Enacted Stigmatization and Stigma Consciousness of Female Physicians: Exploring the Potential Impact on Choice of Medical Specialty

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The present study explores the pervasive discrimination and gender inequities of female physicians in male-dominated medical specialties through the lens of enacted stigmatization and stigma consciousness. While existing literature on both of these topics is robust, there is a gap in the literature exploring the overlapping relationships of these factors. We seek to establish a theoretical foundation for these constructs as depicted by our model and two central propositions in which the relationships of stigmatization and stigma consciousness impact career choice based on gender. The implications of this issue and directions for future research are identified and discussed.

Keywords: stigma, enacted stigmatization, stigma consciousness, gender equality, medical specialty

INTRODUCTION

It is no secret that female physicians are underrepresented in many medical specialties (Chapman, Hwang, Wang, & Deville, 2019). Despite the increasing number of women in medicine, and the gains they have made in recent years, there is still a pervasive glass ceiling that most women cannot seem to break through (Reed & Buddeberg-Fisher, 2002; Wolfert, Rohde, Mielke & Hernández-Durán, 2019). Despite the fact that women are adequately represented in the general medical industry, it is rare to find female doctors in leadership positions in a hospital or in academic medicine, as they are generally found in lower ranks or in general practice (Reimann & Alfermann, 2018; Wolfert, Rohde, Mielke & Hernández-Durán, 2019). Due to the sustained biases associated with gender gaps, "female physicians face barriers to academic career progression [in the medical industry], and are under-represented, compared to their male counterparts, at senior levels" (Fridner, A., Norell, A., Akesson, G., Senden, M., Lovseth, L., & Schenck-Gustafsson, K., 2015, p.1). This paper examines this gender gap through the lens of enacted stigmatization and stigma consciousness which are factors known to influence the job performance of affected individuals and organizational culture (Lyons, Zatzick, Thompson, & Bushe, 2017).

Several factors have been researched in an attempt to explain why this gender imbalance in medical specialties has occurred for so long (Chapman et al., 2019). Different specialties in the medical community are known to experience gender bias. For example, the surgical culture has often been described as an "old boys club" and is just one example of many in the way that certain institutional cultures and norms pose barriers to women (Han et al., 2018; Reimann & Alfermann, 2018; Serrano, 2007). Despite the extensive

literature exploring gender bias in medical specialties, the relationship between this topic and enacted stigmatization and stigma consciousness is still unclear. We address this issue by exploring the existing literature regarding enacted stigmatization and stigma consciousness and asserting propositions as to their potential impact female physicians' choices of medical specialties.

CONCEPTUAL FRAMEWORK AND MODEL DEVELOPMENT

This paper explores existing literature focusing on gender and the career trajectory of women in the field of medicine. The authors note a gap in the literature relating to this topic and the topics of enacted stigmatization and stigma consciousness. This paper looks at the ways in which stigma may relate to gender inequities in upper level or leadership positions in medicine and analyzes existing literature to develop the theoretical propositions associated with the model. We theorize that the experiences of enacted stigmatization relate to stigma consciousness in female physicians. Additionally, we posit that stigma consciousness may be a factor influencing career choices for female physicians. The authors contribute to management and organization science by noting a gap in existing literature worthy of investigation and propose a theoretical model for exploration in future research.

OVERVIEW OF STIGMA

Corrigan and Penn (2015) describe stigma as a social construct that is based on prejudice or negative stereotyping. Stigma can be defined as "the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination in a context in which power is exercised" (Hatzenbuehler, Phelan, & Link, 2013, p. 813). Stigma implies that it is permissible to treat members of certain identity groups differently or negatively because their social identity is devalued in some way. Stigmatized populations can suffer a number of negative effects from stigmatic experiences (Hatzenbuehler et al., 2013). Stigmatic experiences could lead to poor coping behaviors and fear of rejection, which may lead to social isolation.

Goffman's (1963) early research on stigma stated that individuals in a stigmatized group are often viewed by the "normals" as not quite human, allowing the "normals" to rationalize their animosity based on their differences with the "others" (p.5). The term "normals" refers to individuals not part of a stigmatized group. The "normals" may often rationalize their views of stigmatized individuals as "thoroughly bad, dangerous, or weak" and may reduce the individual from "a whole and usual person, to a tainted and discounted one" in their minds (p.3).

Stigmatization of Female Physicians

Traditionally, organizational systems, social structures and views on gender are career development barriers to women (Wolfert, Rohde, Mielke & Hernández-Durán, 2019). Despite the increasing numbers of women among physicians, the sluggish improvement in the career trajectory of female physicians has been the subject of much research (Han, Kim, Kim, Cho, & Chae, 2018). According to Han et al. (2018), unless female physicians refuse to conform to gender values, they are likely to remain stagnant in follower roles, as opposed to advancing to leadership roles.

In general, hospitals and the medical profession at large, have a long-standing tradition of gender discrimination (Chapman et al., 2019; Reimann & Alfermann, 2018; Wolfert, Rohde, Mielke & Hernández-Durán, 2019). "Steep hierarchies, a high related criteria of career opportunities, and networks of exclusively male doctors in specific disciplines characterize hospitals as historically grown gendered organizations" (Reimann & Alfermann, 2018, p.53). Reimann and Alfermann (2018) also stated that female characteristics are primarily associated with the field of nursing and care, while male characteristics are often associated with the doctor, who is often portrayed as a hero or savior to the sick.

Enacted Stigmatization

Herek (2007) defines enacted stigmatization as "the overt behavioral expression of sexual stigma through actions such as the use of… shunning and ostracism of sexual minority individuals, and overt

discrimination and violence" (p. 908). Essentially, enacted stigmatization goes beyond what people *think* of stigmatized individuals to what people *do* to stigmatized individuals.

A common form of enacted stigmatization is discrimination, which often manifests as unwarranted or negative treatment of others based on their gender. In the workplace, discrimination can be informal, such as gossip or crude jokes, or formal, such as being denied promotions or resources (Kawase, Carpelan-Holmström, Kwong, & Sanfey, 2016). Harassment includes a wide variety of threatening or intimidating behaviors, that can be verbal or physical in nature, and can be a very common experience for women in the workplace. Even though corporations and organizations are becoming increasingly more inclusive and tolerant, discriminatory behaviors are still a systemic workplace issue (Zurbrugg & Miner, 2016).

As part of the adverse effects of discrimination, "an individual who is in the minority can experience intense scrutiny and be the victim of biases and prejudices amongst the majority" (Robinson, 2003, p.181). Butkus et al. (2018) cite several studies that demonstrate that in the field of medicine, women have higher rates of workplace discrimination than males, while black women are even more likely to experience gender bias than white women. It is not uncommon for female physicians to suffer from the assumption that they will work minimal hours, or quit altogether, once they have children (Butkus, Serchen, Moyer, Bornstein, & Hingle, 2018; Reimann & Alfermann, 2018; Serrano, 2007). Serrano (2007) cites the example of women getting excluded because meeting times may conflict with family responsibilities. Women are often criticized for their appearance, either being described as unfeminine or too attractive (Mavin & Grandy, 2016). Having qualities such as empathy or the desire to spend more time with patients can be viewed as negative and seen as interfering with being efficient and competent (Robinson, 2003). Overt leadership behaviors or characteristics may distinguish a man as being assertive but may be described as being "bitchy" or "too aggressive" coming from a woman (Robinson, 2003).

In a survey of women urology residents, "several reported alarmingly inappropriate comments about motherhood, pregnancy, and lack of physical stamina and the impact of each on professional performance and potential" (Jackson, Bobbin, Jordan, & Baker, 2009, p. 1871). Butkus et al. (2018) found that physicians who were mothers have difficulties obtaining maternity leave or accessing child care. One respondent to the survey even noted that some of her male counterparts had commented that women should not be allowed to get pregnant or take maternity leave while completing residency. Another respondent was pregnant at the time of the survey and was lectured by her male colleagues about her sex life and irresponsibility in not using contraception. Others reported that they dealt with the assumption that women were not as dedicated and had to endure sexist comments on a regular basis. In a mixed-methods study, McLaughlin, Uggen, and Blackstone (2012) found an increased level of harassment in male-dominated occupations.

Overt biases and prejudices do not seem to be the only thing female physicians have to contend with. In recent years, several studies have shown a drastic compensation inequity between male and female physicians (Apaydin, Chen, & Friedberg, 2018; Butkus et al., 2018; Reimann & Alferman, 2018). In primary care, female physicians made $197,000, which was 16 percent below their male counterparts, who made $229,000 annually. The gap widens to 37 percent in terms of specialties, with men earning $345,000 annually to their female counterparts at $251,000 (Butkus, Serchen, Moyer, Bornstein, & Hingle, 2018).

Stigma Consciousness

Targets of stigma do not experience their stereotyped status in the same way (Pinel, 2004). Pinel (1999) defines stigma consciousness as the extent to which minority individuals internalize, perceive, and accept their stigmatized status, in addition to how their stigmatized status influences their behaviors in these stereotype relevant situations. Members of a stigmatized group can often see how their association with a particular group influences their interpersonal interactions. "Jokes directed at their ingroup, accusations of wrongdoing, a host of nonverbal cues, and the very language people use all serve to remind targets of this lack of respect from society at large" (Pinel & Paulin, 2005, p. 345). Pinel (2004) does make the distinction that stigma consciousness is not necessarily one's awareness of stereotyped status, but rather one's focus on that stereotyped status.

Walsh (2002) provides the example of the differences in the way women and men respond to stress in the operating room. As described by Walsh (2002), a female surgeon may "lose it" by crying, while a male

surgeon may "lose it" by throwing instruments or yelling. While neither of these expressions is ideal, both are expressing emotions. However, because the female surgeon cried, she is more likely to be viewed as weaker or less professional. This could lead to unproductive coping mechanisms, such as feelings of self-doubt or anger, guilt, shame, isolation, and other adverse outcomes in an effort to subdue the stress (Robinson, 2003).

Female physicians can choose to personally reject the stigma that society and the profession associates with their gender, still they maintain the awareness that every social and professional interaction carries with it the possibility of stigmatization. As noted by Rabelo and Cortina (2014), morals and broad cultural perceptions dictate which social groups are valued and not valued, even at an organizational level, meaning workplaces may explicitly or implicitly value different social groups to varying degrees. It is this value difference that perpetuates the issue.

Stigma consciousness can cause a great deal of psychological distress, which ultimately results in a negative impact on a stigmatized individual's workplace experiences. "Work environments often demand conformity to traditional notions of masculinity and femininity" in the form of gender norms (Rabelo, & Cortina, 2014, p. 380). Depending on organizational behavior features, such as culture, traditional notions of masculinity and femininity may present challenges relating to diversity and inclusion. Failing to encourage inclusivity and equity may result in grave workplace consequences for both employee well-being and organizational performance (Reilly, Awad, Kelly, & Rochlen, 2019). Accordingly, those with low expectations of discrimination display less psychological stress than those with high expectations of discrimination (Nouvillas-Palleja, Silvan-Ferrero, de Apodaca, & Molero, 2018).

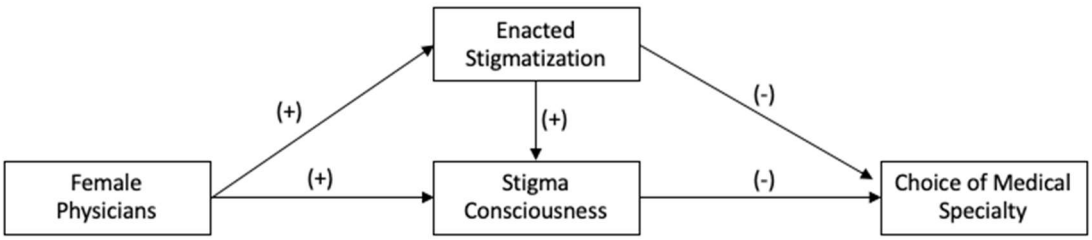
In addition to experiences in the workplace, female physicians are also conscious of their work/family conflicts, as well as domestic responsibilities (Kawase, et. al., 2016). Due to the lengthy medical training period and its correspondence with safe child-bearing years, the timing of pregnancy and childbirth creates significant problems for female physicians (Serrano, 2007). "Women have to deal with the stresses and possible conflicts of being a professional at the same time as [having other familial responsibilities, such as] being a wife and a mother" (Robinson, 2003, p. 184). Robinson goes on to state that while male physicians might also be married and have children, their roles have not historically appeared to conflict.

THEORETICAL PROPOSITIONS

Therefore, the following propositions are offered as a possible explanation as to why certain medical specialties are dominated by males with very few female physicians:

- **P1:** Experiences of enacted stigmatization against female physicians by male physicians will lead to higher levels of stigma consciousness in female physicians and can potentially explain why female physicians are avoiding male-dominated specialties and choosing general or primary care fields in higher numbers.
- **P2:** The phenomenon of stigma consciousness can potentially explain why female physicians are avoiding male-dominated specialties and choosing general or primary care fields in higher numbers.

FIGURE 1
WORKING MODEL OF THE RESEARCH



IMPLICATIONS

Targets of stigma tend to disengage and even remove themselves from a stigmatizing environment, if possible (Pinel & Paulin, 2004). If female physicians are stigmatized in certain specialties, it would make sense that these women would leave those specialties and choose a specialty that is more inviting and accepting. "A general finding is that women are more likely than men to be working in general or primary care fields. Women are far less likely to be found in surgical and hospital medical specialties" (Reed & Buddedberg-Fisher, 2002, p.140). Reyes (2008) does point out that there are certain medical specialties, such as OB-GYN, where not only are the patients women, but they tend to prefer to see a female physician when it comes to issues such as sexuality and childbearing. However, higher demand for female physicians in certain fields does not explain the gender imbalance that currently exists in the medical community at large.

According to the AMA in 2019 (Murphy, 2019), women make up a larger percentage of residents in obstetrics and gynecology, allergy and immunology, pediatrics, medical genetics and genomics, hospice and palliative medicine, and dermatology. Specialties dominated by men included orthopedic surgery, neurological surgery, interventional radiology, thoracic surgery, pain medicine, and radiology. Only four specialties seemed to have an even mix of male and female physicians: sleep medicine, preventive medicine, pathology, and psychiatry (Murphy, 2019). It would make sense to hypothesize that if women are the victims of enacted stigmatization (i.e. discrimination and harassment), they would have higher levels of stigma consciousness, and would therefore remove themselves from those situations or medical specialties.

FUTURE RESEARCH

While much research has been conducted in regard to the disparities between men and women within medical specialties, none has been conducted with specific regards to enacted stigmatization and stigma consciousness. It is important to understand why women are choosing certain medical specialties and why others are dominated by their male counterparts; and if enacted stigmatization and stigma consciousness are significant indicators for this then organizational leadership can target these factors in order to mitigate related issues within organizations. Finally, this model of enacted stigmatization and stigma consciousness should also be applied to other minority groups within the field of medicine, such as physicians of color to determine if stigma plays a part in the specialties those groups choose, as well.

CONCLUSION

Despite the fact that women complete their medical studies with better performance than males, a career in medicine is more difficult for female doctors than for their male counterparts because of the enacted stigmatization relating to their job performance (Heilman et al., 1997; Reimann & Alfermann, 2018). Medical specialties are actually missing out on talent since emerging evidence has shown that that quality of patient care given by female physicians is good, and sometimes better, than care given by male physicians (Chapman et al., 2019). Experiences of enacted stigmatization and stigma consciousness of female physicians can potentially impact both specialty choice and job performance and explain the reason female physicians are avoiding male-dominated medical specialties and focusing more on primary care and general practice fields in higher numbers. This is a critical concern for healthcare management and administration as enacted stigmatization and stigma consciousness have adverse work outcomes from the perspective of organizational behavior (demonstrated by poor group dynamics and equity issues embedded in the organizational culture) as well as human resources factors like recruiting and talent management, employee relations (such as wellbeing and psychological safety) and employee job performance (Reilly et al., 2019).

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