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Gender Inequalities in the Health Setting: The Case of Medicine*

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Gender Inequalities in the Health Setting: The Case of Medicine*

Theme: Promotion and prevention.

Contribution to the discipline: This work revealed gender inequalities in medicine, one of the most emblematic professions (along with nursing) and with the highest number of women from the health area. Recognizing the inequalities confronted by health professionals opens the possibility of guiding efforts and progressing in the construction of a fairer society.

ABSTRACT

Objective: To understand relationships of power according to gender experienced in scenarios of professional performance by Colombian female physicians. **Materials and Methods:** Qualitative study with phenomenological approach, from in-depth interviews to 33 female physicians, ranging in age between 29 and 60 years, and with over five years of professional exercise. Between October 2017 and March 2018, with prior informed consent, the interviews were conducted with questions about the relationships of power and the inequalities experienced with their male colleagues in scenarios of professional performance. **Results:** In the reports by the female physicians interviewed, it is possible to perceive gender inequalities in wages, forms of hiring, responsibilities assigned, recognition by the patients, and access to positions of power in comparison with their male colleagues. **Conclusions:** Medicine maintains a power structure centered on men, with differential opportunities by gender, and characterized by a lower wage, more responsibilities, lesser recognition, and limited access to positions of prestige for women. This phenomenon needs to be explored in other professionals from the health area.

KEYWORDS (SOURCE: DeCS)

Health status disparities; physicians, women; feminization; health equity; gender and health; Colombia.

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Inequidades de género en el ámbito de la salud: el caso de medicina

RESUMEN

Objetivo: comprender las relaciones de poder según el género, vividas en los escenarios de desempeño profesional por médicas colombianas. **Materiales y métodos:** estudio cualitativo con enfoque fenomenológico, a partir de entrevistas en profundidad a 33 médicas, con edades entre 29 y 60 años, y más de cinco años de ejercicio profesional. Entre octubre de 2017 y marzo de 2018, previo consentimiento informado, se realizaron las entrevistas con preguntas sobre las relaciones de poder y las desigualdades experimentadas con sus colegas hombres, en los escenarios de desempeño profesional. **Resultados:** en los relatos de las médicas entrevistadas, se perciben inequidades de género en los salarios, las formas de contratación, las responsabilidades asignadas, el reconocimiento por parte de los pacientes y el acceso a cargos de poder, en comparación con sus colegas hombres. **Conclusiones:** la medicina mantiene una estructura de poder centrada en los hombres, con oportunidades diferenciales por género, y caracterizada por un menor salario, más responsabilidades, menor reconocimiento y un acceso limitado a cargos de prestigio para las mujeres. Se requiere explorar ese fenómeno en otros profesionales del área de la salud.

PALABRAS CLAVE (FUENTE: DECS)

Inequidad en salud; médicos mujeres; feminización; equidad en salud; género y salud; Colombia.

* Proyecto: "Feminización de la medicina y sus posibles consecuencias en el mercado laboral de salud colombiano". Financiado por la Vicerrectoría de Investigaciones y Extensión, Universidad Industrial de Santander. Convocatoria Capital Semilla 2016. Código 2311.

Inequidades de gênero no âmbito da saúde: o caso da medicina

RESUMO

Objetivo: compreender as relações de poder segundo o gênero, vividas nos cenários de desempenho profissional por médicas colombianas. **Materiais e métodos:** estudo qualitativo com abordagem fenomenológica, a partir de entrevistas em profundidade a 33 médicas, entre 29 e 60 anos de idade, e mais de cinco anos de exercício profissional. Entre outubro de 2017 e março de 2018, com prévio consentimento informado, foram realizadas as entrevistas com perguntas sobre as relações de poder e as desigualdades experimentadas com seus colegas homens, nos cenários de desempenho profissional. **Resultados:** nos relatos das médicas entrevistadas, são percebidas inequidades de gênero nos salários, nas formas de contratação, nas responsabilidades designadas, no reconhecimento por parte dos pacientes e no acesso a cargos de poder, em comparação com seus colegas homens. **Conclusões:** a medicina mantém uma estrutura de poder centralizada nos homens, com oportunidades diferenciais por gênero, e caracterizada por um menor salário, mais responsabilidades, menor reconhecimento e um acesso limitado a cargos de prestígio para as mulheres. Faz-se necessário explorar esse fenômeno em outros profissionais da área da saúde.

PALAVRAS-CHAVE (FONTE: DECS)

Disparidades nos níveis de saúde; mulheres médicas; feminização, equidade em saúde; gênero e saúde; Colômbia.

* Projeto: "Feminização da medicina e suas possíveis consequências no mercado de trabalho de saúde". Financiado pela Vice-reitoria de Pesquisas e Extensão, Universidad Industrial de Santander, Colômbia. Chamada *Capital Semilla* 2016. Código 2311.

Introduction

Medicine, one of the health professions of greatest social recognition, had been practiced mostly by men until the past century (1, 2). In recent decades, the entry of women has had a major upswing, even surpassing the number of males in some countries (2, 3, 4, 5). This phenomenon, denominated *feminization of medicine* (4, 6), has not achieved major changes in its masculinized structural model, given that it continues presenting subtle exclusion of women from positions of higher authority, recognition, and prestige (2).

In 1994, the United Nations Organization (UN) held the Convention on the Elimination of all Forms of Violence against Women (7), which advocates for the participation of women in equal conditions as men. In September 2015, the 2030 Agenda was approved for Sustainable Development Objectives (SDO), with 17 objectives and 169 goals centered on the people, which are summarized on the ideal of transforming the world into a better place; combating inequalities; constructing peaceful, fair, and inclusive societies; promoting equality between genders; and generating empowerment of women and girls, among others (8).

With increased access of women to a professional career, and with progress of the SDO, a higher level of empowerment and gender equity are expected, so that they can strengthen the exercise of the profession with distinct contributions and styles (9), leadership alternatives (10), and freedom to develop their skills and potentialities (11) in equal conditions as their male colleagues.

In this regard, research has been conducted to assess the influence of gender on the medical practice and differences have been found in the communication style and in the performance of preventive activities (10), but the experiences of the health professionals have not been explored related to the distribution of power according to sex. Studies have also not delved into *gender inequalities*, defined as unnatural, unjust, and avoidable inequalities (12) between men and women in the professional exercise, which affect negatively, in this case, the female physicians (13). Therein, the need to conduct this study, seeking to understand relationships of power according to gender, experienced by a group of women who practice one of the most valued and recognized health professions: Medicine.

Materials and Methods

A qualitative study with phenomenological approach was carried out (14). It sought to explore the phenomenon of distribution of power according to sex, from the experiences of Colombian female physicians from Bucaramanga, Bogota, or Medellin. The selection criteria included being a female physician, having been working for over five years in any of the fields of the professional exercise of medicine, and authorizing their participation by signing the informed consent. The "snow-ball" strategy was used (15), starting with key informants.

From the phenomenological perspective (16), the analysis sought to reach the essential structures to give meaning to the experiences of the women (17), stemming from two thematic axes defined *a priori*: 1) Relationships of power (18, 19), understood as the experiences of female physicians expressed in reports that reveal the phenomenon of the distribution of power between men and women, with their origins, characteristics, implications, advantages, and disadvantages; and 2) gender equity (20), defined as the perception of fair and equitable distribution of opportunities, responsibilities, wages, and power between male and female health professionals, under equal conditions.

To address the contents, in-depth interviews were conducted with 33 female physicians who gave their informed consent to participate in the study, between October 2017 and February 2018, with which saturation of the categories studied was achieved. The interviews lasted between 20 and 120 minutes and were led by one of the researchers (female physician, nurse, or psychologist), all with Masters or PhD studies, with experience in qualitative research and in conducting previously standardized in-depth interviews. Each researcher kept a field diary with observations, experiences, and reflections that emerged during the work.

During the first contact with the potential participants, they were introduced to the researchers' curriculums and the study objectives. With those expressing interest, an appointment was set to meet face to face, at the place and time defined by them, to comply with the process of written informed consent, solve questions, and carry out the interviews. The places chosen were, mostly, their places of work, offices, or homes. Additionally, their approval was obtained to audio record their narrations. To guarantee anonymity of the participants and safeguard their information, each experience was assigned an identification code.

The interviews were transcribed, read, and coded by the three researchers; thereafter, in consensus, the codes extracted were fine tuned to guarantee the credibility of the results. In total, 3125 codes were obtained related with the experience of relationships of power differential by gender. The information was processed through the *NVivo10* program for qualitative analysis and interpreted by the researchers. The findings were validated in a meeting with participating and non-participating female physicians, in academic committees from the Faculty of Health at the University, and in conferences presented in three national and international events. The presentation and discussion of the findings in the aforementioned scenarios, and with said actors, is guarantee of the methodological rigor of the research.

Before starting the study, the research protocol was endorsed by the Ethics Committee in Scientific Research at Universidad Industrial de Santander. The ethical principles were respected at all times for research with humans, as established in Resolution 008423 of 1993 (21).

Characteristics of the women interviewed

The study invited to participate 38 female physicians, of which 33 (86.8 %) were interviewed. The motives for their not participating were: Two female physicians did not accept being interviewed, and with three, in spite of their accepting, it was impossible to set an appointment, given their occupations. Participant age ranged between 29 and 60 years, with median age of 38 years, average of 39.6 years, and standard deviation of 6.7 years. They had been working between 6 and 35 years, with an average of 21 and a median of 19. Other characteristics of the participants are presented in Table 1.

Results

The reports of experiences lived by the participants account for the disparities in the exercise of power that point to the existence of gender inequalities regarding labor wages, hiring terms, and responsibilities assigned. All this is conjugated into invisible barriers of access to positions of power and prestige, as well as the poor recognition by patients. Table 2 summarizes the resulting categories and subcategories. The following describe the inequalities exposed, accompanied by testimonials from the participants.

Table 1. Characteristics of participating female physicians

Characteristic	Condition	Sample	Percentage (%)
Marital status	Single	6	18.2
	Married	21	63.6
	Common law	3	9.1
	Separated	3	9.1
Number of chil-dren	0	12	36.4
	1	6	18.2
	2	12	36.4
	3	3	9.1
Level of for-mation	General physician	7	21.2
	Gynecology or perina-tology	5	15.2
	Pathologist	3	9.1
	Epidemiologist	3	9.1
	Psychiatrist	3	9.1
	Occupational health	3	9.1
	Health worker	2	6.1
	Pediatrician	2	6.1
	Family physician	1	3
	Administrator	1	3
	Surgeon	1	3
	Anesthesiologist	1	3
	Geneticist	1	3
Nature of the area of work	Public	19	57.6
	Private	4	12.1
	Public and private	10	30.3

Source: Own elaboration.

Table 2. Categories on relationships of power and gender inequalities perceived by some Colombian female physicians

Categories defined <i>a priori</i>	Subcategories
Gender inequalities	Differences in labor wages.
	Work overload because of being a woman.
	Overburdened by work, child rearing, and caring for the family.
Relationships of power	Limited access to positions of leadership and power.
	Lack of recognition by the patients.

Source: Own elaboration.

Inequalities in labor wages

Most of those interviewed reported that the wages they earn are lower than those earned by their male colleagues in equal positions. They estimate differences between 30 % and 50 %. Although they believe that the situation has improved, they state that it is a given that by merely being women they earn less than the men. They report that some managers, with the argument of hiring more personnel, not only pay them less, but make them responsible for "being willing" to receive less wages than the men. Expressing it thus: "The woman's labor is not valued in equal terms as the man's, this is seen often in the administrative part. If she were a man, she would have to be paid more. That makes it easier to hire a female auditor or administrative assistant, but for less salary" (Specialist in Occupational health, 8 years of experience, private sector). "They say women 'are willing' to accept a lower wage than the men, in a rank even higher than that being offered them, and one remains concerned wondering: 'How do we value the work we do that we allow them to take advantage of that situation?'" (Health services administrator, 10 years of experience, private sector).

Regarding the difference in wages, some of the women opt for quitting: "In some institutions, while I am doing exactly the same as my colleague, he gets paid more than I do, 30 % or more. That is one of the reasons why I have had to quit: Economic inequality" (gynecologist, 9 years of experience in public and private sectors).

Some consider that the income gap places them at a disadvantage, given that it implies their working more to obtain pay equivalent to the pay men get. Additionally, the wage difference is used as a pretext to burden them with the household work, as expressed in the following:

...my husband is also a specialist. Never, even if I work the same time he Works, will I earn the money he makes. That implies my having to spend more time at home, taking care of the girls, making lunch; given that he earns more, he works outside more. I would say that if I had more income, the burden of caring for the house would be the same. (Occupational medicine, 12 years of experience, private sector)

Obstacles against hiring

The women interviewed reported that, having been heard that the demands of maternity and child rearing imply women, employ-

ers see as an obstacle their hiring and, thus, tend to justify the preference for males, with excluding forms of hiring: "To hire a woman, there are many obstacles. I see the discrimination, for fear that women get married, request leaves to care for the children, get sick or request maternity leave" (General physician, 6 years of experience, private sector).

Discrimination to hiring is exerted subtly, as they report: "When you are going to be hired, you have to be interviewed, and the other candidate is a man, you note, as of the greeting, the difference in treatment. One knows it will be harder by the fact of being a woman" (Psychiatrist, 5 years of experience, public and private sectors).

Work overload and caring for the family

Some professionals recognized that working in spaces dominated by men implies work overload, given the symbolic significance of certain tasks as exclusive responsibility of the women. Thus, their male counterparts lead them to understand that because of their being women, they must execute tasks the men do not want to carry out, adducing that the women do them better. Independent of the academic level reached, for being women they are assigned additional work, like making reports, writing letters, or organizing matters related with the wellbeing of others. Thus, they expressed: "My coworkers are very uncooperative, they do not like to do anything; they are lazy. They only do what they have to do and what they like to do, but nothing more. A report, a form that needs to be filled out, or another thing, they say: 'Hey you (referring to a woman), do it; you do it perfectly'" (Sub-specialist, 15 years of experience, public and private sectors).

Those who are mothers are delegated with tasks of maternity and child rearing, which, on occasion, come into conflict with their work responsibilities, above all during fortuitous events, like sickness or disability. Reported thus:

...effectively, being a mother is indeed difficult to combine with the medical exercise: Caring for the children, if they get sick, if you don't have someone to help you with house chores, if your spouse is a physician, he continues working, as always, but you have to do things by yourself. (Gynecologist, 6 years of experience, public and private sectors)

Besides working and caring for the children, they also sense they carry the responsibility of caring for the family and for orga-

nizing matters of wellbeing at home, while men only work: “We, as women, have that responsibility of caring for our families. Men go to work, they do not worry, come home and rest. But women go out to work and come home to care for her family: Dads, children” (Occupational medicine, 6 years of experience, private sector).

These challenges require their investing greater efforts than men to keep up to date, besides complying with extra roles: “In such a demanding environment, where the men only worry about that which has to do with their work, never about the home, you as a female physician must dedicate greater physical and mental efforts to be at a competitive level” (General medicine, 12 years of experience, public and private sectors). “It is easier for men, without it sounding chauvinist, but the children are more attached to the mother. Then, I do believe it is easier for men, and much more difficult for a woman, having 100 % of the fields solved: Child rearing, the profession: Double work” (Pathologist, 15 years of experience, public and private sectors).

Limited access to positions of leadership and power

The women consider that, in general, positions of leadership are held by men. They are the ones that figure in social events, business managers, directors of clinics and hospitals. But the women note that in the background there is a team, generally hidden, led by women, who do the most demanding work.

I believe the leadership men have is very notorious. For example, the presidents of the Association have always been men, and congress organizers are men. They are the speakers, they voice opinions, they state, and we “urge them”, but very few women end up having leadership. (Pediatrician, 15 years of experience, public and private sectors)

If the women have the opportunity to reach positions of power, sometimes, they feel relegated to a second plane, as they describe it: “When we sit there, we see it is a man’s world; we women are the secretaries, the advisors, the reporters. No matter how many women are there, the positions of leadership will always be in the hands of men” (Sub-specialist, 20 years of experience, public and private sectors).

Some state with disdain the lack of gender solidarity in situations that imply exercises of power between men and women:

We women are well-mannered, applied and have many biological advantages. The problem is that we have never achieved social advantage as a trade group. This happened with so and so, who was harassing me. My female co-workers got together and gave me the third degree. They asked me: “Why is so and so in a bad mood? We think it is because of you, and you must solve the situation”. Imagine, all of them women and defending the guy! (General physician, 14 years of experience, private sector)

It is striking that some female physicians in positions of power assume authoritarian, cold, distant, or aggressive behaviors with their female co-workers, emulating their male colleagues, as adaptive response to the patriarchal system in which they work: “In positions of power and command is where some women end up adopting those patriarchal behaviors to keep their place in this heavily masculinized world” (Health care worker, 26 years of experience, public and private sectors).

The participants exposed cases in which the men establish tacit agreements to detract or minimize the arguments of the female physicians. The women, in their more conciliatory role, prefer not to argue to avoid controversy. Some experience it thus: “In situations of crisis, of algid discussions, with mostly men, I felt they disrespected me that they did not consider what I thought only because I do not scream like they do; because I am a woman, moderate, I try to hold a dialogue, I try to exert the policy. But, basically, because of the fact of being a woman” (Epidemiologist, 25 years of experience, public sector).

Nevertheless, knowing that the positions of power continue in the hands of men, they foresee, in the union as a trade group, hopes of reaching equality of opportunities: “That we really have the power of decision, we do not have it. If we were a trade group, we would have power, we would have positions of command, we would have equal wages, and we would have the same opportunities” (Sub-specialist, 22 years of experience, public sector).

Lack of recognition by the patients

From such social roots, it is possible to conceive the gender inequalities that women consider manage to permeate the behaviors of patients, who, on occasion, tend to not recognize their status. They state: “Sometimes, the patients don’t address me as ‘doctor’, as they do say ‘doctor’ to the male co-worker. Many times I ask them something and they barely respond. When my male co-worker arrives, who is my same age, with the same physician’s

coat, then there they do start: 'Doctor, look at me here, doctor tell me such a thing...', only because of being a woman" (Occupational medicine, 9 years of experience, private sector).

Patients believe in men more. When I say something to patients, they say: "Yes, the other doctor also told me the same", like reaffirming that what the male doctor said is the truth. Then, you have to make an effort to demonstrate that you are indeed good, that you do know. You have to gather arguments and read scientific articles for them to believe you because while the male physician's word is the word of God, if you are a woman you have to reinforce it. (Psychiatrist, 6 years of experience, public and private sectors)

Discussion

The findings herein show that this group of health professionals experience gender inequalities regarding wages, forms of hiring, responsibilities assigned, access to positions of leadership and power, and recognition by their colleagues and patients, compared to men. That is, the distribution of power according to gender is not equitable.

It is interesting that, in spite of efforts to achieve greater access to the career of medicine by women and, consequently, an academic level and equivalent social valuation in both sexes, said inequity continues. This phenomenon has been observed in prior studies (2), which also found that inequity is greater when wages are higher, independent of age and the educational level of the women (22). The results are consistent with three national studies about wage gaps according to gender. The first (23) found that women not only face a "glass ceiling", but also a "quicksand floor", given that inequities affect those earning a high or low wage, and estimated that if all Colombian women worked, the wage gap would be nearly 50 % higher. Another study concluded that between 25 % and 30 % of the wage differences by gender are associated to discrimination (24). One more holds that, although the educational level of women has improved, a high percentage receives lower wages than the men and works in less productive economic sectors (25).

Another of our findings were the subtle barriers to hiring female physicians. Research conducted with medical students found, explicitly, discrimination based on gender (26). This contrast is of concern because, if as of the training women are discriminated, inequities will perpetuate in the professional performance.

The participants also revealed that organizations maintain invisible barriers that keep women from holding leadership and power positions due to prejudice originated in social codes, as reported by previous studies, which demonstrate scarce participation by women in directive posts and a clear segregation by gender (27). Consequently, female physicians occupy secondary positions due to gender discrimination, with lesser recognition, prestige, and power, as it occurred decades ago (1).

Such is the importance of the gender inequalities considered in a prior study, together with violence, political participation, and work, the spheres of greater magnitude of inequity against women, with indicators of lower power of decision, less opportunities for work, lower income, and double work shift (28).

The participants in this study also accused work overload due to the work shift and caring for the family. In this sense, health care actions tend to be naturalized as appertaining to women (29), which shows asymmetric relationships of power and the symbolic efficacy that associates the act of caring with intrinsically feminine qualities (30). These constructions of gender permeate all the spheres of daily life and reinforce diverse inequalities (28), given that, as stated by Foucault, the exercise of power is not limited to exclusion or repression, but acts also through normalization (18).

The finding of women who, in positions of power, adopt macho behaviors was also reported (31). This behavior helps to maintain the gender inequality and the male ethic of the profession. Under the pretext of gaining recognition from the patient, maintaining the status, and preserving the position, some women assume the dominant patriarchal discourse, add it and reproduce it onto their professional practice (2).

Furthermore, the lack of recognition by patients leads female physicians to limit their affective responses (32), given that they believe they lose power and that they are not taken seriously. It is fitting for female health professionals to internalize and communicate that their leadership style be distinguished from that of men because it promotes creativity, cooperation, and intuition in decision making; hence, it is convenient to become empowered and have confidence on the advantage of the values more culturally developed by women (9).

Finding gender inequalities in medicine is quite disappointing; it means that the historical exclusion of women from the profes-

sion has turned into segregation, that the sexual division of work continues reproducing, and that the career is highlighted by its scarce female representation, both is specializations of greater prestige and power, as in high professional and academic levels (2). Notwithstanding some advances, the persistence of gaps is undeniable between women and men (33). But the principal pitfall for empowerment is the macho culture that, as shown by our findings, crosses social life (34).

This research was not exempt from limitations. In the first place, the representativeness of the sample: Non-participation of five female physicians, two of them in key positions and with similar trajectories, limits the spectrum of testimonies without knowing if their points of view would coincide or disagree with those who did participate. The other three, two surgeons and an anesthesiologist, who were very busy, could have contributed with new experiences, precisely due to their situation of overburden, to the point of not having time to participate in the research. Another limitation, in this case of the analysis performed, is not having compared the significance by age, specialty, or time of professional exercise, which would permit exploring how these variables affect the experience of inequality. The study opted for obtaining a general spectrum of the exercise of power by female physicians from various specialties, according to the general objective of the research. Future work should address this comparative analysis.

Some of the strengths included that the field work was carried out by the researchers themselves and not by support staff, which ensured the necessary academic qualification and experience to guarantee its quality. Likewise, the methodology used through interview techniques, face to face, and field diaries, which, due to the reflexivity, inter-subjectivity, and observational understanding they allow, are fundamental for the analysis, interpretation, and discussion of the findings.

Conclusion

From the results of this study, it may be inferred that medicine maintains a power structure centered on men, with differential opportunities by gender, characterized by lower wages, more responsibilities, lesser recognition, and limited access to positions of prestige for women. As a complement to these results, said phenomenon should be explored in other health area professionals, like nursing, physical therapy, microbiology, or nutrition, seeking to continue constructing a fairer and more equitable society, in compliance with the SDO.

Conflict of interests: None declared.

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