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Ongoing Gender Inequity in Leadership Positions of Academic Oncology Programs
The Broken Pipeline

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Reaching gender parity in medical school enrollment this year should have come as no surprise—women have represented more than 40% of the US medical student body since 1995. What should surprise us is the marked underrepresentation of women in more senior positions in medicine, even now, despite women's long-standing near-parity among medical school enrollees. The study by Chowdhary et al[1] adds to the increasing body of knowledge documenting this concerning fact with a comprehensive overview of gender distribution in the leadership of academic oncology programs in the United States, providing important benchmarking data for the field.

In an analysis of 6030 faculty from 265 Accreditation Council for Graduate Medical Education–accredited oncology programs, they have confirmed findings seen across medicine demonstrating that the gender distribution of leadership of academic oncology programs remains overwhelmingly unequal. Women faculty represented 35.9% of the total faculty body in medical oncology, radiation oncology, and surgical oncology programs, consistent with representation of women in the body of all actively practicing physicians as well as academia at large. However, representation of women in leadership positions was lower, at only 24.4% overall (medical oncology, 31.4%; radiation oncology, 17.4%; and surgical oncology, 11.1%). Additionally, representation of women in chair positions was even worse, with only 16.3% of departments chaired by a woman (medical oncology, 21.7%; radiation oncology, 11.7%; and surgical oncology, 3.8%).

These findings are consistent with previous studies showing that women hold only a small minority of other visible and influential positions in medicine, such as authorship, leadership of medical specialty societies,[2] and editorial board membership.[3] A common metaphor for describing the diminishing proportion of women observed at each level of leadership has been that of a pipeline. Some believe the pipeline is simply long: progress is slow owing to the sheer length of the path to senior positions and the lag time before the people who compose the overwhelmingly male older cohorts retire. If the pipeline were simply slow, representation of women would increase initially in the early ranks and then later in more senior positions over time as women who entered medical school in gender equitable cohorts advanced through their careers. Despite near-parity in medical schools for decades, this has simply not materialized, raising concerns that the pipeline is not simply long but also leaky, with women dropping out of the pathway that leads to leadership in the field owing to gender-specific challenges.

A multitude of factors contribute to this phenomenon. Thanks to the #MeToo movement and the recent landmark report of the National Academies of Sciences, Engineering, and Medicine,[4] a newfound awareness of the prevalence of sexual harassment in medicine has developed. One newly founded organization, TIME'S UP Healthcare, advocates for treating sexual harassment and gender inequity as health care quality improvement challenges requiring changes to structures and processes that will ultimately lead to measurable changes in outcomes. However, despite the power of such movements, challenges and misconceptions linger, including the false belief that sexual harassment must involve sexual coercion or assault. While egregious instances of assault and coercion do occur, a key insight from decades of research in organizational psychology is that gender harassment represents a wider set of shockingly common behaviors. Together with more unconscious forms of gender bias and systemwide policies that disadvantage women,[5] a complex set of barriers contributes to the leaks in the pipeline that leads to leadership for women.

Prior studies have shown that women are paid less,[6] spend more time on parenting and domestic responsibilities, experience higher rates of burnout,[7] and face other challenges in reaching the leadership positions analyzed in the study by Chowdhary et al.[1] Contributing factors include unconscious bias, the motherhood penalty, and lack of mentorship, among others. Recent studies have documented how these challenges play out within the field of oncology specifically. Duma and colleagues[8] documented that women speaking at a prominent national oncology meeting were less likely to be introduced by professional titles. Knoll and colleagues[9] documented that women attend fewer national conferences despite being equally convinced of the important benefits of attendance, and the biggest reported obstacle to attendance was related to childcare.

All of these factors combine to dispel the long (but intact) pipeline myth and lend credence to the idea of a leaky pipeline in which women will, absent intervention to patch the leaks, never make it to leadership positions at the rate expected based on their representation among medical students. As our awareness of these factors contributing to gender inequity continues to increase, we have only one way to move forward—to act just as we do in battling the disease of cancer itself: we must address these issues with evidence-based interventions.

Interventions that have the ability to address the root causes of gender inequity offer the most opportunity to repair the pipeline. For example, unconscious bias training may mitigate inequitable treatment, such as when women are offered less pay, expected to share more administrative burdens, or are evaluated based on past accomplishments when men are evaluated based on future potential. Addressing harassment through strong institution-wide policies helps to create a psychologically safe environment that not only maintains intellectual capital but also promotes organizational performance. Equitable leave policies, for men and women, help to support motherhood in an era when society continues to impose gendered expectations, while also helping to shift norms overall to allow fathers to take on truly equal participation in parenting. Term limits for the upper echelons of leadership give women the opportunity to seek out leadership positions. Evidence suggests that when such interventions are appropriately deployed, they are able to improve representation of women in leadership.[10]

Additionally, the role of mentorship and sponsorship in promoting equity is key. Interestingly, Chowdhary et al[1] found that those departments with women in leadership had a higher rate of women faculty representation (7%-10% higher). In the era when women medical students outnumber men medical students, the need for visible women role models is likely to be especially important as well.

Continuing to work on diversity at all levels is critical—the need to promote gender equity stems not just from respect that should be afforded to each of us individually, but also from documented evidence that gender diversity improves innovation and organizational performance. Studies have even suggested that women may provide better clinical care in some settings, particularly for women patients, suggesting that diversity within the profession is essential to achieve the ends we pursue together. Additionally, a diverse workforce better represents the diverse population and stakeholders served by organizations. Thus, gender equity is critically important.

Chowdhary et al[1] have provided data necessary to outline the work that remains to be done in academic oncology. Oncologists must encourage our profession to begin the process of cultural transformation necessary to improve equity and bring more women into leadership positions. We owe it to each other, to the women in our field who will come after us, and to our patients—it is time to fix that broken pipeline.

ARTICLE INFORMATION

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