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MEDIA RELEASE

ADVANCING WOMEN IN MEDICAL LEADERSHIP: INEQUITY PERSISTS

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DELIBERATE efforts to exclude women from leadership roles are increasingly uncommon and progress is being made, yet gender inequity in medical leadership persists, according to the author of a Perspective published online today by the *Medical Journal of Australia*.

Professor Helena Teede, Executive Director of the Monash Partners Academic Health Sciences Centre at Monash University and Monash Health, noted that “unconscious gender bias still contributes to the so-called glass ceiling or unspoken barriers to career progression, which prevail despite increased qualifications, employability and work performance among women”.

Professor Teede stated that it was beholden on Australia’s current leaders to “move away from perceived gender-characterised leadership styles, to identify non-inclusive leadership styles, recognise that the ‘behaviour we walk past is the behaviour we accept’, and to call out and address this behaviour that challenges credibility and diversity of leadership” together.

Women have attained gender parity in Australian medical schools for decades, Professor Teede wrote.

“However, under-representation of women in senior leadership positions persists, and the age-old argument that this is due to a time lag or pipeline effect clearly no longer applies. In Australia, around 30% of deans, chief medical officers or medical college board or committee members are women, while women make up 12.5% of CEOs in large hospitals.”

As a Professor of Medicine at a relatively young age, Professor Teede said that her roles often involved being the “token” single woman in settings where leadership was often defined around traditionally masculine characteristics, highly competitive leadership styles, non-inclusive behaviours and limited diversity.

“This presented me with personal disincentives to adopting and retaining some roles. Leadership training and mentoring enabled me to progress from initial avoidance to identifying, respectfully challenging and often positively influencing unconscious bias and non-inclusive leadership behaviours.”

In her *MJA* article Professor Teede argued that gender equity had moved from “a battle between genders and deliberate exclusion of women from leadership to a recognition of the need for all to actively champion change, irrespective of gender”, including addressing barriers to progress.

Barriers to female leadership fell under three themes:

- **Capacity:** limitations due to additional household and parenting duties disproportionately shouldered by women. “Australian medical workforce data show women work equal hours initially, have a sharp decline corresponding to maternity leave and early preschool years, then a rise to similar hours to men,” Professor Teede wrote. “Strategies that empower and support women to seek more flexibility and equitable balance for outside work and parenting are clearly important ... greater research and translation into policy and practice is now needed to address these limitations to capacity and enable flexibility”;
- **Capability:** perceived capability or confidence women may hold in their ability to lead. “Women are less likely to advocate for or promote themselves, with less nominations for awards or less actively seeking pay rises or career opportunities ... women who do seek promotion often do so when they are mentored, supported or sponsored by others, which can inform organisational approaches to increasing women in leadership”;
- **Credibility:** perceived traits that are consistent with leadership. “There persists a bias in leadership and organisational culture linking traditionally masculine styles and values to leadership credibility ... which may reduce the motivation for women to seek or retain leadership positions. A preference for distributive leadership is more common among women, who are more likely to seek and consider input from teams and stakeholders”.

Professor Teede wrote that work was underway to codesign a national “program in health care, including an implementation roadmap for organisations and measurable and benchmarked outcomes”.

“More research will be crucial to codesign, implement and evaluate effective strategies to enable gender equity and diversity more broadly at the individual, organisational and systems level and, where effective, these should be scaled across our health system and beyond,” she concluded.

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