Gender Equality in Leadership

What the @#$%^&* is Going on?!  

Kimberley Kelly

According to the well-known McKinsey report, "Despite all the attention organizations say they’re giving to elevating more women into leadership roles, almost no progress has been made at any level." Indeed, Alberta medical schools achieved gender parity for entrants over 25 years ago, thus it is a myth that there are not enough qualified women candidates to lead.

I present two real examples of white, privileged physicians who both graduated from medical school in 1994 to illustrate some of the barriers faced by women leaders.

My first example is from a white male physician. The male physician denies experiencing mistreatment as a medical student. He felt he could apply to any residency position. He was not asked about his marital status or when he might choose to have children during his CARMS interviews. He did not feel bias affected the outcome of any leadership positions he applied for. He was successful with all positions and promotions he applied for. He progressed up the academic and healthcare organizational leadership ladders. He received bonuses and won awards. He was sponsored to attend conferences and also received training opportunities. He received support, through human resources and dedicated time, to contribute to research and has multiple publications. While at work, childcare and child sickness were handled by his wife. He acknowledges that his wife spends more time with household operational duties and does the bookkeeping for their Professional Corporation. He has been led by two women physicians over his career. He has been unaware of any disparity due to gender until six months ago when his wife started talking about it…a lot.

In contrast, the white female physician experienced sexual harassment by a preceptor when she was a medical student. She was told that she shouldn’t consider any surgical specialties if she wanted to have a family. She heard comments stated to her in a derogatory way numerous times during her training like, “You only want to become a family doctor?” She was asked her marital status and when she planned to have children during her CARMS interviews. She was asked out for dates by patients. As an early career physician, she had been touched inappropriately by a male patient who ran his hand down her sternum on two separate occasions. Her College told her that she had to find this patient a new physician. A few years later she experienced intimidation by a medical director upon returning to work as a new mother. She considered future risks to herself and her career and chose to leave the position and start over.

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She was placed on a leadership committee with a male physician who had unsuccessfully engaged in past sexual advances. On this same committee a different male physician shouted at her that she didn’t belong. She chose not to run for re-election and started over. She was told that she should wait until her two sons were older before she ran for a Board position. She ran anyway and was not successful. She sought out leadership opportunities on her own in the non-profit and education sectors. Surprisingly, she discovered she was valued and respected. Her skills and confidence grew. She applied to teach medical students for no pay and designed her own elective. After a few years, she applied for a clinical academic promotion. She learned several months later that her application for promotion was not supported. She sought to understand why, followed through and completed all the suggestions over a two-year timespan. This included research with no protected time nor additional human resources. She funded herself to present at a national conference, paid for childcare to do so, and funded more leadership courses and training. She applied for two University positions but did not advance to the interview stage. She has received no awards. She has written mostly op-eds. She grew tired. She believed that although only mid-career she had done all that she could do.

You may have guessed that the female physician is me and the male physician is my husband. We had very different experiences over the past two decades despite beginning at an equal place as first year medical students. Like many other women in medicine, I have experienced multiple barriers with cumulative effect which have slowed my advancement and decreased my pay. My newest physician leadership task is to advocate for positive change.

When I broach the subject with my colleagues, a common response is, “But I have a female boss. There can’t be a problem.” I would like to challenge your assumptions.

On September 22, 2018, Dr. Alison Clarke became the Alberta Medical Association’s 2018–19 President. On the same date, Dr. Christine Molnar became President-Elect and they will serve as the fifth and sixth women Presidents since AMA’s inception in 1889. Dr. Linda Slocombe, Dr. Jane Ballantine, Dr. Margaret Kirwan, and Dr. Ruth Collins-Nakai are the other four women to serve as AMA Presidents. This is the first time in AMA’s history that there will be back-to-back women Presidents.

I would like you to consider that fact for a moment — two women Presidents in a row. Does it sound unusual or odd? Does it illicit any personal discomfort? Prior to Dr. Clarke’s presidency, the AMA had six male Presidents in succession. Is it typical that we would bring attention to the number of men in a row who have served in top healthcare leadership positions, like Deans at the Faculties of Medicine, CEO’s or Presidents? If you hear the word “President” and you automatically imagine a male leader, you have identified implicit (unconscious) bias.

If one considers the selection processes in place at our healthcare organizations and institutions, it is easy to identify multiple ways in which bias can affect a candidate’s success or failure. When we are on a nominating committee or a search and selection committee:

• Do we give equal weight to all candidates or do we prefer those we know?
• Are we aware of the identifying factors of those from underrepresented leadership groups in our organization?
• If we audited our organizations, would it show that women are represented, promoted, and paid equitably at every level?
• Are we inclusive when we recruit for positions and do we encourage members from underrepresented leadership groups to apply?

Research shows that women are less likely to apply for positions unless they meet 100% of the criteria listed and in my experience, often need to be approached multiple times.

• Are we aware of our own implicit biases?

If you have interviewed potential medical school candidates, you may have already completed Harvard’s Implicit Association Test,a a tool that tests your automatic preferences for factors such as skin-tone, weight, age, race, gender and sexuality. It has been shown that simply being aware of your implicit biases allows for fairer decision-making. Should all leaders and members of nominating committees and search and selection committees complete this tool?

It was interesting for me to learn that both women and men may experience implicit bias in their preferences for male leaders. Data indicates that nearly 50% of men and 33% of women think women are well-represented in leadership in companies where only one in ten senior leaders is a woman. When the C-suite is considered, only 1 in 5 top executives is a woman and fewer than 1 in 30 is a woman of colour.5 Here in Alberta, the CEO of Alberta Health Services and former Dean of Medicine, Dr. Verna Yiu, stands out as an exception.

Recently Donna Strickland, Associate Professor at the University of Waterloo, was awarded the Nobel Prize in physics. Notably, she was the first woman to receive this award in 55 years. It was funny/not funny to read this comment on Twitter by Michael Hendricks, “Application to full Professor is looking like a slam dunk.” This was most certainly embarrassing for the University of Waterloo and was quickly remedied by promoting the Nobel Prize winner to full Professor last week.

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I continue to work with AMA members, fellow Board members (I ran a second time and won), and other partners to examine and improve diversity and inclusivity in our province and country. I am astounded by the progress which has been made, personally and system-wide, in just one year!

As individuals we can address the problem of gender inequity as follows:


2. **Realize your biases.** We are all biased. Identify your implicit biases and challenge yourself, particularly when sitting on selection committees. Who do you automatically choose?

3. **Seek out data.** To identify a problem, we need data and measurement. If your organization’s data is not available, advocate for an audit, transparency of results, and ongoing measurement.

4. **Have individual courage to address this topic.** Demand organizational courage to admit problems and to act.

5. **Look for allies.** Studies document that women earn substantially less than men after adjustment for specialty, hours worked, experience, and practice characteristics. Women often get blamed for the disparities they face. Be curious, generously listen to stories and experiences, be empathetic. Remember that it was just a few months ago that it became somewhat safe to share our stories. Become an ally through action.

6. **Broaden knowledge.** My lived experience is as a white woman. I will never know what it is to be a woman of colour, or a man, or a member of the LGBTQ community. To broaden our knowledge we must listen, learn from our mistakes, take risks, make an effort to understand impact rather than defending positive intention, and notice who is at the centre of attention and power and who is not.

7. **Succession planning.** Leaders need to be mentored and sponsored. Training is essential. Examine your role in developing the potential of leaders around you.

System change is crucial. I am inspired by the collaborative efforts by all provincial partners and their commitment to working together to address these important issues. Partners include the Alberta Medical Association, Alberta Health Services, Alberta Health, College of Physicians and Surgeons of Alberta, Health Quality Council of Alberta, Professional Association of Resident Physicians of Alberta, University of Alberta Faculty of Medicine, University of Alberta Medical Students Association, University of Calgary Faculty of Medicine, University of Calgary Medical Students Association, Well Doc Alberta, Canadian Medical Protective Association, and the Canadian Medical Association. I feel we have turned a corner and we have the momentum and commitment to truly affect positive change in Alberta. I have again become hopeful.

In conclusion, I return to my story. In November, 2017, I begrudgingly attended a CME course on Women’s Leadership in Healthcare at Harvard. I learned about mentorship and sponsorship and their importance in progressing up the leadership chain. I was educated on the gender inequity research and became empowered. I left the conference with a new sense of purpose which was to improve things for those following behind me.

Two weeks later, I was invited to present at the Harvard conference on November 15, 2018. I chose to re-apply for a clinical academic promotion and was successful. I spoke publicly about my harassment on CBC radio. I, along with my seven co-sponsors, were successful grant winners and are creating a CMA community of interest to discuss gender equity on a virtual platform. I applied for a University position and have progressed to the interview stage. I continue to work with AMA members, fellow Board members (I ran a second time and won), and other partners to examine and improve diversity and inclusivity in our province and country. I am astounded by the progress which has been made, personally and system-wide, in just one year!

A final mention of personal gratitude. First to Dr. Pauline Alakija, an Alberta physician trailblazer who has advocated tirelessly on this issue for over a decade. Many physicians and learners, including me, have significantly benefited from Dr. Alakija’s perseverance, education, mentorship, sponsorship and courageous actions; a heartfelt thank you. Also, I would like to thank Dr. Sarah Bates who was the first to open my eyes on my own implicit biases and the significant consequences they had on outcome.

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8. To join the CMA #EquityCOI email yourvoice@cma.ca and indicate your interest. Anticipated start date mid-December, 2018.