This month’s issue of *Family Medicine* features several articles about women in family medicine: as patients, students, residents, and faculty. Women have always constituted a majority of patients in family medicine (and of most health care disciplines), but the increased number and percent of women family physicians has led to a greater awareness, and hopefully understanding, of the health problems that women face, as well as an interest in and ability to provide more effective health care. While male physicians generally are not misogynistic, hostile, demeaning, or paternalistic toward women, their understanding of women’s health issues are one step farther removed from the patient’s experience.

As usual, the results of these studies raise additional questions. In this issue of *Family Medicine*, Cohen and Coco show that the percent of women’s preventive care provided by family physicians has remained stable from 1995 to 2007, at about 20%, and suggest that this requires continued attention to gynecology training. They focus on the 1 month of gynecology required for residents by the Family Medicine Review Committee (RC) (formerly known as the Residency Review Committee or RRC), but I would suggest that reproductive health skills are most often, and most appropriately, learned in the continuity family medicine clinic. Indeed, most ambulatory skills that family physicians need are better learned in this setting. While this has been a long-standing controversy, women’s preventive health care is a good example of a skill set for which the RC should focus more on residents achieving competency than on their spending time with other specialists.

Hutchinson et al focused on the experience of female residents having babies during their training and on the biggest challenges that they face (childcare, breast-feeding, and amount of time off). With 9% of female residents pregnant, this is clearly a major issue for the pregnant residents, their co-residents, and their programs. Another important issue is the impact of dual-career couples in medicine and of changing expectations for male residents when their spouses are pregnant and have babies, issues not addressed in this study.

While Fornari and her colleagues did not demonstrate a significant increase in learning about emergency contraception (EC) among students taught by peers who had played the role of patients seeking EC, the impact on the latter group supports the power of experiential learning. “Knowing” something intellectually is very different from “knowing” it because you have experienced its impact, which creates a greater understanding of the obstacles patients face in gaining access to health care services. This is especially true for services related to sexual health, and these students found both internal (eg, it is hard to ask) and external (eg, even in this major metropolitan area with generally liberal contraception laws and policies, 36% of pharmacists would not fill EC for male students who said they were seeking it for their partners) obstacles. We are still far from health care workers providing for the contraceptive needs of women (EC or otherwise) in an open and nonjudgmental manner, and this is an area that needs to be emphasized in family medicine residencies as well as in the training of other health professionals.
The work of Schrager and colleagues provides some better news. Although the 44% of family medicine faculty who are women were first authors on only 33% of published papers, 45.6% of these were research papers, a much higher percent than for male faculty, with a P value of .066. This is nearly .05 and almost certainly has face-value significance.

Diversity of our workforce provides professional opportunities to those who may not have had them and provides access to care for populations who may be underserved by those who make up the majority of physicians. Workforce diversity also enhances our skills by providing differing perspectives, understandings, and “ways of knowing.” Most of us have taught our students some variation on Mark Twain’s quote: “What gets us into trouble is not what we don’t know. It’s what we know for sure that just ain’t so!” This applies just as much to us as physicians and teachers. If we have never thought about an issue in a particular way, or seen it from a certain viewpoint, we are unlikely to do so unless exposed to the perspective of someone whose life experience has been very different.

The articles in this issue demonstrate several ways in which the increasing number of women in family medicine has had an impact on our practices, our teaching, and ourselves. The good news is that the percent of women in our profession is beginning to approach the percent in the population and that it has had a measurable impact on the practice of family medicine. Beyond gender, however, in respect to race, ethnicity, and class, the women in family medicine closely resemble the men. While the health care issues of middle-class and majority women are being better, if not yet completely, addressed, we still need greater understanding of, knowledge of, and empathy for poor women (and men) and for people whose lives and behaviors, including contraceptive and sexual behaviors, may not reflect the behaviors or attitudes of most physicians.

Medicine must seriously address how we plan to achieve workforce diversity for race, ethnicity, and class, as well as we have for gender. An absolute priority, for medical schools and for family medicine residency programs, should be to recruit women (and men) from underrepresented minority groups, rural areas, and families in the lower tiers of income. The impact that women in our discipline have had on changing attitudes has been enormous; think about how much broader our perspective and how much more effective our practice will be when we succeed in all these areas.

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References