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In August 2018 officials from Tokyo Medical University admitted to systematically altering medical school admission test scores to disadvantage female applicants. Since 2006 the university had been subtracting points from all exam scores, then adding up to 20 points to those of male applicants, with the explicit goal of reducing the percentage of women entering medical school. (The percentage of enrollees who were women had reached 40% in 2010, and now stands at approximately 30%.)

This systematic discrimination against female medical school applicants is not only sexist and scandalous in its own right — not to mention devastating for the women denied access to the profession they desired — but it constitutes a potential threat to patient safety and public health.

Accumulating evidence shows that women deliver superior care. For example, one study of over 1.5 million Medicare patients found that those who were treated by a female physician were less likely to die or be readmitted to the hospital within 30 days than those patients treated by a male physician. A separate study of over 100,000 surgical patients found the same effect: Patients who were operated on by a female surgeon were significantly less likely to die within the next 30 days.

Other research has demonstrated that these differences in outcomes may be particularly pronounced for female patients. A recent study of over 500,000 patients who experienced a sudden heart attack found evidence that *any* patient treated by a female physician was more likely to survive, compared with those treated by a male physician. But the researchers also found strong evidence that the effect was particularly pronounced for female patients.

What accounts for the differences in outcomes achieved by female and male physicians? The underlying mechanisms have yet to be fully explored, but evidence suggests that female physicians bring unique perspectives to their practice that can improve care. For instance, female physicians tend to engage in more preventative care and more-effective doctor-patient communication. Research has also found that female physicians engage in more evidence-based care practices and score higher on medical school examinations, relative to their male colleagues, factors that may account for their better outcomes.

But there are other issues at play. A recent study of surgeons and other operating room (OR) team members revealed that the percentage of women in the OR team was directly associated with more cooperative behavior (critical for effective, safety-focused OR team performance), with a substantial drop in cooperation when the number of men on the OR team exceeded 50%.

In light of this evidence, it is reasonable to conclude that any practice, bias, or treatment that keeps women from entering and advancing in medicine is actually denying patients opportunities to receive higher-quality care. While overt sex-based discrimination like that observed at Tokyo Medical University is uncommon, pernicious attitudes and systemic pressures exist throughout medicine that inhibit the inclusion and development of female physicians.

The underrepresentation of women in medicine is well-documented, with women making up more than half of medical school entrants but fewer than 35% of all active physicians in the U.S. (and far lower percentages of senior leadership positions). This underrepresentation is driven by a range of factors, from different preferences and gendered attitudes about certain medical specialties to persistent wage gaps and biases in hiring or promotion decisions.

Biases that disadvantage women are observable even within the clinical components of medical training, resulting in different experiences for men and women during medical school and residency training. For instance, having autonomy during surgical residency is important for developing skills and preparing for a successful future career. In a clever study of thoracic surgery training, Shari Meyerson and colleagues observed differences in the autonomy given to male and female residents. The researchers sent both residents and faculty surgeons mobile alerts immediately after the completion of a surgery, asking both to independently report the degree of autonomy provided to the resident in the case. Both the faculty and the resident ratings agreed that female surgical residents were given significantly less autonomy in the OR, even after adjusting for a variety of factors related to the case, the faculty surgeon, and the resident's level of experience.

The obvious conclusion is that these barriers restricting the access and development of women's careers in medicine need to be removed, as many have already called for. The field is routinely under-promoting, under-supporting, under-rewarding, and under-training female physicians. And yet, despite these implicit and systematic barriers, female physicians continue to persist and achieve better outcomes than their male colleagues.

A second implication is that male physicians can learn from their female colleagues. In the study of heart attack patients we described earlier, male physicians who had more exposure to female physician colleagues were better able to treat female patients. This suggests that not only will women benefit from having more female physicians in leadership positions, but men will benefit from the education they receive from these women as well.

Allowing things to continue as they have for women in medicine is accepting a system where potentially higher-quality care is denied to patients due to sexism and bad practices. In fact, the difference in patient mortality observed in studies of male and female physicians is approximately the same magnitude as the improvement in mortality that can be attributed to the last decade of scientific improvement in patient care. This means that excluding female physicians in the health care system sets our society back not only in gender equality but also in terms of the progress we should be making in medical care.

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