Women in medical leadership: has the COVID-19 crisis heightened the glass cliff?

For over 30 years, the *Medical Journal of Australia* has published articles identifying gender inequities that contribute to a persisting glass ceiling in women's representation in medical leadership.[1,2] The close of 2021 saw an unprecedented and welcome trend — women occupied many highly visible medical leadership roles in Australia and Aotearoa New Zealand. This included appointed roles, such as jurisdictional chief health officers, but also elected roles, such as presidents of specialty medical colleges, including the colleges for general practice, physicians, surgeons, emergency medicine, anaesthetics, psychiatry, and intensive care.[3] While this achievement should be celebrated, we cannot yet claim gender parity in formal leadership roles across the health system.[4] In this article, we present the possibility of the glass cliff phenomenon in exploring the rise of women medical leaders during the coronavirus disease 2019 (COVID-19) pandemic, and the need for systematised approaches to better support women leaders.

Women as leaders

Although we increasingly recognise the value of health sector leadership reflecting the diversity of the communities it serves, there has been inadequate implementation of strategies to sustainably improve inclusivity and representation of women and other minoritised identities (ie, groups who experience marginalisation due to various factors, including ethnicity, ability, etc).[2-4] This can compound negative impacts on existing minority leaders, who may experience tokenism and negative stereotypes in addition to existing systemic barriers to leadership development. As importantly, the health system fails to benefit from the positive outcomes associated with diversity.

Consider, for example, the countries and jurisdictions led by women who excellently navigated the challenges of the COVID-19 pandemic, such as Aotearoa New Zealand, Taiwan, and some Australian states. Female leadership was associated with lower death rates from COVID-19, attributed to earlier adoption of control measures, although this may be confounded by the higher socio-economic status and cultural norms that are associated with the presence of female political leaders.[5,6] Women leaders were praised by some (and criticised by others) for showing resilience, emotion, and vulnerability, among other stereotypically feminine traits. Researchers argued these traits were invaluable during the prolonged periods of uncertainty the world experienced as the effects of the pandemic unfolded.[6]

The glass cliff: a phenomenon of precarious leadership

Evidence from social and organisational psychology offers a possible explanation for the rise in women leaders during the pandemic. The glass cliff phenomenon, drawn from the glass ceiling concept, refers to the tendency for women and other minoritised people to be appointed to leadership positions in times of crisis, compared with periods of stability.[7] This is because, when circumstances are bad, change is both desired and needed, and women and other minoritised people are often pushed forward as visible signals of change. As described by Ryan and Haslam,[7] while this may be a golden opportunity, it is often an example of a poisoned chalice, as these appointed leaders are expected to perform a miracle to turn the crisis around — anything less is perceived as failure. Rather than reflecting on the individual, these failures may then reinforce negative stereotypes about the capabilities of leaders from minoritised identities.

Adding to the precarity of the situation, women's leadership performance is often evaluated more harshly compared with that of their male counterparts, as research has shown that we have a tendency to mistake confidence (a stereotypically masculine leadership quality) for competence.[8] As our health systems experience sustained challenges imposed by aging populations, the climate crisis, resource constraints and staff shortages,[9] the ways in which we assess the performances of our leaders requires considerable scrutiny.

As we witnessed in 2023 with the resignation of Aotearoa New Zealand Prime Minister Jacinda Ardern, leading with resilience, emotion, and vulnerability — as well as the disproportionate backlash and harassment from the media and social media[10] — takes its toll. Ardern reported feeling she could no longer give everything to being a leader, that she had "no more in the tank",[11] sentiments which are arguably symptoms of the glass cliff phenomenon. The combination of leading in crisis, overly high expectations for excellence paired with criticism for anything less, and harassment from media platforms is a lot for a leader to shoulder. It should not be up to individuals to overcome the glass cliff and bear these challenges alone.

The onus of caring at home and as leaders

It is also important to acknowledge that aspiring female leaders may have other demands in their lives and often receive little institutional support to meet caring obligations at home.[1-3] Work–life balance or integration was a major challenge throughout the pandemic for all Australians,[12,13] but arguably more so for women. The evidence is stacking up: a disproportionate amount of the domestic and caring load fell to women during the COVID-19 lockdowns and restrictions,[14] which were particularly harsh and long in Australia.[15] This included the childcare of younger children, home schooling, caring for aging family members, and even extended to increased housework for women (fathers' levels also rose but

Melissa A Wheeler[1]

Laksmi S Govindasamy[2]

1 RMIT University, Melbourne, VIC.

2 Swinburne University of Technology, Melbourne, VIC.

melissa.wheeler@rmit.edu.au

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were not equal to those of mothers). Consequently, working caregivers reported more stress, exhaustion, burnout, and poorer mental health.[14] This disproportionate division of domestic labour can also have direct career consequences;[16] the opportunity cost of prioritising caring duties was considered a contributing factor to the gender gap in women's scientific publications during the pandemic.[17]

A recent systematic review of the experiences of physician mothers highlighted the unique challenges faced by physicians and doctors-in-training as they navigate the competing priorities of pregnancy, parenthood, and medical practice.[18] While Australian perspectives often align with international findings,[19] no studies from Australia were discovered in this review.[18] Thus, there remains a need for local research to drive evidence-based policies that better support the dual identities of doctors who are carers and the accompanying competing demands. One mechanism of support is to address the longstanding requests for improved flexibility,[1] which will benefit all, but perhaps especially those juggling dual identities. If carers are the only ones allowed to work flexibly, they can fall behind their peers as a result of presenteeism bias, and it is also unfair to assume non-carers experience no work–life conflict.[20]

While it may be difficult to admit, caring takes its toll, depleting cognitive and emotional reserves. So, too, does practising the emotional, nurturing style of leadership that many women leaders throughout the pandemic have admirably shown. The burden of caring, both at work and as a leadership style, will likely decrease the longevity that women leaders are able to sustain in their leadership roles, particularly if they have been elevated to a glass cliff.

Fixing institutions, not individuals

Many gender equity initiatives fail to improve women's representation in leadership for a multitude of reasons.[21] One common finding is that too many initiatives are targeted at professional development for the individuals seeking or holding leadership positions (eg, training women to speak with confidence),[22] which ignores the structural barriers that continue to be unchallenged with such supply side approaches.[23] If we are serious about supporting women and improving the representation of women in medical leadership, evidence-based initiatives need to be implemented at the level of the institution, not the individual.

A recent meta-synthesis provides a good starting point, presenting results from nearly 100 organisational interventions across different industries and various countries.[4] From this review, the authors present tailored recommendations for the health sector, which they claim is still dominated by hierarchical cultures and masculine leadership perceptions. Some include actively promoting organisational strategies to positively impact organisational culture and to promote better awareness of the barriers that women face, including the perception that the under-representation of women in leadership is trivial and can be attributed to "natural" reasons (eg, caregiving roles). Recruiting more women alone will not address this under-representation, because in many cases, they are recruited into cultures that exclude them and even push them out.[24]

Beware of backlash to gender equity initiatives

In addition to the attitudes and barriers described above, a survey of medical professionals showed an unwillingness to support gender equity initiatives due to the misbelief that women are already well represented in medicine.[25] If the majority believe there is no problem, there will be no support for women and leadership in the health care sector. This misbelief may be a symptom of diversity, equity, and inclusion fatigue, and we might expect continued backlash in the form of people tuning out or even lashing out. The evidence-based recommendations we have highlighted here[4,21,25] will be highly relevant for ongoing effective and sustainable initiatives for women in leadership.

Conclusion

While there is much to celebrate with the increased visibility of women medical leaders, we must be mindful of the potential pitfalls associated with the glass cliff phenomenon and the increased demands and expectations that may be faced by leaders of minoritised identities. A renewed focus on institutional changes that facilitate work–life integration and organisational inclusivity may better support current and aspiring leaders, which in turn can deliver the benefits of diverse leadership back to our health system.

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