Gender and professionalism: Does it matter?

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For years, September has been celebrated as Women in Medicine Month,[1] thereby noting the accomplishments of women and celebrating the legacy of women who have contributed to the science, art, and delivery of patient care. This year's celebration is particularly notable as an important new milestone is being celebrated—the significant number of women among current medical school matriculants.

In 2017, for the first time, women were 50.7 percent of the 21,338 matriculants (49.8 percent in 2016.)[2] This proportion is representative of the general population of which women compose 50.8 percent based on the 2010 census.[3] It has only taken 250 years to reach this milestone!

The changing context of our nation—and by natural extension our environment as medical professionals—must be considered in our ongoing and future practice of professionalism as providers, researchers, and educators. Inclusion is a core competence of professionalism that we must seek to optimize,[4] in addition to the other core competencies of altruism, humility, and integrity.[5]

Does gender matter in the context of medical professionalism?

Given the magnitude of this topic and its importance, it is helpful to consider the choice of terms in the title, and a useful roadmap. Gender relates to how individuals are perceived in society, rather than solely their biological assignment at birth. It also recognizes the influence of environment, culture, and societal expectations.[6]

If gender does matter, how do we get there? How do medical professionals become more mindful of the influence that gender has in our professional lives?

There is value in building an inclusive environment that engages diverse perspectives in medicine. And, there is clear evidence that suggests we currently are neither adequately nor effectively accomplishing this goal. Intentionality to achieve this goal is important, and evidence-based solutions do exist.

The ultimate value of considering this context enhances the culture, allowing professionalism to flourish successfully for everyone.

The value proposition at the intersection of gender and professionalism

The social contract between medicine and society has been at the center of many discussions as medicine has evolved from a model of individual physicians practicing in local communities to one of employed physicians delivering care in large health care systems, impacting populations. At the core of this transformation is the recognition that the values of the caring physician who touches individual patients must be preserved at the organizational level if medical professionalism is to remain true to its core tenets of delivering professionalism and healing.

Cruess et al., noted that, "Professionalism is the basis of a professional's social contract with society. Society uses the concept of the profession to assist in the organization of the delivery of essential services that are required. In medicine, it is the services of the healer that are to be organized."[7] Thus, balancing the business needs of a large system with these core values becomes the daily challenge of governing boards and executive leadership as well as providers, researchers, and staff.

Corporate America has long recognized the benefits of advancing the equality of women in leadership positions. In 2015, the McKinsey Global Institute projected that if the gap between women and men in the work force were closed by 2025, $12 trillion could be added to the global economy.[8] Translating this projection to academic medicine, particularly as medicine moves from volume as its currency of reimbursement to value, the benefits of gender diversity are evident.

Reimbursement should be based on outcomes rather than the number of patients seen. One key metric is the 30-day readmission rate, which is rewarded with additional revenue if specific targets are achieved. A recent study examined mortality and readmission rates of patients treated by male physicians versus those treated by female physicians. It found that lower 30-day mortality rates were associated with the care provided by the women physicians compared to the male physicians.[9] This is one example of how women physicians can demonstrate their value to the bottom line as well as their value to patient care.

Another key metric is patient satisfaction. Mast and colleagues noted that the differences associated with physician nonverbal behavior are affected by gender. In their study, patients expressed greater satisfaction with female physicians who exhibited female mannerisms such as leaning toward the patient, and using a softer voice. On the other hand, some patients preferred male physicians who spoke louder and were more distant from the patient.[10] Moreover, Lagro-Janssen observed female physicians to be more patient-oriented compared to male physicians.[11] A meta-analysis by Roter, Hall, and Aoki of the effects of gender on communication with patients confirmed that female physicians engage in more patient-centered communication in primary care settings compared to male physicians.[12]

The importance of delivering patient-centered care has been emphasized by the National Academy of Medicine, noting "engaging patients and families (as a strategy)…to improve health outcomes and efficient use of care."[13]

The value of gender diversity has also been underscored among scientists. Campbell and coworkers reported the benefits of gender-diverse working groups, demonstrating the evidence of such groups publishing in higher impact journals compared to homogenous groups.[14]

Differences in the approach to care by women and men, both measurable and immeasurable, can, over time, enhance the care of patients, contribute to the renewal of medicine's social contract with society, and stimulate innovative research.

Women in leadership

There are few women at the highest levels of leadership in academic medicine or hospital leadership. Despite decades of at least 20 percent woman matriculants entering schools of medicine, only 16 percent of the deans of schools of medicine in 2015 were women, and only 20

percent of professors of medicine are women, an important pipeline to decanal positions.

Disparities have been reported in the promotion rates of women, compared to those of men, when determining promotions to associate professor and professor. This makes it difficult to assess the depth of female talent that never ascends to higher ranks, given the less than predicted numbers of women who are promoted. In 1980, 24.9 percent of medical school graduates were women.[15] Given this data, we would expect that at least 25 percent of deans should have been women by 2018. However, at the current rate it will take 40 years or more before there will be full parity of women and men as deans.

Women compose only 18 percent of hospital CEOs,[16] and in at least one state, women compose only 26 percent of boards and 18 percent of executive management teams in health care systems.[17] Thus, there is a paucity of women who can serve as candidates or role models for key positions of leadership in health care systems that drive the culture.

Disparities in the objective assessment of talent is evident in many training programs. Dayal (AΩA, Rutgers New Jersey Medical School, 1998) and coworkers[18] evaluated the attainment of milestones by male and female emergency medicine residents from eight community and academic training programs. Although there was no difference between male and female residents at the beginning of residency, at subsequent milestone assessments men were more likely to score higher than women. Interestingly, there was no difference between the assessment of these residents by male and female faculty evaluators.

There have been many theories and observations offered to explain the disparities between men and women in academia and health care. Differences in accessing mentors, motherhood, maternity leave, and caregiving responsibilities have been advanced as important contributors. Unconscious bias has also been discussed in the literature, and is now being actively addressed in schools of medicine and medical centers. Enhancing self-awareness of all medical professionals regarding unconscious bias requires intentional attention, particularly for the processes related to search, evaluation, promotion, and publication.[19] The acquisition of research awards should also undergo greater discernment as it is another area where gender disparity has been observed.

To reduce or eliminate bias, decisions need to be made with a clear head and free of idiosyncratic influences. Making important decisions when one is hungry, angry, late, or tired (HALT) eliminates the important step of reflective thinking that can reduce bias.[20]

When gender intersects with ethnicity, there can be an intensified effect which was noted by Ginther and coworkers[21] who reported that Asian and Black doctors were less likely to receive National Institutes of Health funding. Generally, women submitted fewer applications, and investigators who were new submitted only one application during the observation period of the study. Although these observations are credible data points, it is important to delve more deeply into the root causes of these findings.

The concept of culture has been openly discussed in organizational developmental literature for more than 50 years. Culture, defined as "collective values, beliefs and principles of organizational members,"[22] may be described as supportive, non-supportive, or toxic depending on the topic and the circumstances. A recent report from the National Academy of Sciences (NAS) places culture and climate as central to the discussion of sexual harassment. "Sexual Harassment of Women: Climate, Culture, and Consequences in Academic Sciences, Engineering, and Medicine," reports on a frequency of episodes of sexual harassment among medical students and graduate students that exceeds 40 percent. National advocacy efforts associated with the #MeToo movement[23] places an important emphasis on this topic.

The NAS Sexual Harassment Committee, an ad hoc committee under the oversight of the Committee on Women in Science, Engineering, and Medicine, identifies three types of harassment:

1. Gender harassment, including verbal and nonverbal behaviors that contribute to a hostile environment;
2. Unwanted actual sexual advances; and
3. Sexual coercion.[24]

As one who has experienced instances of a toxic environment in the workplace, and personally counseled women, and men, who have been subjected to academic bullying, the reality of these observations is undeniable. When compared to men, more women consider leaving an institution rather than confront unprofessional disruptive behavior.[25] And, as a result of internal and external social, cultural, and environmental stressors, women physicians have been reported to be at greater risk for burnout than men.[26]

A culture that enhances professionalism

Assuming that one is convinced that there is value in advancing efforts to reduce the gender gap in medicine and

science, and there exists an array of challenges that impact men and women differently in the workplace, some may consider these challenges impossible to solve. Borrowing from corporate America, the Korn Ferry Institute gathered the observations from 57 women CEOs who offered recommendations regarding organizations, peers, and women in the workplace.

The women CEOs said that at the organizational level, there must be a clear recognition of the role of unconscious bias in key processes such as recruitment, promotion opportunities, and annual evaluations. These institutional processes reinforce the status quo. One of the women CEOs explained, "Survival of the fittest is not a meritocracy: it inherently favors the dominant group." [17]

Additional recommendations from the women CEOs include the recognition of nontraditional models of leadership; the identification of future leaders early in their careers; reframing the role of leaders as agents of cultural transformation; and encouraging women to assume roles that require profit-and-loss accountability.[17] These are important recommendations for women and men alike.

Faculty development programs have proven to be effective in retaining faculty.[27] Mentorship is critically important in the development of new leaders, as is sponsorship, which can provide key opportunities for greater exposure institutionally, and within professional organizations.

Women and others who may be involved in caregiving may require access to bridge funding to facilitate re-entry into a briefly disrupted career.[28] These individuals may want to consider seeking sponsors and mentors, searching for early roles with measurable results, and finding networking opportunities.

Networking with others within an institution, and externally, is important in building careers. Warner, et al., measured the quality of the network of male and female faculty, and noted that men had more robust networks compared to women as noted by the number of first-, last-, and middle-author publications and h-index. All are important metrics associated with promotion.[29]

Above all, it is important to know one's passion, understand personal strengths, and acknowledge weaknesses.

Enhancing the environment for all

Inclusion and diversity is a larger issue than any one individual or a single gender. It should be considered a focus for all who care about sustaining, and enhancing, medical professionalism. It is important to clearly define the qualities of professionalism that all will share, respect, and collectively strive to achieve. Without this process of consensus-building, there is a risk that ambiguity will cast professionalism as a punitive instrument.[30]

Borrowing from the words of Scribonius in 47 AD, professionalism is a commitment to "compassion, benevolence, and clemency in the relief of human suffering." [31] There is no better way to accomplish this goal than by ensuring the full engagement of all leaders, providers, scientists, and staff who bring a diversity of perspectives and talent to the workplace.

Now is the time to ensure that everyone is on board, ready, and inspired to help solve the complex problems that plague modern society and the medical profession. Only by engaging in reflective thinking, taking into account our ever-changing landscape, will our shared goals be achieved, and in the words of the Alpha Omega Alpha Honor Medical Society, "Be Worthy to Serve the Suffering." [32]

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