Gender leadership bias in academic medicine

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Although women are gradually joining the leadership ranks of U.S. academic medical centers, a gap remains. Just 16 percent of deans and 15 percent of department chairs are women, according to a 2014 report by Association of American Medical Colleges. A study published the same year estimated that in academic medicine, women won't hold as many full professorships as men for several decades.

In an attempt to fast-forward that progress, Sabine Girod, MD, DDS, associate professor of surgery, and Hannah Valantine, MD, a former professor of cardiovascular medicine who is now chief officer for scientific workforce diversity at the National Institutes of Health, led a team that tested whether a 20-minute educational intervention could alter the implicit or explicit biases held by 281 faculty members, from 13 clinical departments, at the Stanford School of Medicine.

The intervention, which was led by pre-trained "champions"—nine men and four women—who had been identified as leaders, did change the faculty members' perception of bias. It also changed their implicit biases of female leaders. The findings were reported in *Academic Medicine* in January. Girod recently shared her thoughts on the research and on female medical leaders with writer Becky Bach.

Q: What are the two main reasons that you believe women remain underrepresented in academic medicine?

Girod: Women are very interested in serving in leadership positions, and they participate in large numbers in the educational opportunities that medical schools and hospitals offer, such as leadership development programs or formal mentorship programs. However, despite this training, they remain underrepresented in mid- and upper-level leadership positions. At the School of Medicine, we currently have only 13 percent of division chiefs who are women, and even fewer are department chairs. This disadvantage then accumulates over time, effectively stunting their careers, because they cannot develop the expected expertise and credentials.

The reason women are not advancing to senior leadership positions is probably multi-factorial, including the fact that many leadership positions are appointed without a formal process. Potential leaders are groomed and usually sponsored by informal leadership networks that too frequently do not include women. In addition, our study suggests that unconscious biases favoring men as leaders may hinder the career advancement of women even if they have the qualification and potential.

Q: What is the difference between implicit and explicit bias?

Girod: Explicit biases are deliberately formed at the conscious level and are easy to self-report. For example, in the context of this study, a person might say that both women and men have the same leadership potential, since it is socially desirable to do so. On the other hand, implicit biases are attitudes held at the unconscious level and are involuntarily formed. These biases are often informed by cues we pick up from our social environments. Even though someone might say women and men have the same leadership potential explicitly, the person may unconsciously associate men with leadership more than women and unknowingly act in ways that impede women in leadership.

Q: What was the most surprising result of this work?

Girod: The most surprising result was that the implicit bias of the participants changed after they heard a 20-minute presentation that summarizes the research literature on implicit bias and provides guidance on how to overcome the undesired effects of implicit bias. Since implicit biases are unconscious, we did not expect to see an effect of this short intervention. Prior research has shown that once you are made aware of your implicit biases, you can actually work to improve upon them. This is clearly what happened among our participants, but we were pleasantly surprised that this process could begin after a mere 20-minute presentation.

Q: How does the presence of female leaders change the environment of medical schools?

Girod: In medical schools, 47 percent of our students and 46 percent of residents are women, and this is only one of the dimensions of diversity. The female students and young physicians are eager to contribute in their chosen field and are looking for role models for successful careers. They do not see enough women in leadership positions to encourage them to persist. Many young women decide not to go into academics or my specific field, surgery, because they are rationally assessing their chances and do see a paucity of women in the leadership. I have this conversation all the time with students and residents. We are losing a large part of the talent pool both at the entry and then again later on when women come to realize they do not have strong opportunities for advancement.

Q: Is bias for male leadership in academic medicine universal? Is it less so in other countries and cultures?

Girod: Bias for male leadership is universal and not only in academic

medicine. Our family, friends, co-workers and the media influence our beliefs and biases. Because biases come from the society in which we live, people tend to share the same biases regardless of their gender and age. The culture needs to change to change these attitudes, but we can be aware of them and consciously direct our decisions. This is an important first step.

More information: Sabine Girod et al. Reducing Implicit Gender Leadership Bias in Academic Medicine With an Educational Intervention, *Academic Medicine* (2016). DOI: 10.1097/ACM.0000000000001099

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