Gender Diversity in Residency Training: The Case for Affirmative Inclusion

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Obstetrics and gynecology was once dominated by men, reflecting the ignominious history of discrimination against female applicants.[1–3] By the 1960s, prejudicial attitudes against women could no longer be accepted. Braslow and Heins[1] underscored 3 sources of this remarkable historical change in medical education: (1) the passage of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972, protecting the rights of women in higher education; (2) the 1970 resolution of the Association of American Medical Colleges on affirmative action and its implementation by medical schools; and (3) the feminist movement, which insisted on equal rights for women as an antidote to the long history of prejudicial attitudes and practices that had previously denied them educational opportunities. Braslow and Heins[1] reported the percentage of women entering medical schools in 1970 was 11.1%, a share that increased to 25.3% a decade later. In the 2015–2016 academic year, women constituted 47% of medical students in the United States.[4]

Since 1994, the American College of Obstetricians and Gynecologists has seen increased representation of women as fellows, from 18.6% in 1994 to 48.9% in 2015 (Tomara Lee, written communication, August 2016). A total of 85% of residents are women,[5] and it is not unusual for all trainees in an obstetrics and gynecology program to be women. Other specialties have experienced a similar demographic shift toward women, including dermatology (64.4%), family medicine (54.8%), pediatrics (73.1%), and allergy and immunology (66.4%). Some subspecialty programs also have a high percentage of women, including adolescent medicine (90.5%) and child abuse (89.7%) within pediatrics.[6] Over the same period, there has been no increase in the representation of men in many specialties. In this article, we focus on obstetrics and gynecology because it is especially illustrative of the dramatic demographic shift in medicine.

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A Fundamental Question

In a prescient 1997 commentary, Lyon asked about training in obstetrics and gynecology: "Where have all the young men gone?"[7] Her concern was that the decreasing percentage of men in the specialty would result in loss of diversity of perspectives.[7] It is time to revisit Lyon's question (which has become more urgent as the percentage of men has further declined) and make the case for gender diversity in obstetrics and gynecology residency training programs. The case 4 decades ago for including more women was based on affirmative action, to correct the historic wrong of discrimination against them in medical education. The case now for including more men is different; it is termed *affirmative inclusion*.

Affirmative Inclusion as Distinct From Affirmative Action

We introduce the concept of affirmative inclusion to avoid confusion with the concept of affirmative action. We performed a search in PubMed using "affirmative inclusion," which yielded no citations, then began an explication of affirmative inclusion in 3 steps to distinguish it from affirmative action.

First, affirmative action aims to prevent the recurrence of invidious (ie, ethically impermissible) discrimination against individuals who are members of groups that have experienced discrimination in the past.[8–11] Preventing discrimination in residency admissions benefits individual applicants by treating them fairly (ie, judging each of them based on academic merit, professionalism, and other desirable attributes). The residency program benefits by preserving its moral integrity from the corrosive effects of discrimination. Affirmative action also aims to promote the educational value that a diverse group of trainees brings to the educational forum given their diverse perspectives, thus preparing them to be more culturally competent. Promoting diversity does not aim to benefit individual applicants; it aims to benefit all of the residents in a program and their future patients. Affirmative action remains an appropriate

policy for medical specialties in which women are underrepresented.

The concept of affirmative action does not apply to a policy of affirmative inclusion in the case of increasing the very low percentage of men in obstetrics and gynecology residency programs, because there were no such historic wrongs against men, the recurrence of which needs to be prevented. In contrast, increasing diversity of perspectives among trainees does apply to the current dearth of men in obstetrics and gynecology residency programs. Lyon stated, "There is virtually no arena of human endeavor that is not made better through diversity of perspective."[7(p634)] She acknowledged that the value of increased gender diversity from having more male residents is partly "symbolic."[7(p634)] At the same time, she emphasized the pedagogical value of male gender diversity ". . . because gynecology deals inextricably with the most sensitive of gender issues, a masculine input, sensitively provided, can't help but make for a more complete opportunity to learn and grow."[7(p634)] The ethical justification of affirmative inclusion of men in obstetrics and gynecology residencies is based primarily on the academic value of pedagogical diversity. Affirmative inclusion should be understood as pursuing academic diversity by increasing the number of men, when they are underrepresented in obstetrics and gynecology residency programs.

Second, affirmative inclusion should enhance the autonomy of women,[12,13] expressed in their preferences for gender of their obstetrician-gynecologists. Although more female patients prefer a female obstetrician-gynecologist, not all do so.[14] Increasing the percentage of men in obstetrics and gynecology will give women options, thus enhancing patient autonomy.

Third, an administrative perspective supports affirmative inclusion, but must avoid misogynistic policies and practices. Physician leaders should keep in mind that not all women reproduce, and more mature women no longer reproduce. Physician leaders value scheduling patients consistently with the physician of their preference. Maternal or paternal leave during and after pregnancy poses a challenge, especially when more than 1 physician is on such leave, which can become an acute problem in small groups. Female or male physicians who take extended time away from practice for child-rearing do so for very good reasons that should be respected by physician leaders. The stability of the physician group that is necessary to meet the needs of all the group's patients is a legitimate concern—increasing the percentage of men or women who have completed their families in a group practice can help alleviate this.

When women make up a substantial percentage of a workforce, or even the majority, compensation decreases.[15] Productivity differences may explain some, but likely not all, of the differences in compensation. Reyes[15] reported that in 2002, in comparison to male obstetrician-gynecologists, female obstetrician-gynecologists worked 10% fewer hours, saw 9% fewer patients, and performed 21% fewer procedures. The resulting income gap "was almost entirely explained by gender differences in productivity and practice patterns."[15(p1031)] However, men still are paid more than women when matched for productivity.[15] Physician leaders have a professional responsibility to address this issue. Reyes underscores this point: "All obstetrician-gynecologists—male *and* female—earn less because obstetrics and gynecology is increasingly regarded as a female-dominated specialty."[15(p1039)] Physician leaders should advocate for equal compensation levels across the board.

Implementing Affirmative Inclusion

In specialties such as obstetrics and gynecology and pediatrics, affirmative inclusion may be implemented in 2 steps. The first entails growing the applicant pool, in which clerkship directors and medical school faculty advisors have crucial roles. Male medical students who express an interest in obstetrics and gynecology, pediatrics, or other specialties and subspecialties populated largely by women should not be discouraged, but encouraged and supported to become competitive applicants. Faculty should support these students, and be sensitive to their potential for experiencing discouragement because of the perception that there are no job opportunities for men in these professional domains.

The second step is to admit competitive male applicants to these residency programs. The process for selecting applicants for interviews should include a reasonable effort to identify competitive male applicants and schedule them for interviews. Selection committees should be attentive to the influence of subjective, biasing factors that might result in male interviewees being systematically ranked lower than female interviewees, or vice versa. The selection committee, especially in larger programs, should determine whether the list of top-ranked applicants has no male applicants, and in that case, should try to rebalance the rank list, with the aim of including at least 1 competitive male applicant. Affirmative inclusion should never be interpreted to justify ranking a less qualified male applicant. The selection committee therefore should maintain its commitment to high quality by preventing 2 academically unacceptable

outcomes of the ranking process: (1) *not* including competitive male applicants in the list of top-ranked applicants, and (2) including *non*-competitive male applicants in the list of top-ranked applicants.

Conclusion

Affirmative action remains an appropriate remedy for residency training programs in which women are underrepresented. Affirmative inclusion should guide residency programs in which men are underrepresented.

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