

## Women in Medical Leadership: Having A Quota Makes for Better Representation

Gender parity in medical leadership has been well identified across multiple healthcare settings worldwide and in Australia (1, 2). Yet, the covert aspects of inequity, the underlying and motivating factors, and urgency to address this issue have not been adequately appreciated (3). In this article, we discussed establishing gender quota in medical leadership, an approach that has been adopted by other fields as a cornerstone of promoting gender equity. We illustrated the barriers to female medical leadership in a swiss cheese model, and propose systemic changes including but not limited to gender quota in promoting gender equity in medical leadership.

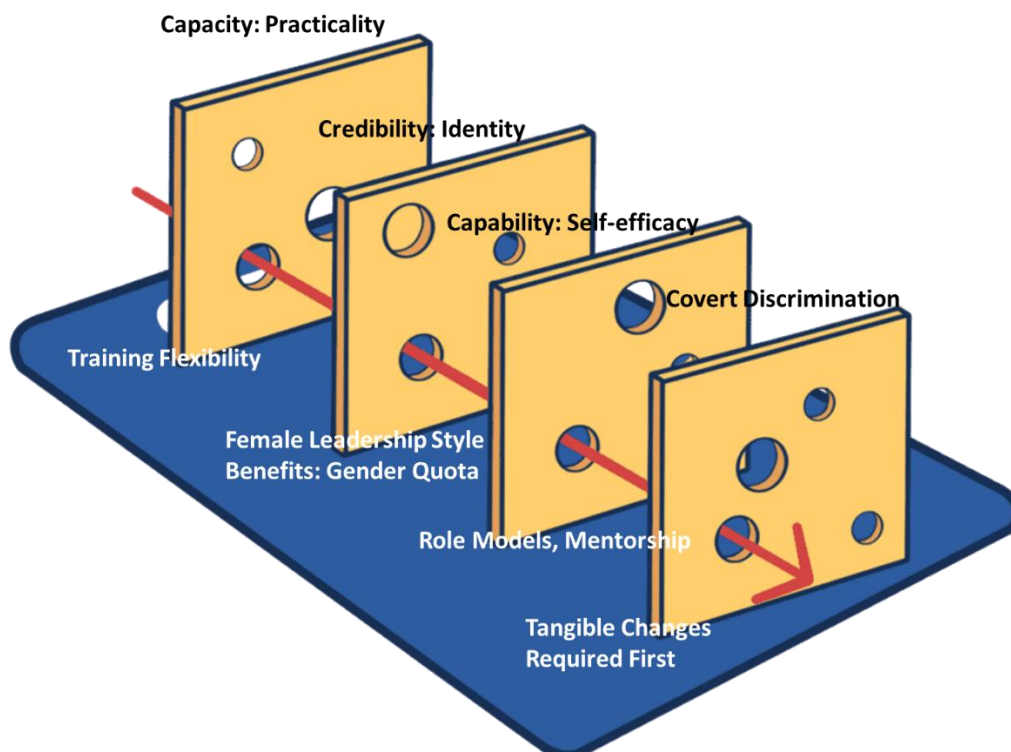
To discuss quota in the context of gender equity, we should first agree upon a definition. Gender equity is defined as the “fairness of treatment for women and men according to their respective needs”, focusing on the means to achieve, versus gender equality, focusing on the end goal (4). Hence, gender equity does not require equal opportunities, but sets the stage for gender equality, equal outcomes (5). Gender quota is a method to promote gender equity, and has been adopted across multiple fields including political, economic, and business models. The Australian Labour Party has had a gender quota since the 1990s; Timor-Leste used gender quota to achieve one of the highest female representations in parliament globally; and Norway’s conservatory party trailblazed mandatory gender quota in all public limited companies (6). These pioneering examples demonstrated that gender quota is advantageous: it serves as a first step to expedite social changes, institutionalises hiring processes against gender biases, and raises competences of both male and female members (7-9). Gender quota also comes with disadvantages, including positive discrimination that favours woman despite substandard merit, and the fact that it doesn’t address covert gender biases (7, 8).

Lessons from other fields inform us how gender quota may be applied in medical leadership. Although Australian medical schools have attained gender parity for decades, female underrepresentation is observed in senior medical leadership roles (10). If we liken failure to achieve gender equity in medical leadership to a swiss cheese model (Image 1), we can consider individual factors to barriers in which systemic efforts may be able to prompt changes (10). In the 2019 Lancet journal’s issue dedicated to women in medicine, three barriers to female advancement were identified. First, the practical challenge of balancing work with childcare and family. Second, social and cultural expectations of female identity. And third, the lack of mentorship, role modelling, and career support (11). Professor Helena Teede, who achieved professor of medicine at a young age, resonated with these points and proposed that barriers to female leadership fall under 3Cs: capacity, capability, and credibility (12).

Capacity closely relates to the first point of practicality, which policies enabling work flexibility will address (12). Credibility relates to the second point of female’s sociocultural perceived identity; Prof Teede expands upon this to underscore how the perceived masculine

styles of leadership often deter females from seeking promotion (7, 12). Indeed, successful females with emulative desire and competency are often regarded through a coloured film of gender inequality, nicknamed as “strong woman” or “manly-woman”. This harks to the feminist Virginia’s Woolf’s assertion in 1930s: “It is fatal to be a man or woman pure and simple: one must be a woman manly, or a man womanly”(13). However, the traditional male leadership style of assertiveness, individualism, and goal-orientation does not always contribute to leadership efficacy (14). In contrast, the feminine leadership style has been coined “transformational”- being more socially-expressive, motivational, and creative (5, 15). This is advantageous especially in medicine given its emphasis on its people-centredness (16). Rather than moulding females to embody traditional masculine leadership qualities, encouraging female leadership styles via formal processes such as implementing a gender quota, may produce synergistic outcomes of both leadership styles (15).

The third barrier, capability, highlights females’ tendency to self-doubt and experience imposter syndrome. Having mentorship and role models, as suggested in the third point, may effectively target (12, 17, 18). Similar findings on women in surgical training echoed the above 3 Cs as barriers to success, and further suggested the significant role of the 4<sup>th</sup> C: covert discrimination. For example, preferencing male colleagues for opportunities in absence of overt bias, and double standards towards valid reasons to take leave (19). These covert biases arise from longstanding sociocultural beliefs of gender roles, and will be an ongoing issue where a significant number of tangible changes are required prior to apparent cultural shifts (7, 8, 10).



**Image1. Swiss Cheese Model of Barriers to Gender Equity in Medical Leadership.**

These four Cs listed above (black) describe significant individual factors that contribute to barriers of female medical leadership; four corresponding systemic implementations are suggested below (white). Another significant systemic barrier to gender inequity lies in implicit bias, which having organisational changes such as gender quota, in addition to implicit bias trainings amongst hiring committees will render a more transparent hiring process (1, 20). Kang and Kaplan suggested to “bring about equity by design”, supporting the notion that promoting gender equity in medical leadership should shy away from targeting individual attitudes and move towards systemic organisational changes (21). Furthermore, studies have shown that women leadership in medicine is hindered by lack of policy implementation which leadership development programmes and high-level national strategies may positively influence individual's leadership enactment, thereby shifting cultural norms (22, 23).

In summary, quota would serve as a steppingstone to which gender equity is implemented in medical leadership. Other endeavours should take place concurrently: formal processes including training flexibility, establishing mentoring and professional development initiatives, as enacted by the royal college of physicians (RCP) in the UK and Royal Australian College of Surgeons (RACS) in Australia (11), as well as addressing informal practices that hinder female leadership: i.e. defining what is valued as quality work (24). All of these pursuits aim for the ultimate change of culture and climate in medicine, which, although will be a long journey, offers a bright outlook (9).

## References

1. Hempenstall A, Tomlinson J, Bismark MM. Gender inequity in medicine and medical leadership. *Med J Aust.* 2019;211(10):475- e1.
2. Yount KM, Cheong YF, Miedema SS, Chen JS, Menstell E, Maxwell L, et al. Gender equality in global health leadership: Cross-sectional survey of global health graduates. *Glob Public Health.* 2020;15(6):852-64.
3. Fine C, Sojo V. Women's value: beyond the business case for diversity and inclusion. *The Lancet.* 2019;393(10171):515-6.
4. ABC of women worker's rights and gender equality. Geneva: International Labour Office 2000.
5. Mencarini L. Gender Equity. In: Michalos AC, editor. *Encyclopedia of Quality of Life and Well-Being Research.* Dordrecht: Springer Netherlands; 2014. p. 2437-8.
6. Women's Political Representation: Do Gender Quotas Work? 2019.
7. Muraya KW, Govender V, Mbachu C, Uguru NP, Molyneux S. 'Gender is not even a side issue...it's a non-issue': career trajectories and experiences from the perspective of male and female healthcare managers in Kenya. *Health Policy and Planning.* 2019;34(4):249-56.
8. Is it time to stop arguing against gender quotas? 2019.
9. Coe IR, Wiley R, Bekker L-G. Organisational best practices towards gender equality in science and medicine. *The Lancet.* 2019;393(10171):587-93.
10. Reason J. The contribution of latent human failures to the breakdown of complex systems. *Philos Trans R Soc Lond B Biol Sci.* 1990;327(1241):475-84.
11. Boylan J, Dacre J, Gordon H. Addressing women's under-representation in medical leadership. *The Lancet.* 2019;393(10171):e14.
12. Teede HJ. Advancing women in medical leadership. *Med J Aust.* 2019;211(9):392-4 e1.
13. Woolf V. *A Room of One's Own:* Hogarth Press; 1929.
14. Eagly AH. Female Leadership Advantage and Disadvantage: Resolving the Contradictions. *Psychology of Women Quarterly.* 2007;31(1):1-12.
15. Radu C, Deaconu A, Frasineanu C. *Leadership and Gender Differences—Are Men and Women Leading in the Same Way?* 2017.
16. Downs JA, Reif LK, Hokororo A, Fitzgerald DW. Increasing women in leadership in global health. *Acad Med.* 2014;89(8):1103-7.
17. Brown K, editor *Imposter Phenomenon.* Gastroenterology Women's Coalition Symposium; 2018; Washington, DC.
18. KPMG. *Experiencing Imposter Syndrome.* KPMG; 2020.
19. Liang R, Dornan T, Nestel D. Why do women leave surgical training? A qualitative and feminist study. *The Lancet.* 2019;393(10171):541-9.
20. Mousa M, Boyle JA, Teede HJ. Advancing women in medical leadership. *Med J Aust.* 2020;212(4):190- e1.
21. Kang SK, Kaplan S. Working toward gender diversity and inclusion in medicine: myths and solutions. *Lancet (London, England).* 2019;393(10171):579-86.
22. Alwazzan L, Al-Angari SS. Women's leadership in academic medicine: a systematic review of extent, condition and interventions. *BMJ open.* 2020;10(1):e032232.
23. McKimm J, Da Silva AS, Taylor C, Edwards S, Greenhill J. *Women and Leadership in Medicine and Medical Education: International Perspectives.* Gender, Careers and Inequalities in Medicine and Medical Education: International Perspectives. International Perspectives on Equality, Diversity and Inclusion. 2: Emerald Group Publishing Limited; 2015. p. 69-98.

24. Davies SE, Harman S, Manjoo R, Tanyag M, Wenham C. Why it must be a feminist global health agenda. *The Lancet*. 2019;393(10171):601-3.