Women in Medical Leadership: Building Solutions

Facilitated dialogue to enhance the recommendations of the Female Physician Leaders in Alberta Health Services *report – November 18, 2019 in Calgary, Alberta*

ACH-, COMMUNITY-, CLS-, FMC-, PLC-, RGH- AND SHC MEDICAL STAFF ASSOCIATIONS
SUBSIDIARIES OF THE CALGARY AND AREA MEDICAL STAFF SOCIETY

Introduction

Women represent more than 50% of all medical school students and 40% of physicians, and yet female physicians represent only 26% of leadership positions within Alberta Health Services (AHS).[1]

Why is this disparity concerning?

At its core, gender equity reflects the value that all persons are fundamentally equal and valuable. As such, circumstances where certain individuals or groups are persistently and systematically disadvantaged due to their membership in a particular demographic (e.g. gender, ethnicity, religion, etc.) are inequitable, and thus, ethically problematic. Many organizations have recognized this issue and have taken steps to try to minimize inequity. For example, AHS has developed the Our People Strategy which articulates a commitment to creating a culture in which everyone feels safe, healthy, valued and included, and can reach their full potential.[2] To fulfill this commitment and ones made by similar organizations, barriers to female physicians attaining and remaining in leadership positions must be identified and addressed.

Increasing the number of female physicians in leadership roles is also likely to incorporate a wider range of perspectives, leadership styles, and strengths. Deliberately pursuing strategies to include female physicians more representatively in leadership roles will help to achieve stronger, more diverse leadership, more fulfilled physician partners, healthier workplaces,[3] and better overall outcomes for Albertans.[4,5,6]

Building Solutions

Physicians from across Calgary met on November 18, 2019 to discuss recommendations from the *Female Physician Leaders in Alberta Health Service* report, released in December 2018. Facilitated "Solution Circles" of approximately 10 people per group discussed topics drawn from the above report, with the joint goals of obtaining additional contributions from stakeholders and developing a concrete action plan to further the 2018 recommendations. Interest in this event exceeded the capacity of the room, reflecting the commitment and urgency felt to advance this important issue.

Solution Circle topics included: Education for diversity in leadership; Women in academic medicine; Management of adverse events in the workplace; Promoting wellness/balance in leadership; Hiring and recruitment; Female leader sponsorship; Networking for aspiring and existing female leaders; and Culture in medicine, the benefits of having an increased female presence in leadership.

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[1] Alberta Health Services. (2018). Female Physician Leaders in Alberta Health Services.
[2] Alberta Health Services. (2016). Our People Strategy: Because We are Stronger Together.
[3] Alberta Health Services. (2016). Creating Diversified, Respectful, and Inclusive Teams.
[4] Neubert, MJ and Palmer, LD. (2013). Emergence of women in healthcare leadership: Transforming the impact of gender difference. *The Journal of Men's Health and Gender.* 1(4).
[5] Tsugawa, Y, et al. (2017). Comparison of Hospital Mortality and Readmission Rates for Medicare Patients Treated by Male vs Female Physicians. J*AMA Internal Medicine*. 177(2), 206. doi: 10.1001/jamainternmed.2016.7875
[6] Greenwood, BN, Carnahan, S, & Huang, L. (2018). Patient–physician gender concordance and increased mortality among female heart attack patients. *Proceedings of the National Academy of Sciences*, *115*(34), 8569–8574. doi: 10.1073/pnas.1800097115

Key Themes from the Facilitated Discussion

The gender disparity in physician leadership roles is symptomatic of a number of contributing factors endemic to health care and academic medicine. These include entrenched gender hierarchies, implicit and explicit discrimination, sexual harassment, gender pay gaps, and a failure to recognize and accommodate the familial responsibilities and expectations of women.[7] These factors, individually and cumulatively, affect women's options and opportunities in the workplace.

Specific themes generated from the Solution Circles are summarized below. Barriers were identified at both the individual and the organizational level.

Each of these headings represents individual factors which cumulatively result in overwhelming hurdles facing women in leadership and perpetuate inequity.

Implicit Bias

Individual: Women may not regard themselves as sufficiently qualified to pursue leadership roles.

Organizational: Female candidates are often viewed as less competent or their work histories less valued (for example, administration and teaching roles valued less than clinical and research roles). False beliefs and assumptions about female physicians regarding their competency and leadership capabilities may persist. Hiring committees and practices are not sufficiently focused on transparency and equity.

Explicit Bias/Gender Difference

Individual: Clinical practice may be different for women, who may receive more complex referrals and manage more complex psychosocial patient issues, requiring more clinic time than their male colleagues. This phenomena often goes unrecognized and often reduces opportunities to generate income in a fee for service environment, and leaves less time for leadership activities.

Organizational: Perception that traditional female characteristics are not sufficient for, or valued in, leadership. Males and females are evaluated differently - women on their accomplishments and men on their potential. In general, female workers are seen to be less competent than their male counterparts. There are insufficient, safe opportunities to talk about issues relating to gender equity. There are no formal opportunities for redress when gender discrimination/harassment occurs. This becomes particularly important when there is a power differential.

[7] Ruzycki, SM, et al. (2019). Association of Physician Characteristics with Perceptions and Experiences of Gender Equity in an Academic Internal Medicine Department. *JAMA Network Open.* 2(11)

Power Gap

Individual: An individual is limited by the need to seek a mentor/sponsor in the absence of a formal system. Those interested in finding a mentor or sponsor have to rely on others agreeing to this role. There is also the potential for male leader reluctance to take on female mentees/sponsees in the context of the #MeToo movement. Women may have less access to those in positions of power.

Organizational: In the current hierarchical system, insufficient formal systems exist for mentorship/sponsorship. Inclusion (tokenism) is not sufficient; women need real decision-making authority and meaningful support in leadership roles. Questions about female leadership are not included in the sphere of negotiation between the medical community and government or other third parties.

Knowledge and Skill Gap

Individual: There is a lack of knowledge about opportunities, about paths to achieve leadership roles and to participate in academic medicine, and about available training opportunities. There is a lack of information about how leadership training connects with leadership opportunities, and about the roles of sponsors and mentors.

Organizational: There is a lack of transparent process for how leadership development takes place. Positions leading to advancement may not be posted. Hiring processes are not sufficiently transparent. There is a lack of training among existing leaders about implicit bias, the value of diversity, multiple models and styles of leadership. There is a paucity of data about female leadership, both from the perspective of extant resources and outcome measures. There is a current lack of knowledge and skills about how to effectively respond to adverse events (harassment, abuse) and to take effective action.

Access

Individual: Proximity (physical/social) to sponsors and mentors is necessary/helpful for leadership development. Access to sponsorship or mentorship can be ad hoc; it is not equitably distributed. Applicants who have not had access to sponsors (or effective sponsors) are at a disadvantage. Timing of meetings (evenings/weekends) and access to childcare, among other factors, disproportionately limit women's ability to access leadership growth opportunities

Organizational: There is no protected time for leadership or leadership development; many physicians have to give up clinical time to lead, whereas non-physician colleagues are paid for their leadership work. Access to salaried positions is limited which would allow for protected time to develop and sustain leaders. Leadership development opportunities must acknowledge the access limitations of women.

Parental/Social Roles

Individual: Parental leave inequity may unduly disadvantage women (e.g. they may not be present for discussions about leadership positions, or may not be considered due to their absence). The gap on a résumé due to familial roles (e.g. maternity, parenting, caregiving) is a liability. There are challenges with paternity leave as well, suggesting that medical culture has challenges with physician parenthood in general. The demands of professional and non-professional roles (parent, spouse, caregiver) leads to many self selecting away from applying for and remaining in leadership roles.

Organizational: There is a lack of formal structures or financial investment to support family roles (e.g. effective maternity leave coverage, supports for additional care). Timing/cost of training opportunities may not reflect the demands of parenting (e.g. the second shift) and may make such opportunities inaccessible (e.g. by scheduling opportunities during key parenting times). Leaders are often identified through activities engaged in during their careers, from medical school onward; those who may be ready for leadership later in their careers would not have a comparable history of leadership development.

Culture of Civility and Respect

Individual: Female physician leaders and all physicians are experiencing microaggressions*, disruptive behavior and harassment which are largely unreported due to concerns of not being taken seriously, fear of retaliation, and because previously raised concerns were not addressed or were dismissed. The behaviors come from other leaders, physicians, nursing and from patients. (1. AHS 2018) These adverse experiences are impactful and sometimes traumatic, resulting in the individuals being silenced and marginalized. This negatively affects mental health.

Organizational: Currently the majority of Zone Clinical Department Heads are male at 83% (1. AHS report 2018) Male leaders and male physicians are unaware of the types of microaggressions females experience and are less able to recognize microaggressions.(7. Common Types of Gender-Based Microaggressions in Medicine, Academic Medicine Periyakoil et al, October 2019) Current leaders must recognize the need for addressing microaggressions within medical culture to enable directed change. Prevention of gender based harassment and psychological safety are legal requirements in Alberta workplaces.

> *Microaggressions are defined as everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership.[8]

Summary

These multitude of inter-related factors, if left unaddressed, will perpetuate existing inequities, restrict growth in leadership and, ultimately, negatively affect patient care.

Addressing the gender gap in physician leadership requires an intentional, concerted, proactive approach beyond simply raising awareness of the issue.

[8] Derald Wing Sue, Ph.D. (2010). Microaggressions in Everyday Life: Race, Gender, and Sexual Orientation. Copyright © 2010, John Wiley and Sons[8]

Detailed Recommendations

Female physicians choosing to pursue, be selected for, and remain in leadership roles may be affected by many of the above-mentioned factors, at the following decision-points throughout a leadership career. As a result, to address the gender gap in leadership, strategies must be implemented to address barriers at each stage along this trajectory. Suggestions made by the Solution Circles are included below.

1) Leadership Training

- Leadership education opportunities have to accessible
- Maintain funding for leadership education
- Payment structures must be adjusted to accurately reflect the work of leadership and FTEs must accurately reflect the work of leadership
- Increase financial and administrative support to take on research and leadership
- Create a general mechanism for women to learn more about academic medicine
- Intentional and transparent succession planning

2) Developing Leaders: Formal and Informal Connections

- Improve structures to formalize and create mentorship and sponsorship opportunities (e.g. formalize these for faculty).
- Each physician, irrespective of gender, should be required to sponsor at least one person per year (with some form of remuneration or recognition in some cases)
- Royal College of Physicians and Surgeons and College of Family Physicians could facilitate sponsorship of female leaders by developing a curriculum about sponsorship
- Bring along junior colleagues to events
- Increase social events to allow for “natural” networking to occur
- Host targeted events to allow those in power to see who is interested in leadership
- Create events where children can attend (e.g. provide childcare)
- Encourage “women supporting women” by adopting compassionate leadership, offering support, and providing balanced feedback to female colleagues
- Strengthen Medical Staff Association lounges at hospital sites to create a collaborative environment
- Strengthen community connections for those outside of hospitals
- Address the need for female leaders’ sponsorship early in medical school with early real-life experience tailored to encouraging female leaders
- Investigate novel approaches to using technology to engage women in leadership education, events and opportunities

3) Applying for Leadership Roles

- Leadership role demands must match the FTE
- Allow for more flexibility and accommodation in leadership duties to make the roles more attractive to broader groups of people
- Standardize transparent practices for posting positions and hiring
- Devise and uphold specific leadership selection criteria across all levels of the medical career trajectory. This includes Equity, Diversity and Inclusion (EDI) statements, awareness and implementation

4) Being Selected for Leadership Roles

- Train hiring committees in unconscious bias, wellness, respect, equity, diversity, inclusivity, and strength-based leadership
- Blind name/gender information of applicants during relevant phases of hiring/assessment
- Avoid leadership decisions based on the "he's a good guy" mentality; rather, focus on a merit-based sponsorship of leadership-inclined physicians
- Consider applicants who are interested in taking on leadership roles later in their career (e.g. after children have grown)

5) Being Sustained in Leadership Roles

- Mandate training for leaders in unconscious bias, wellness, respect, equity, diversity, inclusivity, and strength-based leadership
- Make EDI a key performance indicator for leaders
- Consider the Athena SWAN (Scientific Women's Academic Network) model to promote and value diversity in organizations
- Create safe spaces to allow women to speak up about gender inequity
- Provide education about how and when to speak up about adverse events (harassment, abuse)
- Increased accountability for leaders including a safe process for evaluation by their direct reports
- Introduce data and metrics to evaluate leaders objectively and transparently. We will improve what we care enough to measure.

6) Concerted Effort to Improve Civility and Respect in AHS Culture

- Create a confidential reporting registry to identify adverse behavior events and to identify possible "hotspots" of poor workplace behavior
- Create a multidisciplinary professionalism committee to investigate reports of unprofessional behavior and for promotion of education and a retaliation-free culture
- Training must be mandatory for all physicians regarding microaggression awareness: microaggression definition, the effects on physician well-being and patient outcomes

- Support all leaders to handle microaggressions with educational tools they can utilize to promote culture change, maintain professional standing, and mitigate the effects of complaints/reports
- Data collection in the form of a periodic professionalism survey to evaluate the effectiveness of culture change initiatives

Priority Initiatives: 2020

The following are recommendations for implementation in the next 12 months as priority action:

- All leaders must be made aware that gender based harassment is illegal and workplace psychological safety is a legal requirement in the province of Alberta
- Posting all leadership positions on a common platform
- Formalize mentorship and sponsorship programs
- Education about EDI culture in medicine
- Province wide implementation of the Saegis/CMPA endorsed Just Culture Algorithm Tool which addresses system factors, individual factors and culture when evaluating reported errors and events
- Awareness campaign presenting women in traditionally male leadership roles
- Add EDI as a key performance indicator and core competency for all leaders