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Leadership Inequity, Burnout, and Lower Engagement of Women in Medicine

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Abstract
Gender parity has been reached in graduation rates from medical school, yet women in medicine continue to face obstacles in promotion, compensation and opportunities, leading to leadership inequity, higher burnout and lower engagement. These complex issues with gender are just one aspect of the wide challenges related to diversity, equity and inclusion among medical professionals. While there are no "one size fits all" approaches, psychologists are well positioned to lead efforts related to promoting leadership equity, reducing burnout and raising engagement because of their training in communication skills, programmatic development and empathetic listening. This paper details several evidence-based efforts in which psychologists can lead in these ongoing issues for women in medicine.

Keywords Burnout · Medicine · Women · Inequality · Leadership

Clinical Vignette

Dr. Smith identifies as a 36-year-old cisgender woman (she/her/hers) who works as a full-time, un-tenured, assistant professor and neurologist at a large academic center. She has a large clinical practice with limited grant funding for clinical research. She is a mom to a young son Max. Recently she started her current professional staff position in the Midwest after completing her postdoctoral fellowship and serving as faculty for several years at another academic institution on the West Coast. She and her husband moved specifically for her career opportunities at this medical institution. When asked, she expressed some ambivalence about leaving family and her support systems on the West Coast. However, she also relayed that she and her family were very excited for her to start work at one of the nation's leading hospitals with potential for her to move into leadership. Family stress was high during and following the move. In addition, her husband had not yet found a position in his field, leading to financial concerns because of the purchase of a home based on anticipation of dual incomes.

Just one month after starting her staff position, Dr. Smith was ecstatic to confirm she was pregnant with her second child. Given the known challenges and expense of appropriate daycare, this caused worry about negotiating career and home stresses. Additionally, the financial pressure grew when her husband did not become employed. She worried about his lack of financial contribution to the household, especially when she would be on maternity leave. Dr. Smith's pregnancy was unremarkable with the exception of significant additional fatigue. The COVID-19 pandemic further aggravated her overall health and sense of well-being (Laraja et al., 2022).

Certain large medical institutions have leadership personnel who are committed to managing burnout among their professional staff (Olson et al., 2019; Shanafelt et al., 2015). Fortunately, Dr. Smith's institution is one of just a small number with a well-established program addressing burnout. She self-identified to receive help through this program. The program is led by Dr. Brown, a health service psychologist who, in addition to clinical responsibilities, leads engagement efforts for her institute. In this capacity, Dr. Brown offers acute individual intervention for burnout, addresses leadership inequality through development programs, and is responsible for interventions to improve staff engagement with a focus specifically on groups that traditionally have lower engagement, including women and those underrepresented in medicine (URiM). During her leadership, she has become a trusted member of the department, and caregivers feel comfortable reaching out to her. One of the key roles the program offers is a safe space for professional staff to seek help for burnout that is (1) not a part of the medical record and thus completely confidential and (2) not reported to any other individuals. Finally, these women (and the entire

institute) benefit from the psychologist's role influencing and combatting long-term systemic bias, which leads to improved staff engagement.

In March 2022, Dr. Smith connected with this psychologist to discuss concerns about increasing stress and burnout related to unrealistic expectations that she has for herself, as well as feelings of exhaustion. She was also feeling generally disillusioned at the lack of visible women role models in leadership positions. Dr. Brown and Dr. Smith worked closely together for 2 months to evaluate her concerns, reshape her self-imposed and negative definitions, acknowledge systemic bias impacting her experiences and her well-being, and discuss individual approaches to improve well-being. They also reviewed available programs that address leadership inequity and those that support leadership training and women's well-being in medicine.

In early May 2022, Dr. Smith delivered her baby. She returned to work in the middle of June and called Dr. Brown shortly thereafter. Dr. Smith's husband found a job in his field, she was adjusting to being a mom of two, and she realized that many of the unrealistic expectations she stressed about were externally imposed in response to the need to "prove herself constantly" to the men in her department. However, she currently struggles with managing her many roles of mom, wife, doctor, and daughter to aging parents across the country, as well as the systemic biases that face diverse populations. Dr. Smith also continues to feel disillusioned regarding her hopes of moving into leadership. She feels she has little time and energy outside of her career to focus on leadership development. Like many, she expresses the need to accomplish things at 2-3 times the level and effort as her male colleagues to prove herself. Her motivation to advance her own career has been stifled by the disproportionate number of men climbing the leadership ladder.

Dr. Smith met with Dr. Brown to talk about her disillusionment and how best to be proactive with her career aspirations. Possible next steps related to the vignette are presented in this paper.

Introduction

Discrimination related to historic gender roles is a long-standing problem across healthcare with considerable negative impact on leadership inequity, burnout, and low engagement among those identifying as women in medicine. However, this only represents one of the many challenges related to diversity, equity, and inclusion (DEI). Research has demonstrated that the effect of the combination of gender with URiM or Black, Indigenous, People of Color (BIPOC) status is dramatic (Saboor et al., 2022). While limited, studies indicate that women who identify as other than cisgender face additional and unique inequity and challenges (Reece-Nguyen et al., 2022). While all these represent important hurdles, efforts to address gender-related problems have potential for meaningful progress. In fact, gender discrimination remains among the most pervasive and damaging barriers for professionals in medicine (Quinn & Smith, 2018). The present article will focus primarily on impacts on cisgendered women working in medical settings; when the terms women/female or men/male are used it will indicate cisgendered unless otherwise noted. However, contributions that detail the spectrum of "gender-related" are certainly warranted in future work.

Leadership inequity, which includes promotion, recognition, representation, and compensation disparity have shown slow progress despite the rapidly increasing presence of women in medicine (Carr et al., 2018). Burnout, first described in 1974 and expanded over time, explains a multidimensional stress syndrome consisting of mental fatigue (emotional exhaustion), negative perceptions and feelings about clients or patients (depersonalization), and reduced perceptions of professional competence (Maslach & Jackson, 1981). While all professional healthcare staff can be vulnerable to burnout, these concerns were aggravated during the COVID-19 pandemic and reinforced that women in medicine face unique additional professional challenges (Laraja et al., 2022). More recently, engagement has been appreciated as a critical component of staff retention, financial success, patient safety, patient quality, and career satisfaction. It is distressing yet not surprising to note that women in medicine consistently report lower engagement than their male colleagues (Alli et al., 2021). Higher burnout and lower engagement come with tangible costs including elevated healthcare expenses and reduced patient safety and quality (Hall et al., 2016).

The goal of this paper is to offer practical suggestions for how health service psychologists can address the problems related to leadership inequity, burnout, and low engagement for women in medicine. The authors detail areas that health service psychologists are well positioned to incorporate into their practice, including for providers who experience or are at high risk for burnout. These topics include programmatic interventions designed to combat systemic bias and improve staff engagement and institutional efforts to promote leadership equity. Specifically, these suggestions focus on ways to expand upon and enhance mindful engagement and foster leadership development for women professionals (Olson et al., 2019; Shanafelt et al., 2015).

Burnout and Low Engagement

Professional women in medicine have gained parity in medical school graduation rates yet continue to face significant obstacles in promotion, compensation, recognition,

speaking opportunities, and invitations to advisory boards and steering committees, all of which can contribute to significant leadership inequity and lower engagement at work (Carr et al., 2018; Lautenberger & Dandar, 2020; Shillcutt & Silver, 2018; Silver et al., 2017; Travis et al., 2013). Women in medicine also report higher levels of stress that generally fall into the broad categories of marginalized status and discrimination, compensation inequity, mentoring and role model deficiency, advancement challenges, disproportionate burden for home responsibilities, harassment/microaggressions, work-life control negotiations with the dual-couple careers, and isolation (Robinson, 2003).

Like many working women, those in medicine are likely the primary caretakers in the home while also being highly committed to their careers (Troppmann, 2009). This problem was further aggravated during the COVID-19 pandemic, when women disproportionately co-managed childcare, homeschooling, and their jobs because many women were in "essential" roles such as healthcare (Lefkowitz & Armin, 2021). Research consistently shows gender-based wage and wealth gaps, demonstrating that women on average earn 81 cents for every dollar paid to men in the United States and as much as $2 million less over a 40-year physician career (U.S. Bureau of Labor Statistics, 2020). Combined, this negatively affects women's careers and job satisfaction, contributing to burnout that is currently at an all-time high (42% overall physicians and 51% female physicians; Whaley et al., 2021).

Healthcare burnout and low engagement are increasingly recognized as a financial and quality problem. The term "burnout" was coined in the 1970s to describe the consequences of severe work-related stress relative to high ideals (Freudenberger, 1974). In the healthcare context, burnout can lead to depersonalized care, erode empathic and communicative skills, and interfere with the provision of best practices in medical management. Three components of burnout are emotional exhaustion; disinterest in empathic, personalized care and communication with patients; and decreased sense of personal accomplishment, which can all lead to distress and depression. Women in medicine are particularly at risk for burnout compared to other professions (Romani, 2014).

Burnout negatively impacts patient care outcomes; results in high rates of physician turnover; and negatively impacts clinicians' health, well-being, and relationships (Hakanen & Schaufeli, 2012; Shanafelt et al., 2015). As a result, healthcare leaders are working to understand how best to mitigate burnout and bolster clinicians' well-being (Hall et al., 2016; Swensen et al., 2016). Thus, burnout is a critical quality and patient-safety issue—as well as a financial burden for healthcare systems—and impacts the relationships and health and well-being of healthcare providers, with women in medicine more profoundly impacted by multiple factors discussed (Hakanen & Schaufeli, 2012; Wright & Katz, 2018).

Burnout and engagement are closely tied and sometimes intertwined in the literature. Employee engagement is generally described as the *positive antipode*, or inverse, of burnout (Fragoso et al., 2016). In 1990, this construct was described as the cognitive, physical, and emotional energy invested in a work role (Kahn, 1990). Engagement and burnout have also been linked in the literature to a variety of work-related outcomes, such as health problems, stress, absenteeism, job performance, and positive job attitudes. Burnout rates are typically related to individual reporting, while engagement is measured and trends are followed through system-wide experience survey results, such as one designed by Press Ganey® (Hodkinson et al., 2022).

The Medscape (2021) National Physician Burnout and Suicide Report demonstrated that physician burnout is a critically unaddressed issue (Chandawarkar & Chaparro, 2021). Over the past decade, there has been a 10% increase in the number of women reporting burnout, totaling 51% in the year 2021. Not surprisingly, this finding contrasts with male physicians, of whom just 36% report burnout (Chandawarkar & Chaparro, 2021). Several recent studies found factors that predicted burnout among clinicians during the COVID-19 pandemic and confirmed that women were more impacted than men (Alrawashdeh et al., 2021; Linzer et al., 2020).

Unique Problems Within the Healthcare Sector

While confidentiality is always a priority with psychological interventions, it is important to consider specific impacts for interventions related to physician burnout that are managed by the employer. Psychologists embedded within medical centers are presented with important ethical concerns frequently including, but not limited to, confidentiality, sharing of information through the electronic medical record (EMR), obtaining informed consent, and cultural competency in the medical setting. One important piece of informed consent is making sure the person is clear about how records will be kept and who has access to these records and patient information. While the benefits and challenges of the EMR are numerous with ease of care coordination and communication across a health system, for interventions related to burnout, privacy considerations may limit some from engaging in needed care (Clemens, 2012). Those seeking help for this may fear being labeled with a mental illness or stigmatized.

For psychologists embedded in a medical setting, a principle-based ethics approach is recommended (Knapp et al., 2017). This model attempts to address shortcomings

of both deontological ethics (intentions are most important) and utilitarian ethics (outcomes are most important) when weighing various ethical duties such as fidelity, justice, beneficence, and nonmaleficence in helping professionals experiencing burnout. Principle-based ethics acknowledges that it may be impossible to follow one ethical principle without violating another and encourages the psychologist to seek morally preferable alternatives or the lowest level of infringement. Knapp et al. (2017) offered a five-step model for psychologists to consider in ethical decision-making that includes (1) identifying the problem, (2) developing alternatives, (3) evaluating options, (4) suggesting action, and (5) implementing evaluation. This five-step model could be used to determine the best course of action in addressing burnout in the workplace.

A frank discussion on confidentiality, information sensitivity and ethical considerations may be a useful first step to maximize engagement and help Dr. Smith understand the risks and benefits of receiving care for burnout (Nielsen et al., 2013). To this effect, ethical principles were weighed to ensure protection and confidentiality. For example, fidelity (establishing trust/confidentiality) was weighed with integrity (including access to information in the EMR). Dr. Brown and the leadership team determined that to engage healthcare professionals in well-being and burnout topics, optimal deployment of evidence-based psychology interventions required careful adherence to confidentiality.

Professional women in medicine have made progress in gender equity but continue to report high levels of sexual harassment, discrimination, and other inappropriate behaviors at work (Maso & Theobald, 2022). Since women still constitute less than 50% of the physician workforce, they continue to have underrepresented status and experience discrimination and microaggressions (Steiner-Hofbauer et al., 2022). With high rates of sexual harassment, bullying and microaggressions against women in medicine, it may be useful for psychologists working in this area to have increased training to provide adequate direction on these topics. For example, Jagsi et al. (2016) reported that although sexual harassment appears to be declining, it is still common in academic medicine with 30% reporting experiences of sexual harassment. While Dr. Smith's case did not specifically report harassment or other inappropriate behavior, these factors are historically known to contribute to or cause burnout and should be evaluated by a psychologist during an acute intervention. Generally, application of "duty to warn" ethics prevail in burnout interventions to ensure confidentiality and protect vulnerable individuals.

Further research is needed to ensure optimal acute intervention for the many physicians, disproportionately women and URiM, who suffer from burnout. These include assessing current practices in obtaining informed consent and confidentiality, as well as participating in burnout and engagement research efforts. Multidisciplinary team decisions and established guidelines in integrated healthcare settings are critical for this mission and for establishment of best practices.

It is not unusual for a health service psychologist to practice in isolation in a medical clinic with little interaction with other psychologists. Therefore, developing strong relationships with other health service psychologists and medical providers outside and inside one's institution is often useful for the individual psychologist's well-being as well as for optimization of programmatic interventions. Familiarity with the similarities and differences between the American Psychological Association guidelines and other professional ethics codes such as the American Medical Association may be valuable to guide conversations and develop multidisciplinary policies (Hudgins et al., 2013; Van Liew, 2012). Psychologists can also consult with their hospital's legal teams regarding policies and informed consent practices. Most integrated healthcare settings have an Institutional Review Board or bioethics committees that can assist multidisciplinary teams facing difficult ethical decisions, particularly related to research.

Programmatic Interventions to Improve Engagement

Several interventions have recently been highlighted in the literature leading to more positive engagement. First was an introduction of flexible scheduling and virtual care. While many healthcare systems organically did this during the COVID-19 pandemic, the adoption of virtual practice and more flexible and autonomous schedules should be sustained, encouraged, and supported. Based on a small research study where providers participated in either a flexible schedule (FS) or a standard schedule (SS), those in the FS group were more likely to indicate improvement in work-related stress compared to those in the SS group. This study also discovered that early career (within the first 10 years post-training) status was a predictor of burnout, again demonstrating a need to focus specifically on the younger caregiver (Sullivan et al., 2022).

Implementation of an interdisciplinary engagement committee is encouraged across healthcare institutions. This committee should be designed to address the specific needs of each institution and groups within that institution, including special attention to historically underrepresented or marginalized populations. The first task of such a committee should be the agreement on priority goals based on a needs assessment. Achievement of these priorities can then utilize a multifaceted approach to many issues, including communication improvement, well-being programs, staff

development, retention, respect and recognition, along with elimination of toxic work environments.

One of the approaches for which health service psychologists are strongly suited is in the realm of workplace engagement. Many institutions now routinely measure professional staff engagement at a departmental or institutional level through regular surveys. One such example is the Caregiver Experience Survey by Press Ganey®.

This survey takes about 15 min to complete and can be deployed at regular intervals to measure and analyze workplace engagement using six items that determine the Engagement Indicator Score (EIS). These responses are confidential, and the scores can be analyzed using a variety of stratifications including gender. Scores range from 0–5, with 5 being optimal, and is based on Meyer and Allen's Affective Commitment construct (Meyer & Allen, 1997). Aspects that contribute to this include attachment, loyalty, pride, satisfaction, and recommendation as both a place to work and as a place to receive care (Meyer & Allen, 1997; Meyer et al., 2002).

Psychologists can manage acute burnout at a personalized level in the form of individual psychotherapy or group counseling. It is important to establish the standard of care practice as a psychologist, as there are significant confidentiality concerns if one practices in a larger medical setting and others have access to the EMR or if it is a small institution with little capacity for anonymity. Individual intervention must be the cornerstone of a successful program but is not sufficient for long-term success. Wellness programs and acute intervention can be successful but will never overcome problems associated with a toxic workplace, inappropriate behaviors, sexual harassment, and discrimination.

When assessing engagement for women in medicine, it is critical to appreciate specific factors and how they are changing over time. For example, while the number of women physicians is growing, representing 52% of entering medical students, women only hold just 9% of full professorship rank. In addition, they still represent just over 36% of practicing physicians with significant concentration in a small number of specialties such as pediatrics, obstetrics/gynecology, child/adolescent psychiatry, and neonatal medicine (Lautenberger & Dandar, 2020). A higher percentage of women leave medicine or opt to work part-time, further obscuring the real picture of their engagement. Overall, the average age of women physicians is younger than men, representing a majority of those in practice who are < 35 years old (Lautenberger & Dandar, 2020). Optimally interpreting and understanding critical aspects of engagement scores requires appreciation of these trends.

Nationally and at individual institutions, surveys show that particularly in the early years of their career, women demonstrate the least engagement in all 6 categories of the Press Ganey® survey (Hodkinson et al., 2022; Linzer et al., 2020; Sullivan et al., 2022). There is also a clear relationship between low engagement and the significant and costly problems of burnout. The silver lining is that having access to these data, coupled with programmatic commitment and change, can lead to meaningful improvements in professional engagement. Slowly, many institutions are recognizing the need to address this important issue (Panagioti et al., 2017).

Conclusions

Establishing a program to reduce leadership inequity, burnout, and low engagement for women in medicine takes time. It is not a "one-size-fits-all" solution for any system; it is useful to individualize strategies to meet local needs and build on the practices demonstrated to have positive impact. However, using the foundation of other successful programs should support the process and help realize success. Psychologists are well-positioned to lead burnout and engagement efforts because of training in and skill with communication, programmatic development, organizational systems, and empathetic listening. Efforts to utilize their expertise for mitigating burnout risk and leading programs for women's professional development in their medical careers should be encouraged. Closing with our vignette, based cumulatively on many individuals seeking intervention, Dr. Smith not only benefitted from support for her own financial and work-life negotiation challenges, but was introduced to opportunities for growth with confirmation of her institution's commitment to diversity, equity, and inclusion.

Key Considerations

- Professional women in medicine continue to face significant obstacles in promotion, compensation, recognition, and other opportunities, demonstrating the pervasive issue of gender leadership inequity.
- Burnout can negatively impact patient care, result in high rates of physician turnover, and negatively impact clinicians' health, well-being, and relationships.
- Creating programmatic change is a multistep process. There is no "one-size-fits-all" process for any system.
- Psychologists are well positioned to lead these efforts because of training in and skill with communication, programmatic development, organizational systems, and empathetic listening.

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Declarations

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