Impressions from the 17th WONCA World Conference for Family Doctors, Orlando, USA, 13-17October 2004 – Part 2

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Summary of Women's Symposium

One highlight of the WONCA meeting was a tract sponsored by the newly established *WONCA Working Party on Women and Family Medicine (WWPWFM).* This working party is one of six working parties in WONCA. The executive committee is made up of women family physicians from each of the WONCA regions (Ibero America, North America, Asia/ Pacific, Europe, Africa, Middle East / India). The Chair is Cheryl Levitt MD (Canada) and Vice-Chair is Amanda Howe (Great Britain). The current WWPWFM goals include 1) publishing in monograph form the synthesis compiled by Drs C. Levitt, B. Lent and L. Candib of published material describing the status of women family/general practitioners 2) establishing and maintaining a WoncaWomen website linked to the WONCA web site 3) realizing the newly developed action plan, and 4) preparing a symposium for the next world meeting focusing on the practice of women family physicians in Asia.

The Symposium for Women in Family Medicine was introduced by *Lucy Candib MD* who spoke about conceptualizations of power. Deborah Tannen's work and others has illustrated that men tend to be socialized in a hierarchical fashion, and they tend to understand power as limited, meaning if one group or person has power then the other group or person has less. This understanding contrasts with women who tend to see power as shared, increasing in relationships and diminished by isolation. These contrasting suppositions underlie many gender issues in medicine. Further, more women, because of their social roles, are often more connected with daily life. The pragmatic issues of family care such as food preparation and household maintenance are easily understood and impact the daily lives of many women physicians. This perspective enters the clinical world of practice by enhancing relationships with many patients but limiting some traditional professional roles such as in leadership. Considering the concerns of men and women, the powerful and the disenfranchised, offers family medicine a growth opportunity. The symposium was established to examine concerns of women and offer different models of practice to enhance the discipline.

Drs Barbara Lent and Cheryl Levitt presented *Women Family Physicians in Canada Effecting Change.* The Association of Canadian Medical Colleges and the College of Family Physicians of Canada have both established Gender Equity Committees. Through these committees curriculum has been improved in targeted areas of breast feeding, reproductive choice, child health, violence & abuse, gender as a determinant of health, and patient-clinician boundary issues. How did this happen? The speakers attributed this to individual passion and persistence, looking for and copying successful models, and the right timing within a supportive professional environment. Nonetheless they reminded the audience that only one of seventeen medical school deans is female and that there are only two female chairs of sixteen family medicine departments in Canada.

Recruitment and retention strategies developed in the National Health Service of the United Kingdom was the focus of a presentation by *Amanda Howe MD.* She described a history of unequal numbers of women and inequitable compensation for women in the NHS. The career progression of women was slow and there was a lack of flexible contracts for leaves and part time work. At the present time however the majority of medical students are female and both men and women are requesting part time practice arrangements. There is still a salary gap for most women compared to men and a leadership gap with only four of thirty two general practice heads at medical schools being female however flexible training programs and practice contracts are being developed. The flexibility is often in the area of night call and extended leaves most commonly related to family roles. Dr. Howe felt that a major concern now was the assumption of a status decline in the profession as the number of certified women increases.

Dr Amanda Barnard in a presentation *"Women in rural general practice – A force for change from the bush to initiatives in gender education in medical schools"* described how concerns about and from rural doctors in Australia resulted in programmatic changes in medical education. Less than 30% of general practitioners in Australia are female, and in rural practice the numbers are even fewer. In the bush there is a strong ethos of independence and service but with increasing numbers of women this traditionally male culture was challenged. This precipitated an analysis of issues for rural practice. In what Dr. Barnard then described as a particular confluence of political and economic circumstances a general practice advisory group with specific sensitivity to issues for women physicians was established and charged with making recommendations for sustainable rural practice models. Out of this group was born recommendations for curricular change, a Gender and Medicine Conceptual Guide, and an "evidence based gender perspective" throughout the 5 year undergraduate medical curriculum of Monash University in Victoria. Information about this curriculum can be found at *http://www.med.monash.edu.au/gendermed/gendermed.html.* She, however, finished this story of success reminding the audience that only two of the twelve full professors in general practice are female.

The challenge of women practicing in rural Alaska was addressed by *Barb Doty MD* in a presentation titled *"Setting*

up a family friendly practice: a day care in the office." Dr. Doty reminded the attendees of the problems of isolation, limited partner support, long work hours, and lack of cross coverage and resources faced by all rural physicians. This can be especially problematic for physicians who may have additional personal family responsibilities. Nonetheless Dr. Doty felt that with the history of strong frontier women there is often less prejudice against women physicians. The pragmatic issues of limited child care options for staff and physicians, especially those physicians who may be called away to provide obstetrical care, lead her group of women physicians to establish a day care in their practice. It is in a separate area attached to her office with a sleep and play room and a kitchen. It is staffed by individuals who are cross trained to provide office support and has been active for 18 years. It is financially viable and Dr Doty described it as a great recruiting tool. They have documented less turnover among staff.

"Learning about new reproductive options and confronting the resistance and opposition." was presented by *Linda Prine MD.* Dr. Prine began by providing the attendees with information from Association of Reproductive Health Professionals *http://www.arhp.org* and The Alan Guttmacher Institute *http://www.agi-usa.org/sections/index.html* that world wide maternal mortality of 600 million deaths annually has not improved in 50yrs. There are an estimated 52 million unplanned pregnancies yearly and in 44% of countries abortion is illegal. This results in an estimated 80,000 women dieing yearly from unsafe abortions. In the US where abortion is legal and safe the maternal mortality is 0.5/100,000 abortions. She then went on to describe her teaching and practice with newer methods of pregnancy termination including manual vacuum abortion (MVA), and medical terminations using mifepristone and misoprostol. She argued strongly that offering our patients the options to continue or terminate a pregnancy is well within the scope of family medicine and general practice. The access project mission is to integrate early abortion into primary medical care http://www.theaccessproject.org .

Prof Marietjie de Villiers described family / general practice in South Africa as existing in "survival mode". In her presentation *"Advan-cing the cause of women family doctors in a 'besieged' medical profession".* Dr. de Villiers described extremely limited resources, regulatory restrictions and a resultant mass exodus of physicians from South Africa. Graduating physicians have a 1 year required community service and a 2 year internship. In an attempt to distribute physicians to populations of need the government requires a certification of need to set up practice and most recently the government has also required a dispensing license. All of this is in the face of HIV/AIDS infection in 15.7% of the country's health care workers. For women physicians who face gender issues described by other speakers in this symposium, practice in this setting is even more stressful. Dr. de Villiers feels that that success for women family physicians cannot be separated from the success of health care delivery within the country and success will come by physicians uniting with other health care professionals to educate governmental bodies and improve health throughout the country.

Women and leadership in Family Medicine in Nine European countries 2004, a qualitative study was presented by *Gabie de Jong.* In this interview study women family physicians were interviewed for their assessments of their abilities, career development, and any barriers they confronted in their work. Information about the context of their work and families, training and self assessed competencies as well as goals was obtained. While analysis is still ongoing, initial results indicate that these women fell well trained and both able and willing to be leaders in their field. However they also spoke of conflicting career goals and life goals, and of comfort with network relationships but discomfort with organizational hierarchies. While there were themes echoed by more respondents in certain countries the overall thrust showed little variation. These family physician respondents sited organizational constraints as the biggest barrier to their leadership development.

A description of the status of family medicine and the role of female family physicians in South America was given by *Liliana Arias* who spoke of *"Facing the old role models: The challenge for women family physicians in Latin America."* Dr. Arias is the first female Dean of Medicine in Latin America (Universidad del Valle en Colombia). She reminded the audience that the number of women in medicine and status of family medicine and primary care are very different in the different countries of Latin America. Cuba and Mexico have strong family medicine programs. However Chile, Venezuela, and Ecuador are examples of countries lacking primary health care policies, and in which family medicine may not be taught at the medical schools. In many Latin American countries there is an excess of physicians. Family medicine and primary care is often combined with public health. Family physicians may have low incomes and there are few opportunities for female leadership. The recognition that family medicine and primary care is the most efficient and effective means to deliver health care is convincing some governments to support the development of the discipline.

The final symposium speaker was *Dr Zorayda Leopando* from the Philippines. Dr. Leopando spoke about *"Women's reproductive Healthcare in Asia / Pacific."* In Asia 37% of physicians are female. Their practices largely focus on women's health especially reproductive rights. Dr. Leopando has long been a leader of women in Asia and spoke about the development of leadership by women physicians as they speak for their women patients. She described the key developments in the history of WONCA. She recalled the development of the women's special interest group in 1998, the Christchurch workshop in 2000 developing Strategic Objectives from the Beijing Platform of the United Nations Fourth World Conference on Women in 1995. This was endorsed by WONCA in 2001. The Strategic Objectives from the Beijing Platform of Action include 1) women and poverty, 2) education and training of women, 3) women and health, 4) violence against women, 5) women and armed conflict, 6) women and the economy, 7) women in power and decision making , 8) institutional mechanisms for the advancement of women, 9) human rights of women, 10) women and the media, 11) women and the environment, and 12) the girl child. She noted that this is the first WONCA conference with reserved program time for a symposium on women's issues.

Conclusion

I enjoyed the conference in the sense of connecting with role players in Family Medicine on a global basis again, meeting up with previous contacts and forging new networks. This is one of the greatest benefits of attending a WONCA conference. I was also proud to see how the discipline has developed and the quality of the work that we do globally.