The Gender Gap in Medical Leadership: Glass Ceiling, Domestic Tethers, or Both?

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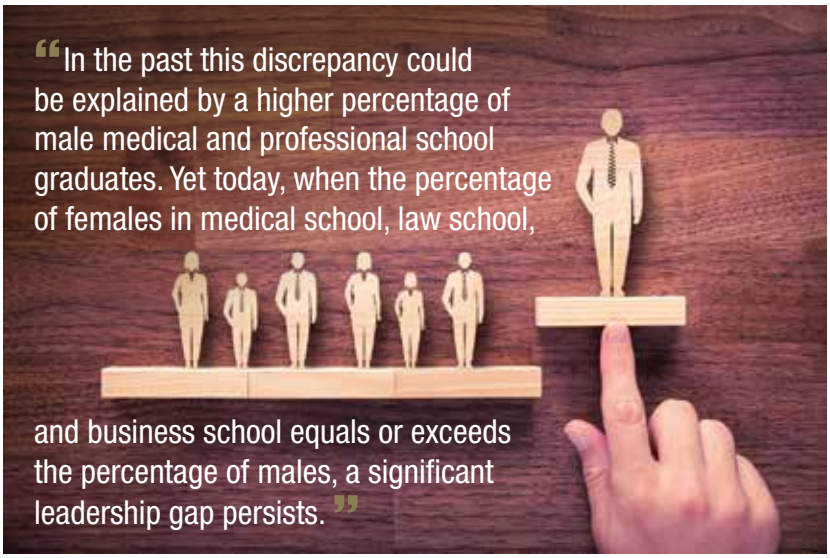
The number of women enrolled in medical schools has risen from less than 25% in the 1970s to over 47% today.[1,2] In spite of this, we continue to see striking under-representation of women in leadership positions in academic medicine, professional organizations, and health services in general. Women comprise only 38% of full-time faculty, 21% of full professors, and 30% of new tenures in academic medicine. Only 18% of hospital CEOs are women, and the percentage of female department chairs and deans at US medical schools remains low, at 15% and 16% respectively.[2,3] This leadership gap is not unique to medicine. It mirrors trends in law, where women continue to constitute a disproportionate minority of partners within firms; and business, where women are less likely than men to hold corporate executive positions. In the past this discrepancy could be explained by a higher percentage of male medical and professional school graduates. Yet today, when the percentage of females in medical school, law school, and business school equals or exceeds the percentage of males, a significant leadership gap persists.



Much of the literature on the leadership gap has focused on the seemingly impenetrable "glass ceiling" effect of institutional culture and structure, which prevents women from advancing to senior positions. The glass ceiling is supported by conscious and unconscious gender stereotypes and biases, lack of policies that support work-life balance, lack of mentors or role models for women interested in high-level career advancement, and a paucity of networks that can open doors to women.[3] Sheryl Sandberg's recent book, Lean In, focused attention on the individual factors that hinder the advancement of women and has challenged women to overcome their own low expectations and self-defeating behaviors. But are these institutional and individual challenges the main road blocks for women? Are education programs so egalitarian in their policies and cultures that women succeed at the training phase of their careers but fall out in the employment phase, or is there another factor at play?

A closer look at the issue of gender equity at home might begin to explain some of the disparities at work. Women continue to shoulder the lion's share of unpaid domestic work, be it household chores or parenting responsibilities, even in countries where they constitute more than half the workforce. In Australia, women spend twice as much time as men on child-care and unpaid household work.[4] In the U.S., where women constitute 50% of the labor force, they spend an average of 40 hours a week — the equivalent of a second full time job — performing domestic work in the home. Although U.S. fathers have certainly increased their domestic workload over the past 40 years, on a weekly basis it remains half a mother's.[5] Disparities in household responsibilities have historically been explained by economic calculations, but this doesn't necessarily hold in medicine, where the earning potential of both women and men is high. Yet studies on domestic responsibilities have found the same pattern of gender inequity in physician domestic partnerships as in the general population. Shollen et al. report that, despite spending equal hours at work, female academic medical faculty spent substantially more time per week on domestic work than their male colleagues (31 hours vs 19).[6] Jolly et al. found that among high-achieving young physician researchers who were married or partnered, women spent 8.5 hours more per week on domestic activities.[7] Even within specialties notorious for poor work-life balance such as surgery, where average working hours per week are around 60, conflicts between work and personal demands were resolved in favor of the female surgeon's work only 59% of the time, compared to 87.3% of the time for male surgeons.

The implications of such domestic inequities on the career advancement of women are significant. Over two-thirds of high-achieving women decrease their work schedules during their careers, and approximately one third take extended leave from their jobs. In a study of Spanish physicians Ariizabalga found that, after completing their specialty training, women held more than twice the number of part-time medical positions as men. Consequently, while their male colleagues were applying for promotions, female physicians with similar years of professional experience had not yet moved into full-time positions.[8] While approximately half the graduating medical students in the U.S. are women, only 38% of full-time faculty positions are held by women and the departure of women from full-time academia is disproportionately higher than that of men.[2] In the UK's National Health Service, 63% of women work part-time compared to 8% of men.[9] While these flexible tracks may help women remain in the

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workforce during the demanding child-rearing years, getting off track can be detrimental to career advancement and promotion, especially in comparison to men who usually start and remain in full-time service.[3,10]

Women who remain in full-time employment are not immune to the impact of domestic tethers on career advancement. Family responsibilities compete with work responsibilities in the lives of female physicians far more frequently than in the lives of their male colleagues. A large cross-sectional survey of U.S. surgeons found that female surgeons were five times more likely to care for a child home from school than male surgeons. In addition, they more often subjugated their career for their spouse's/partner's when work-life conflicts arose and were more likely to report that their commitment to their children deterred their career advancement. Another study that looked at gender differences in the domestic and parenting work of high-achieving young physician researchers found that women spent more time on household work and less time on research than their male colleagues, suggesting that when home responsibilities compete with research responsibilities, the research productivity of women is more likely to be impacted.[7] The gender disparity in the burden of domestic work inevitably places women at a disadvantage compared to men, who are more at liberty to invest additional time in work and who experience fewer work-life disruptions.

The impact of these disparities stretches beyond productivity and work time. In a qualitative study exploring under-representation of women in leadership positions, one male study participant described his advantage over women: "I could at any time turn up to a meeting on a weeknight. I could be away overnight. I could do what I have to do to be noticed and available."[1] A woman's more restricted ability to attend off-hour meetings and other functions may exclude her from opportunities and from the notice of those who have the power to advance her career. And the restricted mobility of women, who are more likely to be in two-career relationships, can also limit opportunities and advancement options. In a study exploring barriers to leave, female faculty eligible for leave took fewer and shorter sabbaticals.11 In a survey of health care executives, less than 60% of women reported a willingness to move in pursuit of career advancement compared to more than 75% of men.[3]

Understanding the impact of domestic tethers should not belittle the daunting barrier of the glass ceiling. Even in specialties such as pediatrics and ob-gyn, where women are an overwhelming majority, only 20% and 22% of department chairs are female. This indicates the enduring strength of cultural and structural barriers. At the same time, understanding that equity at work cannot be achieved without equity at home is critical to the advancement of female professionals. Our culture must set an expectation of equitably allocated responsibilities between partners at home, and institutions need to make success possible for both men and women with significant family responsibilities by investing in on-site child care, fitting meetings and development opportunities into regular work hours, and introducing parental leave policies that recognize men as equal partners at home and women as equal partners at work.

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