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Paging Equality: A Study of Women Leadership Positions in Medicine

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Abstract:

In this paper, I have examined how gender bias is perpetuated in the medical field through examining the lack of women in leadership positions. I looked at the efforts of John Hopkins, Harvard, and University of California Davis to correct these institutional biases and facilitate a change for women. I used criteria suggested by Professor Shelley Correll from Stanford to scrutinize the methods implemented by the respective medical schools. I also examined the available data to determine effectiveness. I concluded that the University of California Davis Medical School Women in Medical and Health Science program had the most effective program to gain more women in leadership positions at their medical school. I recommend that other medical schools and teaching hospitals adopt their progressive and inclusive program.

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Paging Equality: A Study of Women Leadership Positions in Medicine

In the past few decades, the number of women enrolled in medical school has skyrocketed, creating room for women to make a difference in this prestigious and important field. However, this shift in the gender makeup of graduating MDs is not yet manifested on the professional stage of practicing physicians and medical academia. As of October 2015, women make up roughly 50% of medical students but only 33% of practicing physicians (Kaiser Family Foundation). Worse yet, there exists a stratification of women in lower paying and less prestigious specialties, due in part to the existing gender bias in medicine (Wu 222). This bias includes societal expectations for maintaining a family— i.e. work life balance. This gender biased societal norm is far less important for male coworkers.

Manwai Ku, a doctoral student in the Department of Sociology at Stanford argues that men and women enter in to their respective occupational fields previously conditioned with values socially produced and reinforced throughout their lifetimes (Ku 223). General research has shown feminine stereotypes also perpetuate the idea of women possessing more warm and caring characteristics while men are viewed to be more technical and skill oriented. Keeping this in mind, women may gravitate towards specialties more oriented around patient care like primary medicine or pediatrics and men may be more attracted to specialties like orthopedic surgery. However, other factors must be considered as to why women choose these specialties; for example the lack of role models in higher-ranking positions. In academic medicine only 21% of professors are women and only 15% of department chairs are women. In hospitals, 46% of

residents are women but only 26% of division chiefs are female physicians (AAMC). And leaders tend to promote people like themselves so men promote more men.

In this paper, I am addressing the important issue of why women are not progressing into the leadership positions and how to facilitate change to correct this imbalance. We are seeing progress and there is hope. Many prestigious learning institutions are already implementing change in order to achieve this goal. I will be comparing and contrasting John Hopkins School of Medicine's Office of Women in Science and Medicine, Harvard School of Medicine's Joint Committee on the Status of Women, and University of California Davis School of Medicine's Women in Medicine and Health Sciences program (WIMHS). Through facilitating change in their Department, how has each program contributed to women in academic medicine and what are their program's limitations?

In Dr. Gail Erlick Robinson's article published in 2003, she cites significant yet unsurprising evidence for the discrimination women still face. It was discovered that 47% of practicing female doctors had experienced gender-biased harassment. In a recent reported study with fulltime faculty at 24 medical schools, female medical students reported rates of discrimination ranging from 47-70%, from within the medical school (cited in Robinson 181). This constant institutionalized stress of discrimination, that women routinely face, is not conducive to building self confidence, especially in the absence of female mentors. Robinson also cites that, "in a study of female surgeons, Ferris et al. found that 80% of 415 respondents reported they did not have a female mentor" (cited in Robinson 182). The lack of women holding positions in the upper echelons of medicine and academic medicine leads to a lack in the number of available female mentors for young female physicians. This lack of mentoring lends itself to an environment in which men are advantaged and women are disadvantaged or, put another way,

face more discrimination. In order to combat this unfair gender based outcome, young women need more female mentors, but in order to obtain more mentors, women need to be identified, encouraged and then propelled into more leadership positions.

The Voice and Influence Program is a series of online videos produced by Shelley Correll, a professor of Sociology at Stanford, to inform the public about ways to empower both men and women to be effective in reducing gender bias, thus strengthening organizations (*Creating a Level Playing Field*). Professor Correll talks about how to “level the playing field”. She describes gender stereotyping as “cognitive shortcuts that introduce error in decision making” (4:41) This self-perpetuating gender bias is what leads institutions like Johns Hopkins to continually hire more men than women medical faculty even though there are an equal number of qualified women in the selection pool. This is a significant problem because mentorship for female physicians starts as young as the undergraduate experience. She suggests ways to inhibit these cognitive shortcuts so that gender bias is less likely to take place. It is through the lens of this advice that I assess, analyze and compare the three existing programs respective efforts for change at Johns Hopkins, Harvard, and UC Davis. What each program should aim to do is: 1. educate people about stereotypes (21:20), 2. establish clear criteria for making decisions (21:53), 3. scrutinize that criteria for possible bias while being transparent (20:45), and 4. vouch for the competence of women (24:34).

Having women in leadership roles in medical school is an important factor in encouraging women to progress in their medical careers. In a study done among undergraduate females pursuing the pre med track, they found that “successful female role models increase perceived compatibility between being a woman and being pre med, in turn increasing sense of belonging in pre med, finally resulting in greater interest in being pre med and in pursuing a

career as a physician” (Rosenthal, Levy, London 472). If there are plentiful mentors at the medical school, then they can encourage more women to pursue surgical fields and somewhat combat the stereotype threat that is found to affect female surgical residents (Salles).

In 2005, Johns Hopkins University published a report on the Status of Women Faculty at their Medical School. Although dated, this report tracks key issues and plans to minimize them. One of the root causes they cite contributing to obstacles for women’s success and upward mobility is gender-schemas. “Women are undervalued, under-recognized for their contributions and under-rewarded” (JHSM Table 2). The percentage of faculty positions held by women had been stagnant over the past two decades at the medical school, but women had increasingly entered the pool of eligible PHD candidates. Presently women are equally represented in this pool, however, not in terms of acquiring these faculty positions (Table 2). When this report was written, 20% of tenured faculty were women. In 2015, ten years later, this number has only increased by 2% (JHMS). This is disappointing considering this report details possible solutions to the problem and goals to reach parity within ten years. An obvious and important question becomes- what happened and why wasn't it successful in promoting women into positions of leadership?

The mechanisms listed to achieve these goals were too vague. They vowed to “commit resources to increase representation of senior scholarly women” (4.2.2) but didn’t indicate how much or where these funds will come from. In terms of the hiring process, they declared they will establish a search committee and a candidate list as well as make the criteria for hiring clear. (4.2.3) Future plans are expressed more clearly in the Presidents and Provost’s response report on what they plan on doing to aid the Office of Women in Science and Medicine. The same goals are articulated with only slightly more detailed approaches. Phrases like, “retraining search

committee members and department leaders” (29) express good intent but the results don’t show any effectiveness behind their approach. It would be easier to determine why if they specified how they retrained the search committee members in these publicly accessible reports. Several times in both reports, 2015 is mentioned as the year the Medical School leadership will reach gender parity, but here we are in 2015 and this goal is far from realized.

Johns Hopkins was successful in utilizing some of Professor Correll’s advice such as educating people about the existing issues and establishing clear criteria for making decisions. However, since Johns Hopkins does not specify the criteria in their reports, it is difficult to “scrutinize” it, as Professor Correll recommended. The criteria could be indirectly filtering out women and this is a possible reason they have not achieved their goal.

Harvard Medical School’s Joint Committee on the Status of Women is very transparent in that they publish annual reports on their progress and new implementations. In their most recent report they detail their three newly minted taskforces, the Childcare Taskforce, the Flextime and Job Sharing Taskforce, and the Salary and Equity Taskforce (Harvard 5). This shows a conscious effort and productive dialogue to address some of the biggest hindrances in women’s careers. However, I could not find any data showing progress, or lack thereof, since the committee was created over three decades ago. This indicated to me a probable lack of success since most humans are quick to promote and publish their accomplishments and receive recognition from their peers.

That being said, the online timeline, though not up to date, has listed many of JCSW accomplishments such as initiating Harvard Medical School’s Maternity Leave Policy in 2003. Nothing is posted past 2008. Under the accomplishments section on their website reads, “We have had a strong history of advocacy and innovation. JCSW work led to the creation of

Mother's rooms, the Ombuds' Office, the Office of Work and Family, the HMS Dean's Leadership Awards, and the Child Care Summit." This is specific progress but more empirical data is needed to conclude the effectiveness of such programs. The end result needs to be monitored. Hospitals and Medical Schools should annually publish how many women are in positions of leadership as compared to prior periods.

The University of California Davis Medical School's program is one of the most comprehensive in nature. The program for Women in Medical and Health Sciences (WIMHS) "provides an inclusive and supportive climate and unique opportunities for female faculty to network, interact, and collaborate with each other." (Bauman, Howell, Villablanca) Faculty members at the University of California Davis Medical School wrote an article tracking "the components and evolution" of this program since its founding in 2000. Written in 2014, the evidence found, and the change described in the article, is contemporary and comprehensive. They cite the program's defined goals to advocate for women's advancement in leadership, produce a climate that promotes equity, collect and apply data to inform decisions, develop mentoring programs, celebrate women's accomplishments, and to work with other institutions to advance women nationally. (Bauman, Howell, Villablanca)

This program outlined specific ways in which they planned on realizing their goals. One unique facet of their plan was the utilization of social media. WIMHS created a website that is updated quarterly with future events, outlining everything from their "strategic plan" to "Family Leave Resources". (WIMHS) The website is user friendly with easy access to articles and resources to learn more about their mission. The content for Johns Hopkins and Harvard is not nearly as easily accessible or consolidated. WIMHS also created a blog and Facebook page that celebrates the work of women and educates the public almost daily. This shows the tremendous

constant effort and outreach required for actual change. Additionally, it shows that clear, concise and measurable goals are needed to effect real change. By articulating their goals and publishing these to the people involved, it “put stake in the ground” for UC Davis. The result is a much higher rate of women in leadership positions as compared to Harvard and Johns Hopkins who were well intentioned but vague and less committed in their goals and objectives. The data in the following paragraph clearly shows the quantitative result and differences between these top medical schools.

As compared to Johns Hopkins, UC Davis Medical School demonstrates much more effectiveness from their programs. In the article detailing the WIMHS program, the authors cite data from the year of the programs inception and data ten years later. The percentage of female faculty increased from nearly 20% to nearly 40% (A 100% increase) and the percentage of department chairs increased from 5% to nearly 25% (A 500% increase). While there is still work to be done, UC Davis over this ten-year period proves that it is possible that conscious efforts with publicly stated and measurable goals can contribute to a more equal environment. This result is also starkly contrasted with the meager 2% increase that Johns Hopkins saw in ten years, though they cited similar goals. This divergence of results is most likely credited to the more deliberate, measurable, and thorough programs implemented by WIMHS. Similar results hold as well when comparing UC Davis to Harvard or Stamford. It is clear that a stated goal by itself is not enough. It must be consistently measured, encouraged, and valued to become effective at promoting the change of increasing the number of women that are in positions of authority in medical schools.

In 2015, Dr. Louise Marie Roth from the University of Arizona conducted a study on different P4P (Pay for performance) programs meant to equalize the salary playing field,

examining how they widen or narrow the pay gap in medicine. She suggests that, “the gender pay gap within medicine is also larger than in other professions or the labor force as a whole” (cited in Roth 4). This is true even when “controlling for work effort and experience, specialty, practice type, family status and other relevant characteristics” (cited in Roth 4). The fact that female physicians earn on average 19.3% less than comparable men (cited in Roth 11), must be mentioned when examining why women are less ambitious in advancing through the medical field. Roth found an even more staggering difference in data from 2003. Men typically earned \$70,811 more than women doing the same job, with the average income of physicians being \$203,889. Among physicians who received bonuses without specific criteria for receiving these bonuses, the gap was \$88,190.70. The gap for bonuses with specified criteria was \$54,460.20 (Roth 11). This significant decrease demonstrates the importance of having clear, objective standards when giving bonuses.

This idea aligns with Professor Correll’s Voice and Influence programs’ stance on having specific criteria when hiring employees. A specific criterion forces a person to be more objective and reduces the chance for gender bias. However, as Professor Correll said the criteria must be scrutinized. Dr. Roth scrutinizes the criteria for which the different programs are evaluating their physicians. She found that with unspecified criteria, the pay gap was the worst. When the specified criterion was patient satisfaction there was no real difference in how much men and women were paid. When the criteria was productivity, which is the most objective criteria, women were paid at a rate 2.8% higher than men in bonuses, which actively decreases the gender pay gap (Roth 13). By putting in to motion the idea of scrutinizing the criteria, this one researcher was able to discover a practical and effective approach to help women receive equal pay for equal work, even in medicine.

The clear discrepancy in salaries among male and female physicians is a reflection of our cultural bias that permeates medicine as much or more as the other professions. This bias reinforces ideas that men are more competent or successful. Given this cultural bias, it is not surprising that not only do women choose less rigorous and prestigious specialties; they are also less likely to be promoted to leadership positions. The fact that women performed equally or slightly better, under the productivity basis, demonstrates that women are an asset as physicians and deserve to be represented and paid as such. The productivity basis is “typically defined as measure of labor output.” (Roth 5) Or in other words, “Relevant productivity-related characteristics include hours per week and years in practice.” They work just as hard and are just as affective as men. Now it is up to the medical institutions to implement whatever changes are needed to reward women for their hard work and encourage them to take risks to advance their careers.

The measures taken by Johns Hopkins, Harvard, and University of California Davis, all are valid efforts to solve the persisting problem of gender bias in medicine. Their efforts should not go unnoticed; however, since women have not reached parity within these institutions, (with UC Davis getting accolades for getting close to closing the gap) further analysis and work is necessary. As long as the issues of gender pay gaps, a lack of mentorship, and gender-stereotyped threat persists, women will not be as successful or paid as well as men in the medical and academic field.

Since the University of California Davis saw noteworthy success after the birth of their Women in Medicine and Health Sciences program, I conclude that using this program as a model would benefit women physicians nationally. By openly benchmarking with other similar medical institutions, using best practices, and focused on measurable results, I believe it is quite possible

to close the gender gap in the next ten years. Through employing annual workshops and lecture series, and celebrating women's accomplishments through recognition internally and externally including social media, in another ten years, hopefully the picture of parity for women in medicine will this time be visible and real.

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