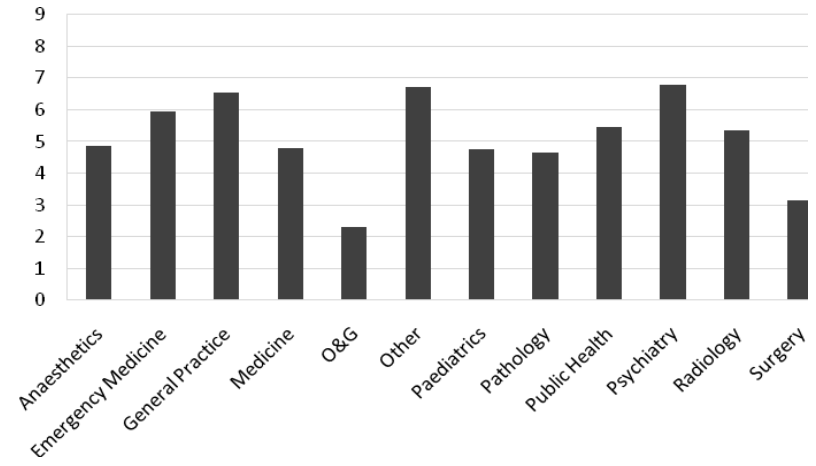
Flexibility varies by specialty



Interest



Flexibility

Lawrence and Poole 2003

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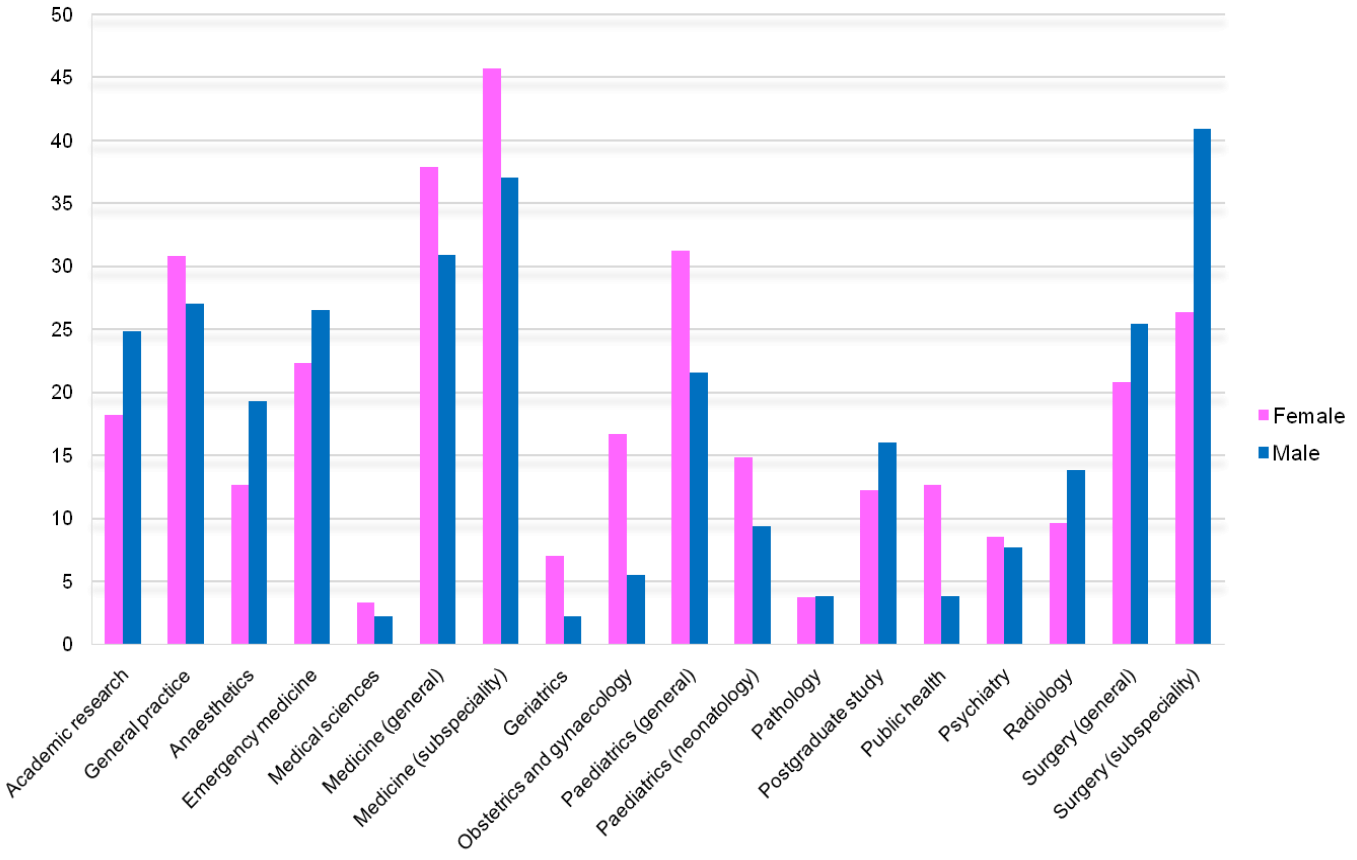
Student career interest by gender



Poole 2010 unpublished

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Proportion of Female Trainees

♀ **trainees under-represented**

general surgery (38%)
orthopaedic surgery (12%)
private accident and medical practice (24%)

♀ **trainees over-represented**

general practice (58%)
obstetrics and gynaecology (79%)
paediatrics (70%)
pathology (60%)
public health (69%)

40-50% anaesthesia, emergency medicine, internal medicine, and intensive care, psychiatry

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Medical women in NZ

Around 55% of undergraduate students

40% of the workforce MCNZ 2010

Still relatively few professors, Deans, national professional leaders







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Women 'segregated' horizontally and vertically in the medical workforce

Kilminster 2007

Table 12: Proportion of women by work role at main work site

	Percentage of women					
Role at main work site	**1980**	**1990**	**2000**	**2008**	**2009**	**2010**
House officer	32	44	47	56	57	59
Registrar	23	29	38	46	44	46
Medical officer	38	32	40	43	45	47
Primary care other than GP	49	42	43	43	46	44
Other	46	25	35	42	48	44
General practitioner	13	24	37	43	44	44
Specialist	9	13	19	26	27	27

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Effects of a more feminised medical workforce:

- The doctor – patient relationship
- Local delivery of health care
- Societal delivery of health care
- The medical profession itself

Levinson 2004

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Potential negatives

- Larger numbers of doctors required
- 'Lower' and slower career trajectories
- Fewer prepared to work rurally
- Fewer specialist FTEs in some specialties
- Fewer risk takers and innovators

Grant 2006

- Lowered "status" of medical profession

Black 2004

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Potential Positives

- More likely to stay in NZ — MCNZ 2001
- Workforce more likely to match health needs — Lakhan 2003
  - chronic disease management in teams
  - generalists - GP / gen med / geriatrics
  - public health
- More flexibility in training and working life for all doctors
  - Healthier doctor workforce — Lemaire 2010

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Society

- Valuing of all the roles required to achieve good health outcomes for NZs
  - Generalist specialists vs. Organ specialists
  - removal of perverse incentives
- "whole of career" research
- Availability of Child and Elder care near places of work

Deech 2009

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Education and Training

- Competency vs. only time-based
- More modular
- Training networks e.g. hubs
- Career and life advice
- Mentorship and tracking over “leaky” transitions

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Comparison of training programmes

	General Practice	Medicine	Orthopaedics	O & G
Name	GPEP	PREP	SET	ITP
Min. length (yrs)	2+ 1 + 2 =5	1 + 3 + 3 =7	2 + 5 =7	2 + 4 + 2 =8
Flexible	Yes	Yes – up to 8 years for AT	*No*	Yes, max 11 years
Min. time (FTE)	0.2	0.4	*1.0*	0.5
Move city?	No	Some	Yes	Yes

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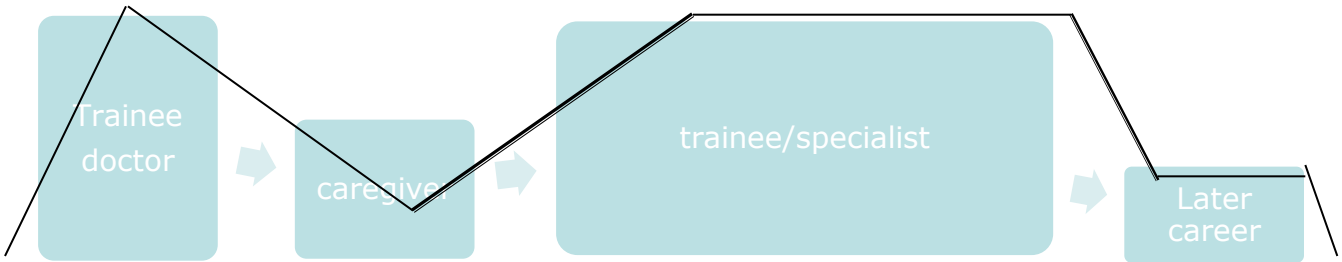
Employers / Workplace

1. More flexible work practices
   - Recognition, validation and management of "M" shaped career
     - support through interruptions
     - part-time / job-sharing / later entry / facilitated re-entry
     - quotas of career maintenance positions (?25%)



2. Support for women to lead

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Summary Points

1. Medical workforce is becoming more feminised
2. Women already shown fitness for future roles needed in NZ health system
3. Women's lives don't change much!
4. For women doctors to participate fully requires joined-up system thinking

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"No doctor should be wasted ...

because they cannot find a place in the system that is compatible with their other roles as a parent and partner.

We should make our goal a profession where every woman and every man goes as far as they wish and as far as their talents permit."

Baroness Deech; Chair of the National Working Group on Women in Medicine 2009