Gender Equity in Leadership: SGIM, It's Our Problem!

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J Gen Intern Med 35(6):1631–2
DOI: 10.1007/s11606-020-05710-8

The findings of the analysis of leadership in Hospital Medicine published in this edition of JGIM[1] expose the fallacies of commonly held beliefs about leadership attainment by women in academic medicine, namely, that it is a pipeline issue. There is a continued misperception that as the number of women within academic medicine increases, their presence will be reflected in the proportion of women in leadership roles. Herzke and colleagues surveyed leadership in Hospital Medicine programs, a relatively new field that has emerged within General Internal Medicine over the past 20 years. Hospital Medicine has emerged at a time where nearly 50% of all medical students were women,[2, 3] during a time where programs to enhance leadership skills of women have proliferated,[4] and research has highlighted the gaps and need to diversify leadership in academic fields.[5, 6] Yet with the sources to the pipeline seemingly equal, as women comprise 50% of the workforce in Hospital Medicine, with similar years of experience to their male peers, women have not become the leaders in this emerging field.

As pointed out by the survey of Herzke and colleagues, most Hospital Medicine programs are subdivisions within General Internal Medicine, and leaders in General Internal Medicine have broad influence on the choices of leaders in Hospital Medicine. The lack of greater representation of women in leadership roles strongly suggests the role of implicit bias in the processes and programs that develop and recruit faculty into leadership roles. These findings align with other work to suggest that General Internal Medicine is not immune from discrimination against women in academic medicine in its policies; Blazey–Martin and colleagues have reported that after adjusting for time, rank, and full-time work status, the gender gap in pay in academic medicine is larger among generalists than it is for basic scientists, medical or surgical specialists.[7] As academic General Internal Medicine leads many initiatives nationally to provide better care to diverse clinical populations and strives for health equity, we now need to apply our methodologies to address the challenges within our field, and ensure that career advancement and leadership opportunities are available to all. We in General Internal Medicine are the problem, and we need to become the solution.

We need to stop looking at this as a problem of fixing the women. While career development and leadership programs and training on negotiating skills are important, they have not solved the problem. Such programs in fact may reinforce a notion that women are at the core of the lack of their advancement. We need to refrain from assertions that women do not aspire to leadership positions, and only prefer careers with greater flexibility for work-life integration. In fact, one of the attractions of Hospital Medicine careers for both men and women is the ability to address work-life integration with work duties that provide more flexibility for time with family, or less spill-over of clinical demands into non-working hours. We need to look at our policies which enable some faculty to rise to leadership positions, and prevent others from achieving their career potential. We need to engage all talent; when we fail to do so, we risk the high cost that comes from lack of retention among academic general internists. There are a number of activities, processes, and programs that individual divisions and the Society of General Internal Medicine can and must take on to address this problem.

(1) General Internal Medicine and Hospital Medicine must collect, review, and openly report data on the advancement of women and underrepresented women among medical faculty into leadership positions. This analysis must consider all leadership positions, especially early career leadership positions that lead to career advancement, to ensure we are offering and training the pipeline of all early career faculty. Such reviews should consider whether the positions of leadership are those of executive positions (addressing policy, finance, operations) as well as nurturing ones, such as mentorship and teaching, as positions with executive functions are more likely to provide paths to career advancement. We are trained to be evidence-based and review the data. We need to use this approach to examine our own collective accomplishments.

(2) General Internal Medicine divisions must develop processes to conduct confidential exit interviews to understand the impact of efforts on retention and career advancement. As large divisions, we have the ability to gain insights rapidly into how our institutional activities influence our lack of retention, both with those leaving to another location and those leaving academic careers

Published online March 10, 2020

for other practice opportunities. More national research in this area can provide critical insights into the reasons that both women and men of all backgrounds leave our field.

(3) General Internal Medicine divisions should develop processes for recruitment, including explicit strategies to seek out diverse candidates and training search committee members to address and overcome implicit bias. Training of search committee members is needed on behavioral interviewing techniques, to select leaders based on their past methods of approaching problems, and evidence of collaboration and negotiation to achieve solutions, leadership qualities that are often not visible on a curriculum vitae.

(4) General Internal Medicine and Departments of Medicine should develop open processes and announcements when hiring for leadership positions, to ensure that all those interested and qualified can identify themselves. This does not require external searches for all positions, but can include internal search processes, especially for early career leadership opportunities.

(5) General Internal Medicine divisions should have explicit and transparent processes for determining all compensation and benefits, including research packages.[8] There is no data to indicate that training women on salary negotiations is effective, as implicit biases exist when women versus men ask for additional resources. In contrast, including explicit statements in the recruitment process when salary or other benefits are negotiable has been shown to be most effective to promote equity.[9] Divisions should conduct regular internal equity audits of salary, and start up and retention packages, with discussions and processes to adjust for outliers.

(6) General Internal Medicine must review procedures and policies to address sexual harassment, bias, and discrimination. Unfortunately, sexual harassment, bias, and discrimination did not disappear with the advent of the "Me Too" movement. We must employ evidence-based approaches from medicine and other fields, while also collecting new data on innovations that are effective in academic settings. Although many academic setting now offer or require training to identify and prevent sexual harassment in the workforce, there is little evidence of their effectiveness, and data to suggest that these programs may enable perpetrators.[10] Emerging evidence suggests that by-stander training may be more effective as a strategy to address harassment in the workplace.[10] While overt discrimination may be waning, growing evidence points to the impact of implicit bias in our daily work decisions including recruitment efforts, promotion, and advancement. Identifying implicit bias alone is unlikely to influence attitude and behavioral change. Training to develop strategies to recognize and counterbalance implicit biases has been effective in both changing attitudes and changing outcomes of faculty hiring.[11, 12]

General Internal Medicine has the skills to conduct these activities. The Society of General Internal Medicine can encourage and even fund national processes to monitor and promote equity, and identify new processes that are evidence-based to promote diversity in our leadership. We can and must do this.

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Compliance with Ethical Standards:

Conflict of Interest: *The author declares that she does not have a conflict of interest..*

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