

Changing the Culture of Academic Medicine to Eliminate the Gender Leadership Gap: 50/50 by 2020

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Abstract

Central to the daily struggles that successful working women face is the misalignment of the current work culture and the values of the workforce. In addition to contributing to work–life integration conflicts, this disconnect perpetuates the gender leadership gap. The dearth of women at the highest ranks of academic medicine not only sends a clear message to women that they must choose between career advancement and their personal life but also represents a loss of talent for academic health centers as they fail to recruit and retain the best

and the brightest. To close the gender leadership gap and to meet the needs of the next generation of physicians, scientists, and educators, the authors argue that the culture of academic medicine must change to one in which flexibility and work–life integration are core parts of the definition of success. Faculty must see flexibility policies, such as tenure clock extensions and parental leaves, as career advancing rather than career limiting. To achieve these goals, the authors describe the Stanford University School of Medicine Academic Biomedical

Career Customization (ABCC) model. This framework includes individualized career plans, which span a faculty member's career, with options to flex up or down in research, patient care, administration, and teaching, and mentoring discussions, which ensure that faculty take full advantage of the existing policies designed to make career customization possible. The authors argue that with vision, determination, and focus, the academic medicine community can eliminate the gender leadership gap to achieve 50/50 by 2020.

Coverage in the *Atlantic* and the *New York Times* of the difficult choices facing working women^{1,2} has raised much needed national awareness to the daily struggles of successful women. As women who have risen through the ranks of academic medicine in the male-dominated fields of cardiology and rheumatology while raising children, we are all too familiar with the struggles described by Anne-Marie Slaughter, a Princeton professor, and the advice advocated by Sheryl Sandberg, chief operating officer of Facebook. We are thrilled that their candid and insightful observations have sparked a global debate on the issue. We have spent our own careers “leaning in” and advancing, while actively trying to change the system to create a culture that is more sustainable and inclusive. We believe

that, to close the gender leadership gap, we must act on two fronts—provide women with the tools to advance within the existing structures, as professed by Sandberg, while also actively changing the underlying structures that reinforce gender inequality, as advocated by Slaughter.

At the core of this debate is the misalignment of our current work culture (predicated on the model of one spouse staying at home) with the values of the 21st-century workforce (50% of which are women). The recent study by Shanafelt and colleagues,³ which showed that nearly half of doctors are burned out, brought attention to the severity of the work–life integration problem in medicine today. This disconnect perpetuates the gender gap in leadership. In academic medicine, as in most fields, we cannot attribute this gap to a lack of women entering the profession—women have represented nearly 50% of U.S. medical school graduates for 10 years and over 50% of PhD graduates in the biological sciences. Yet, they account for only 19% of full professors, 13% of department chairs, and 11% of deans.⁴ This lack of female role models in leadership positions sends a clear message to women that they must choose between career advancement and their personal life. Even more pernicious is that this message creates a vicious cycle

of inequity and transforms our robust pipeline into a funnel.

The message to women that work–life integration is a matter of personal choice and that one should choose between career and family is hurting our ability as a profession to recruit and retain the best and the brightest. Yet, these messages are deeply seated in our culture and have become ingrained in the core values of most of our medical school professors. Research indicates that faculty struggle with integrating career and family not because of a lack of sound work–life integration policies but because these policies are misaligned with their core values of what defines success. As a result, we see limited use of many flexibility policies, such as tenure clock extensions and parental leaves, because faculty feel they may be seen as “not serious” about their careers or that they may burden their colleagues. Shifting the workplace culture to one that supports work–life integration will require an integrated approach—working with institutional leaders and faculty members to create a permissive environment and reframing flexibility policies as career advancing rather than career limiting. In conjunction with this culture change, we must ensure that women have the tools to accelerate their careers through

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ongoing professional and leadership development and sponsors at the highest levels of academic medicine to help in this process.

As it is currently constructed, workplace culture does not allow for work–life integration, and women and men struggle to “have it all.” However, we run the risk of diminishing the importance of the issue nationally by framing it as one of “having it all.” Rather, we see it as a national imperative for recruiting, retaining, and advancing the most talented researchers, physicians, and educators, and leveraging diversity to solve the complex problems facing medicine. All institutions must adapt their workforce practices. It is the only way to close the gender leadership gap. The debate, as it stands (flexibility versus advancement, organizational change versus “leaning in”), has yet to yield concrete solutions. Flexibility can be a reality, and countless studies have demonstrated a link between flexibility practices and the retention of talent in the workplace.^{5,6} What remains elusive is a culture in which advancement is not construed as the antithesis of work–life integration, where forgoing flexibility is not framed as the price to pay for advancement.

What do we gain from continuing to support an outdated work culture, turning away the intellectual capital that is essential for the future of our nation? Imagine a culture that considers work–life integration as one of its core values—where career planning, advancement, and goal setting discussions explicitly include work–life integration plans; where the norm is for everyone, including the most senior leaders, to articulate work–life integration goals and successes; and where ongoing measurement and reporting on the impact of work–life integration on productivity metrics is a priority. Our hypothesis is that such a culture will positively affect the conventional metrics of academic productivity for all—groundbreaking research, excellent patient care, and a world-class education. A by-product of this shift will be the increased retention of women, with the goal of 50% of faculty being women by the year 2020, and a narrowing of the gender leadership gap. And we will have stopped wasting our talent.

At the Stanford University School of Medicine, we are striving to change

the culture of academic medicine. Doing so is no easy feat—our faculty combine clinical, research, teaching, and administrative responsibilities and report the highest number of hours worked across the university.⁷ Over the past two years, we completed a deep internal assessment and designed an action plan by engaging a multidisciplinary team of thought leaders from across the campus and a design thinking firm, Jump Associates. Our plan, entitled Academic Biomedical Career Customization (ABCC), provides solutions to both work–life and work–work conflicts, the latter referring to the struggles faculty experience in managing the demands of all the academic missions and service. The ABCC model has received support from the highest leadership levels across campus and has been awarded the Alfred P. Sloan Award for Excellence in Faculty Career Flexibility.

Adapted from Deloitte’s Mass Career Customization model for flexibility, the ABCC framework involves the creation of individualized career plans that span a faculty member’s entire career, with built-in options to flex up or down in research, patient care, administration, and teaching. The model seeks to change the work culture of academic medicine through mentoring discussions to ensure that faculty members take full advantage of the existing policies designed to make career customization possible. It is organized around teams of faculty members who work in concert with their department chairs, assisted by professional career-life coaches, to create individual plans that will ensure that faculty and their teams consider work–life integration needs as a core part of the career planning process. Each faculty member structures his or her individualized career plan along five dimensions—pace (anticipated time to promotion); workload (disaggregated into clinical, research, teaching, and administration); role as an individual contributor or leader; schedule predictability; and work–life integration. Each faculty member’s plan reflects his or her desired relative contributions of each dimension over a three- to five-year period, indicating points of anticipated dialing up or down to fit the individual’s needs and life situations. Team members discuss these plans, review them regularly, and adjust them to ensure that all the academic missions and the

administrative responsibilities for the team are met.

Basic science faculty, whose predominant responsibility is research, achieve flexibility through tradeoffs in teaching and service, which can be done effectively by others. Specifically, faculty earn credits for taking on these responsibilities when they can, bank their earned credits, and trade them for services that afford them time for high-priority work-related tasks or for time for home and family responsibilities. This “banking system” rewards individual faculty for taking on the shared responsibilities of the group, thereby providing concrete benefits to alleviate work–life and work–work conflict when needed. Our menu of services, for which credits can be exchanged, includes housecleaning and meals delivered at home, outsourcing errands, and editing and PowerPoint design support services.

These services also provide support for clinical teams at work and at home. For example, one of our participating teams is using the ABCC framework to prepare for the simultaneous maternity leave and sabbatical leave of two faculty members. Team members are participating in transparent discussions about the redistribution of the clinical, teaching, leadership, and administrative work in accordance with each faculty member’s career goals and work–life integration needs now and in the future. The availability of the support services enables the team to alleviate the daily work–life integration conflicts as they engage in this redistribution of duties to ensure that the new flexibility plan works for everyone. The ABCC model’s short-term success metrics include perceived work–life integration assessed by the individual faculty member; availability of the faculty member as assessed by his/her constituency (colleagues, students, staff, and family members); career development; and institutional support. Long-term success metrics include faculty retention, advancement, and productivity across missions, and sustained cultural change.

With the support of our dean, hospital CEO, university provost, and president, we have begun to shift the culture of academic medicine to one in which faculty can combine successful careers, family responsibilities, and personal

interests over the course of their careers. This model is in sharp contrast to the “up or out” model that exists currently in academic medicine. If our solution succeeds in this complex environment, it is likely to provide a model for other disciplines and institutions.

If you think this issue does not affect you, think again. There has never been a more important time for our academic institutions to go beyond discussing the problem to implementing change. Academic medical faculty provide the intellectual capital for innovations in biomedical research, health care delivery, and the education of the next generation of physicians and scientists. Our ability to recruit and retain the best and the brightest is negatively affected by our outdated 20th-century workplace culture. The Association of American Medical Colleges predicts a shortage of 90,000 doctors by 2015 with the passage of health care reform. Younger generations of men and women are rejecting the outdated ladder system of academic medicine. Our health as a nation and our ability to maintain our global competitive

edge in biomedical innovations depend on our ability to change the culture of academic medicine. With vision, determination, and focus, we will succeed in this important mission and eliminate the gender leadership gap to achieve 50/50 by 2020.

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References

- 1 Slaughter AM. Why women still can’t have it all. *The Atlantic*. July/August 2012.

- 2 Kantor J. A titan’s how-to on breaking the glass ceiling. *N Y Times*. February 21, 2013. <http://www.nytimes.com/2013/02/22/us/sheryl-sandberg-lean-in-author-hopes-to-spur-movement.html>. Accessed June 14, 2013.
- 3 Shanafelt TD, Boone S, Tan L, et al. Burnout and satisfaction with work–life balance among US physicians relative to the general US population. *Arch Intern Med*. 2012;172:1377–1385.
- 4 Women in Academic Medicine Statistics and Medical School Benchmarking, 2009–2010. <https://www.aamc.org/members/gwims/statistics/>. Accessed February 21, 2012.
- 5 Villablanca AC, Beckett L, Nettiksimmons J, Howell LP. Career flexibility and family-friendly policies: An NIH-funded study to enhance women’s careers in biomedical sciences. *J Womens Health (Larchmt)*. 2011;20:1485–1496.
- 6 Bond JT, Thompson C, Galinsky E, Pottas D. Highlights of the National Study of the Changing Workforce. New York, NY: Families and Work Institute; 2002.
- 7 Stanford University Panel on Faculty Equity and Quality of Life. Report on the Quality of Life of Stanford Faculty. 2010. <https://facultydevelopment.stanford.edu/sites/default/files/documents/fqol-report-jan2010.pdf>. Accessed June 14, 2013.