



The ongoing need for feminism in medicine
Le besoin continu du féminisme en médecine

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The ongoing need for feminism in medicine Le besoin continu du féminisme en médecine

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If women now form more than half of medical school cohorts in North America, what role could feminism possibly still have in medicine? As a medical student, I have repeatedly encountered this question. I argue that feminism remains relevant and has an essential role to play in addressing ongoing gender biases in the medical profession.

An article published this past July in the *Journal of Vascular Surgery* titled “Prevalence of unprofessional social media content among young vascular surgeons” provides a striking example of sexism in medicine. The authors argue that “publicly available social media content” may affect future patients’ choice of physicians or medical facilities; unprofessional content, according to the authors, includes photos in “provocative” Halloween costumes and bikinis. The smear of “unprofessionalism” was blatantly targeting female physicians. The article was met with immediate outcry from the medical community and was subsequently retracted with an ensuing apology from the editor. While the retraction was laudable and the outpouring of support for female physicians was encouraging, the momentum gained from this event should be used to catalyze a larger discussion on gender equity in medicine that extends beyond the double standards regarding “professionalism.”

This recent article is but one example of sexism and gender inequity in the medical profession. Women may have achieved parity in terms of medical school enrolment, but the same cannot be said for other levels of medical power and authority. Women continue to remain underrepresented in senior leadership positions such as department chairs, deans of medical institutions, and CEOs of hospitals.^{1,2} Moreover, a minority of women participate

in guideline committees, and fewer are senior authors or editors-in-chief in medical journals. Similarly, women do not attain promotions and leadership positions at the same rate as their male colleagues.^{1,2} It is not difficult to imagine that Black, Indigenous, and racialized women have an even steeper climb, given that they are underrepresented at the medical student level.³

Women also continue to be clustered in the lowest paying specialties. Additionally, a pay gap between male and female physicians within the same specialty has been consistently demonstrated.^{2,4} This gap persists even after adjusting for confounding factors such as years in rank and practice characteristics. Surprisingly, discrepancies in pay also appear in a fee-for-service payment model such as that in Canada.^{2,4} Furthermore, workplace discrimination against female physicians is commonplace, as women report higher levels of disrespect from colleagues and being treated less formally than men.^{1,2} Evidently, there remains much work to be done to eliminate sexism.

Many of these issues remained anecdotal until research rendered them more tangible, which is why research has been crucial to facilitating discussions of gender inequity. It must be emphasized, however, that any discussion of gender requires a discussion of race, power, privilege, and identity, all of which are intricately linked. Moreover, we must recognize the role that medicine has played as an institution in perpetuating systemic racism and sexism. As providers, we understand that gender is a social determinant of health; the link between gender bias and poor health outcomes in patients is well established. We also know that a diverse workforce, including racialized women, enhances patient care and improves health

outcomes.⁵ By advocating for gender equity as a health matter, we can serve as powerful agents of change. We can start by looking critically at the policies that contribute to gender inequity within our own profession.

Recognizing the issues that remain problematic does not minimize the progress that has been made. Indeed, we have seen significant strides in eliminating gender discrimination, as evidenced by the increasing number of women practicing medicine and the increasing resources that have been devoted to challenging the male-centric paradigm in medical education. It would be negligent, however, to say that sexism and gender inequity are artefacts of the past. In employing the rhetoric of “simply being grateful for where we are,” we engage in wanton complacency—and *that* is a disservice to the feminists whose decades of work have brought us thus far. Time itself will not achieve gender equity, so let us stop using enrolment numbers as a shield to avoid having important discussions in our field. The work of feminism in medicine is not nearly done.

Conflicts of Interest: None declared.

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