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The Role of Obstetrics and Gynecology in Shaping Gender-diverse Leadership in Medicine

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Abstract: Gender inequity persists in academic medicine. This article reviews the historical context, ongoing leadership challenges, and societal biases. The persistent barriers to gender equity in leadership roles, pay, and professional recognition are considered through the lens of obstetrics and gynecology where these issues persist despite a significant presence of women in the field. The impact of gender stereotypes, the role of intersectionality, and the need for systemic change are evident. Embracing diverse leadership styles and creating inclusive pathways to leadership will help actualize the potential benefits of a gender-diverse workforce, enhancing health care outcomes and fostering innovation.

Key words: leadership, women in medicine, gender equity, professional advancement

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The story of gender inequity in medicine has been cast as a tragedy. Women struggle to achieve equity in salary, rank, leadership roles, and well-being in a field dominated by masculine norms. But tragic victims are innocent bystanders, harmed by actions outside of their influence. This view underestimates the agency women have and the opportunities for change available to improve gender inequity in our profession. It also fails to recognize what is lost when rigid stereotypes of success mean talented leaders fail to actualize their potential. Instead, this story is a drama situated in historical and social contexts. The complexities of the plot have not been unraveled and the conflict remains yet to be resolved. Looking at the undercurrents of inertia, gender bias, and misogyny in our structures, we

can see the path to cultivating gender equity within our field. A more diverse workforce that discovers the full potential of women and gender minorities has the prospect to heal some of the problems plaguing the current health care system. Although this piece will use binary terms to explore what research and history can tell us about the role of gender, this language does not encapsulate our evolving understanding of this construct.

Zooming in on the role of obstetrics and gynecology (OBGYN) in this story reframes it as a question: why does a field dominated by women struggle in this way? Critical mass theory posits that once a minority represents over 35% of a group, their performance is enhanced and their presence leads to culture change.[1] Women have represented a critical mass in the specialty for decades. And yet, disproportionate gender representation in leadership persists in the discipline.[2] OBGYN should be a beacon for gender equity professions within and outside of medicine. Historically, maternity care was where the first women physicians found their place, and since 2012, women have constituted over half of the fellows of the American College of Obstetricians and Gynecologists.[3]

Beyond mere numbers, there are cultural reasons that women should emerge as leaders in OBGYN. Every OBGYN is trained in leadership skills. In "When Women Lead: What We Achieve, Why We Succeed and What We Can Learn," an examination of successful women leaders across industries, Boorstin[4] describes effective leaders as making decisions "earlier, faster, and with greater conviction. They do so consistently—even amid ambiguity, with incomplete information, and in unfamiliar domains." Look no further than the nearest labor floor to see these skills in action. Research identifies women leaders as more interpersonally sensitive than men, which is valued more in professional cultures that prize demeanor and interpersonal interactions. Women are given more opportunities across professions when they pursue work that aligns with gender stereotypes: behaving altruistically, demonstrating warmth, and emphasizing the social mission of their work.[4] Caring for mothers and addressing reproductive health needs is not a far leap from nurturing feminine stereotypes.

So why, when women are set up with skills for leadership, a foothold in the profession, and a culture that aligns with gendered stereotypes do women still struggle to succeed and advance in OBGYN? What can be done to bring the characters in this story towards a denouement that points to equitable paths forward? Second-wave feminism has been criticized for being "by, for, and about white, middle-class women."[5] "Intersectionality" proposes acknowledging the intertwined social identities of race and class and how they create unique experiences beyond gender differences. Larger disparities exist for individuals bearing multiple identities. The needs of women cannot be assumed to be uniform. Creating structures and processes that support individual experiences and acknowledge marginalized identities may ensure that nonbinary and non-white individuals are lifted up. After examining the gendered paradigm that exists in medicine and how we got to the current state, we can then explore the experiences of women leaders in other fields to define and help guide the way forward. These steps can help us move beyond entrenched stereotypes and binary conceptions of gender, and recognize the amplified needs of future leaders from underrepresented racial and ethnic backgrounds.

THE PROBLEM OF GENDER IN MEDICINE

Women physicians lag behind men in academic success measured in research, leadership, and pay. While numbers of medical school graduates reached gender

parity in the mid-2000s, there followed a lag in professional advancement not explained by the timeline.[6] Over the decade from 2012 to 2022, there was only a 9% increase in representation by women in higher-powered positions in a timeline in OBGYN and other fields.[7] Women experience an average pay cut of $20,000, greater harassment, and lower well-being.[8] This bias and discrimination begins during education through sexism, harassment, and weak letters of recommendation, and channels women into lower-paying fields and roles.[9] These realities are "too often amplified for women of colour, of low socioeconomic status and social class," or belong to other traditionally devalued groups such as gender minorities, older adults, and those with disabilities.[9]

In addition to these "macro-inequities," micro-inequities cause mid-career women to lose traction in their professional growth. These include stress, anxiety, and disappointment related to stereotypes and marginalization that may take the form of speaking opportunities, awards, and professional recommendations. Spending disproportionate time on domestic labor interferes with research and other activities that accelerate career trajectories.[10] Given these disparities, it is not surprising that women suffer worse burnout.[11] In recent years, women leaders have increased in academic medicine, but largely in areas of education, diversity, and student affairs that are congruent with gender stereotypes and do not lead to mission leadership in the way clinical and research tracks do. Despite greater representation by women, the same pattern exists in OBGYN.[2]

A LEGACY OF BIAS AND STEREOTYPES

Women healers are as old as history, but the women who first received official medical degrees in Victorian times faced overt discrimination and exclusion. Pursuing education, independence and agency contrasted with the "elegant recreations, exercises and pursuits" that young ladies were encouraged to pursue to cultivate "their spirit of obedience and submission, pliability of temper and humility of mind."[12] Seeking a place in medicine was unladylike, unsavory, and deeply unsettling for the male establishment. Faculty and students repeatedly voted to keep women from their institutions. In one 1860s protest, Harvard students asserted, "No women of true delicacy would be willing in the presence of men to listen to the discussion of the subjects that come under the consideration of the student of medicine."[12] *The Lancet* published arguments against women in the professions claiming that no feminine gender nouns existed for "physician, surgeon, lawyer, senator, etc" and that women thus must practice midwifery and focus on children's diseases. The author went on to add that such women must necessarily remain celibate since it would be difficult for a pregnant obstetrician to perform her duties.[12]

With *The Lancet* asserting in 1870 that women are "sexually, constitutionally, and mentally unfitted for hard and incessant toil,"[12] it is surprising that women doctors were more welcome to pursue the arduous, wearing, and unremunerative care of indigent women and children. Nevertheless, these early pioneers persisted and worked to make a place for their gender in the field of medicine. Importantly, they did so without directly challenging gender stereotypes. Elizabeth Blackwell, the first woman to receive a medical degree in the United States argued that women's acceptable roles caring for their homes and families could be expanded by developing expertise in sanitation, nutrition, and hygiene.[12] While we might celebrate that there is less overt misogyny and explicit bias in medicine today, it is important to acknowledge this past, because its shadow persists. By not challenging the dominant masculine

stereotypes as synonymous with success in medicine, we have arrived at our present reality.[11] Even today, with data showing improved outcomes for patients of women doctors in primary care, surgery, and emergency rooms, women's pursuit of roles that align with gender stereotypes has them doing more education, mentorship, and other "institutional housekeeping" that does not translate into individual success.[13]

THE IMPACT OF CORONAVIRUS DISEASE

The coronavirus disease 2019 pandemic exposed many fault lines in our society and health care system, and the experience of women physicians is a glaring example. While the early pandemic saw increased research productivity by men, the same was not seen in women who shouldered greater domestic burdens.[14] The National Academies of Sciences, Engineering, and Medicine monitored the impact of the pandemic on women, cautioning that the blurring of lines between home and work may roll back decades of progress for women in science, especially for those from marginalized backgrounds. However, the disruptions of habits and introduction of virtual and hybrid approaches to work offer flexibility that may improve progress for women.[15] It is important to capitalize on this opportunity to see the problems clearly and not backslide into the biased habits that characterize the professional culture in academic medicine.

GENDER DIVERSE LEADERSHIP: CHALLENGES AND POTENTIAL

Even as our understanding of gender expands to embrace a broader and more fluid conception of gender identity, masculine stereotypes continue to define ideal management archetypes, and feminine stereotypes contrast them. Agentic traits such as bold, competitive, decisive, and analytical, are male-typed and associated consciously and unconsciously with leadership. Stereotypically feminine behaviors such as vulnerability, empathy, and communal orientation contrast with archetypes of leadership, even though these behaviors are recognized as essential for leaders.[16] However, women leaders demonstrating agency experience backlash for "violating expectations of warmth and so-called feminine niceness,"[9] a phenomenon known as the "abrasiveness trap."[17] Evaluation of women leaders across fields: Chief Executive Officers,[4] engineers,[18] surgeons,[19] all look beyond leadership skills to their ability to uphold feminine standards for caring behavior, appearance, and roles in their families. This unveils another paradox: for men with traditional relationships, "their families represent support systems, not care liabilities."[2] The very family roles women are judged to uphold keep them from engaging in networking opportunities outside of traditional hours and represent a "second shift" of duties at home when the professional workday is done.

Gendered patterns in evaluations demonstrate that competence is judged differently for women. Because of low expectations, a lower minimum standard is needed to be considered acceptable, but a higher confirmatory standard is required to merit the highest appraisals of performance.[4] Chief Executive Officer performance reviews reflect this difference in standards, demonstrating negative feedback for 71% of women and 2% of men.[17] This dynamic is especially true for people of color and from underrepresented groups.[20] Confidence is identified as a top leadership difference between men and women. Whether they have internalized these biases themselves, or habituated to avoid self-promotion, women underestimate their own leadership skills.[21]

That lack of confidence is unjustified. Research on professional behaviors consistently reveals areas where women outperform men in skills essential for leadership. Studies of emotional and social intelligence show women outperforming men in 12 key areas, with greatest differences in emotional self-awareness and empathy.[4] Women excel at developing others, role modeling, participative decision-making, coaching and mentoring, influence, inspirational leadership, conflict management, organizational awareness, adaptability, teamwork, and achievement orientation, and are more likely to demonstrate a growth mindset and vulnerability.[4] Having a larger number of women members in a group leads to greater social sensitivity and collective intelligence, across a variety of tasks.[22] Communal leadership styles, associated with women leaders, are not "stereotypically feminine, warm and fuzzy" but rather have to do with "embracing the discomfort that can come when outsiders stimulate new perspectives."[4] These qualities among individual leaders may help organizations to work adaptively, consider multiple perspectives and embrace diversity.[4] Recognizing the essential function these communal behaviors contribute to the success of the collective, and not simply focusing on the traditionally masculine type behaviors allows a more expansive view of what a leader does.

SURMOUNTING BARRIERS TO GENDERED-DIVERSE LEADERSHIP

Creating an equitable environment where diverse types of leadership are prized will require deliberate action. Women and people of color have been criticized for subscribing to the "myth of meritocracy;" the notion that hard work, long hours, and education credentials are rewarded automatically. In reality, much professional success relies on relationships that lead to opportunities.[23] Successful programs must pay out specific behavioral steps and measure progress.[9] This starts at recruitment and continues through mentoring, advancement, and support within the work. Explicit change is needed to counteract the biases and inequities embedded within our professional systems.

Equity in advancement begins with recruitment. Resumes may speak to the opportunities available to that person rather than their potential. Gender is ubiquitous, and universally woven into norms and stereotypes we all hold.[9] Unconscious bias training and looking for evidence of bias are important, but must be supplemented by feedback and coaching leaders of all genders. Pressures exist at every juncture in education, training, practice, and promotion to push out people who do not fit with dominant norms. The professional environment plays an important role. Studies of ambition show that women and men start with similar ambitions, but aging and family pressures may diminish those of women. These changes are not observed in gender-diverse environments.[24] Women residents with strong mentorship and the presence of a female program director report similar ambitions to their male counterparts.[25] Conversely, women surgical trainees experiencing more frequent microaggressions are more likely to leave medicine or retire early.[26] Women continue to thrive in environments and positions that reflect their professional values: the intellectual quality of their team, job security, authenticity at work, flexibility, recognition, and the ability to give back to society.[23] Without careful attention, these priorities result in lower salaries, higher workloads, and fewer advancement opportunities.[2]

Women may need to proactively develop skills that have not been emphasized because of incongruity with gender norms, such as negotiation. While self-promotion

may have been discouraged, women have been encouraged to care for others, so negotiations reframed to be on behalf of group or organizational success may be successful.[4] Building local and national networks creates community and combats isolation, and helps with imposter syndrome. Women attending career development through programs focused on advancing leaders in academic medicine reflected the ways that participating in this external programming improved their institutional progression through increased self-awareness, professional skills, organizational visibility, and perspective.[27]

Interchange between existing systems and diverse leaders is essential for creating a climate of inclusion. Mentoring programs and diversity task forces focused on representation among minority women in particular have been effective.[9] Women are reluctant to engage in the kind of sponsorship that leads to opportunities and ask for favors.[23] However, many successful women leaders can point to a strong backer, often male, who championed their success putting their own reputation on the line to do so. Structured relationships are important because relying on connections based on affinity risks bias. Formalizing these relationships and networking opportunities helps women and minorities who may not have the support to engage in informal, after-hours relationship building. Individual and institutional engagement in professional development programs can bolster the development of critical actors motivated and prepared to advocate for culture change.[27]

This effort to integrate work and life is novel for physicians. Elizabeth Blackwell rejoiced in the fulfillment and independence of working in medicine instead of in her home. "How good work is.... In all human relations, the woman has to yield, to modify her individuality—even the best husband and children compel some daily sacrifice of self, but true work is perfect freedom, and full satisfaction."[12] What doctors today are attempting to do is different, and more challenging, than those early iconoclasts who cast off the shackles of stereotypical responsibilities and expectations for women. As our current era projects an ideal of freedom from the defining influences of gendered expectations, members of the profession must recognize how deeply inscribed these expectations are.

Including diverse leadership in administrative decisions may create structures and processes that address disparities such as flexible schedules and practices that allow for parenting duties, and making strong and decisive reactions to sexual harassment.[10] Equitable and transparent parental leave and breastfeeding protection policies that align with professional society recommendations are needed.[28,29] Health benefits for trainees that may delay childbearing should be considered including fertility preservation and access to reproductive technologies. Parent and family-centric policies should encompass meeting times and environments, flexible scheduling, childcare, and career development initiatives. Stanford Medical Center piloted an innovative "time bank" to ensure that faculty were rewarded for "institutional housekeeping" as a way to reduce physician burnout. Time spent on these activities was traded for either in-home support, such as meal delivery and cleaning services, or support at work, including assistance with grant writing and submission. This cost-effective program provided all participants (regardless of gender) with improved perceived flexibility, wellness, and institutional satisfaction.[30] Embracing the potential for virtual experiences to expand access to networking at meetings and conferences is an important and timely opportunity.

CONCLUSION

Health care needs a gender-diverse workforce. In other fields, organizations with a

greater percentage of women in leadership roles perform better. In the top 20% of financial performers, 37% of leaders are women.[21] This difference may reflect the contributions of those women, and also may be a marker for organizations whose culture and structures are more evolved and more capable of cultivating leadership outside of biased gender structures. The research in medicine and other fields shows that ambition is not inherently gendered. Rather, it is shaped over the course of a career through internal and external influences. It took 150 years for a group of women accepted to the University of Edinburgh to receive medical degrees, posthumously, after being denied graduation and tormented by rioters hurling mud and trash their way.[12] Change has been made, but at too slow a pace. This progress continues to threaten health care despite the growing proportion of women in the workforce. Within this landscape, OBGYN has the opportunity to prove that actualizing the potential of a diverse gender leadership is possible and reap the benefits of doing so. By challenging dominant stereotypes of leadership and deliberately creating structures that nurture leadership potential among diverse individuals, we can create a better future.

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