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Review

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Engaging women in academic medicine in the UK: report of a workshop at the Association of Physicians Annual Meeting, 2 April 2009

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Summary

In April 2009, at the Association of Physicians of Great Britain and Ireland (APGBI) Annual Meeting in Birmingham, a workshop was held to consider the changing demographics of the medical profession, its potential effects on the Association's stated aims of promoting academic excellence and ways of ensuring that medical academia is attractive to everyone with the ability and drive it needs. This paper reports the discussions of the workshop participants and also summarises recommendations for actions by both the Association and its membership, which will encourage interest, equal opportunities and personal development for all in academic medicine.

Introduction

Over 60% of medical graduates are now women, and for 25 years women have made up over 40% of medical graduates. However, many areas of specialization remain unattractive or inaccessible to women, for example, surgery and cardiology. There is a particular underrepresentation of women in academic medicine, i.e. those employed by a university medical school.

The changing demography of the medical profession has been the subject of several reports and studies, some of which have sought to address the need to retain expensively trained women in medical employment.[1,2] Another, published after this workshop, addressed the implications of the changing gender balance in the profession for work patterns and speciality preferences.[3] The question of how to ensure that medical academia attracts and retains the brightest and best of all graduates has been the focus of two other studies.[4,5]

Data are scarce on the career progress of those who do begin the process of academic career development, which is often through a Training Fellowship from the Medical Research Council, Wellcome Trust, Cancer Research UK or the British Heart Foundation. These organizations have in general not retained such information or find it difficult to retrieve and access. More recently, alternative career pathways have been developed by the National Institute for Health Research (NIHR) for academic trainees, starting as Academic Clinical Fellows and Clinical Lecturers (and there are related schemes in Scotland, Ireland and Wales), and it is to be hoped and expected that the career pathways of these new recruits will be followed.

The Wellcome Trust does have information on the gender of their applicants and on those who have

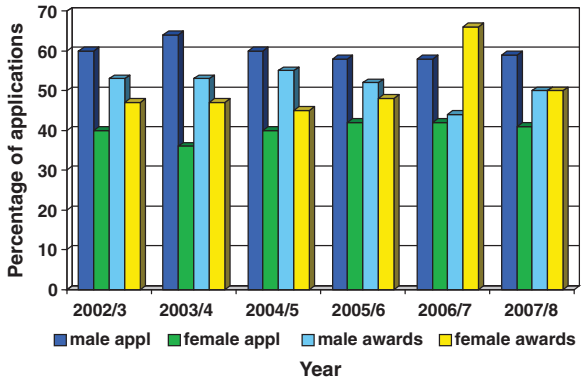

Figure 1. Wellcome Trust Clinical Research Training Fellowships.

received Clinical Training Fellowships over the past 5 years (personal communication to Dr McEwan from Dr John Williams). These data show that only a third of Training Fellowship applicants are women, despite women making up 50–60% of medical graduates. However, their success rate is higher than that of male applicants, as women make up almost half of those who receive an award, as shown in Figure 1. This shows that a smaller proportion of women in medicine are applying for Wellcome Training Fellowships, with the implication that they are not attracted to research and an academic career. However, there may be other explanations such as lack of role models or poor academic mentorship to encourage applications. They may simply not know how to go about the process of getting started. The initial lower number of applications from women doctors raises the possibility that some able women may never enter academia, and their economic and scientific potential is lost. Nevertheless, those who do apply and start such an endeavour are of high quality.

It is recognized that only a small proportion of all PhD graduates remain in academic career track. There are no cohort studies of the careers of those trainee doctors who have received governmental or charitable Fellowships, but data from the Medical Schools Council in 2007 indicate that only 36% of clinical lecturers (the next step in the academic career pathway) are women. Since the proportion of women in clinical lecturer posts is lower than the proportion in the Wellcome Training Fellowship programme, the suspicion must be that an even larger proportion of women than men do not remain in academic career tracks, perhaps 'dropping out' immediately after MD/PhD studies. What determines this lack of continuation in academic medicine is of concern for the profession, because it may effectively deplete the pool of people with the ability needed to ensure the innovation that generates UK income from medical research.

Data from the Medical Schools Council and Council of Heads of Dental Schools indicate that women are underrepresented in the clinical academic workforce at all levels, and career progression is clearly limited, as indicated by the fact that in 2008 only 13% of clinical professors were women. In 2009, the highest levels of leadership in academic medicine are markedly deficient of women with only 1 of 32 members of the Medical Schools Council (Heads of Medical Schools) being females.

The proportion of women members of APGBI probably reflects their representation in senior levels of medical academia (though the Association has not held data on gender and it is difficult to derive as membership details include only initials of forenames). The Association's desire to promote clinical academic excellence requires that the brightest and best of all doctors are recruited and retained in academic medicine. In order to raise awareness of these issues, a workshop was held at the Association's Annual Meeting in 2009, during which a series of questions relating to career development were addressed. The workshop was advertised to all members and took place in the morning before the main meeting began in the afternoon. Those attending this workshop (Appendix 1) were mainly, though not exclusively, women and because female membership is probably only ~10–15% of total, there was a significant proportion of the women members attending the Annual Meeting. The Association's membership is all from a senior level in clinical academia (senior lecturer and above), so these discussions reflect the views of those who have effectively 'made it'.

The format of the workshop was an introduction and review of the reports, *Women in Academic Medicine*[4] and *Women in Clinical Academia*.[5] There followed open discussion, then smaller parallel group sessions in which specific questions were addressed. Personal positive and negative experiences of women and their male colleagues in respect of their undoubtedly successful careers in academic medicine (marked by their membership of the Association) were used to define further areas that require to be addressed in order to ensure that academic medicine in the future includes an appropriate representation of able women. In recognition of the crucial role of the leaders in academic medicine (including members of the APGBI) in the implementation of the recommendations of the recent reports, the aim was to both draw attention to them and formulate further specific advice.

Questions addressed by the participants

What made a positive difference in career advancement for you individually?

As indicated previously in the published reports, there was universal agreement that a good role model and a supportive mentor/departmental lead were crucial for career progression. For those participating, this was usually a man as there have always been so few women in leadership roles in clinical academia. However, it was also reported that the total academic environment was crucial. Several people cited their time at the Hammersmith/Royal Postgraduate Medical School in the 1980s as a key to their success. An institution dedicated to academic endeavours, a community of clinically driven research-orientated individuals, to support and encourage, was recognized as important. The leaders of academic institutions must see themselves as responsible and key in the creation of that environment.

What has been the hardest and most frustrating aspect of your career development?

There were many frustrations and hurdles that had to be considered. Some are unchangeable or a reflection of cultural norms, rather than medical academia. Many will persist as long as women continue to have the greatest role in child rearing and domestic duties. Others reflected the difficulties women have in promoting themselves in the informal ('old boys') networks.

Flexibilty is recognized as intrinsic to an academic career, but that flexibility is often not focused on the need to combine roles as a carer of children and parents along with work. Two levels of flexibility had to be combined: flexibility in the type of work (clinical, teaching and research activities, including writing and planning) and, for women, flexibility between work and home and caring responsibilities (e.g. childbearing and rearing).

Geographical limitations were felt to be much greater for women than men. The difficulty of moving to what might have been the best job, when a partner is unwilling/already established, is very difficult and can be frustrating. Men with wives who do not work outside the home or have more moveable skills/jobs were seen as having career advantages over the woman with a partner.

Childcare was seen as crucially important, and had to be recognized as such by both individuals and institutions. Both are areas where the experience and advice from those who had managed it before was very useful, but childcare is often superseded later by elder care. Quality childcare should be considered an important investment for individuals personally and for their employers.

The burden of clinical service load was considered to be becoming more difficult in some Trusts than the responsibilities of childcare, e.g. because of a lack of support for locums during a National Health Service (NHS) colleague's leave.

Managing a good work–life balance was particularly hard. The demands of clinical service and academic pressures to succeed in publications and grants caused guilt about lack of traditional family time and fear of burn-out and exhaustion.

Several women commented upon the lack of openness in the senior appointments process and that poor practice continues, e.g. networks of senior men succession plan, stylized male rather than female (cooperation) attributes are used in planning and rewards at senior levels. This contributed to fear to acknowledge and be identified as a woman. This role play is manifest in behaviour, even in one's success, as a pseudo/honorary man, rather than be considered a feminist or even just a woman with several valuable facets to life. There was even experience of a promotions workshop, which suggested adopting attributes more commonly manifest in men in order to succeed.

How could the APGBI (and members' organizations) promote the attractions of an academic career in ways that will attract young women?

The following points summarize actions that the workshop participants felt would be required by the leaders of academic medicine to ensure that they recruit the best available of all medical graduates.

The recognition of the issue is the first requirement for progress. In effect, champions of women in academia are still required.

- The members of the Association should recognize their conscious and unconscious biases as well as their leadership responsibilities in this area.
- There is a need for publicizing female role models (full- and part-time) at all levels of academic careers and across all specialities.
- Association members should identify and promote the recognition of successful women who might have unconventional career paths, including those who have deferred and had a slower academic career because of breaks for childbearing and part-time working. Quality childcare should be considered an important

investment for individuals personally and their employers.
- Members of the Association, particularly women, should be encouraged to invest time in career advice and teaching of medical students, extolling the attractions of academic careers for women as well as men.
- The members of the Association with Postgraduate Deanery roles should lobby for new ways in which the clinical training can be combined with academic training and work, and mitigate against stigmatization of a longer training time that may come with part-time work.

How might the Association membership support those in the early and middle stages of an academic career?

Mentorship

There was acknowledgement of a general profession-wide sense of undervalue, reduction in professional status, lack of autonomy and role as employees in the system. This is worsened by shift working that reduced camaraderie. However, academic medicine could be promoted as retaining many of these to its advantage. Mentorship of women and men has been promoted in all the reports of the past few years in respect of medical careers in general, and academic medicine in particular, and schemes must be developed and participation encouraged.

- Training Fellows must be made aware of their value to their institutions and departments and be made to feel honoured by the award and cherished by their mentors. It was reported at the workshop that supportive networks of peers and seniors can help retain such Fellows, and hosting simple 'get togethers' can expand the circle of role models and encourage the engagement of all. Women are likely to benefit substantially from this because of their lack of role models.
- Mentorship can take several forms and one can have several different mentors. Mentorship should be recognized within job plans.
- Women trainees should be encouraged to seek mentors who can empathize with their difficulties, in addition to males with relevant scientific experiences.
- Women members of the Association should recognize their responsibilities as mentors.

Appraisal

No one wants to see any reduction in the qualities and standards of those in academic careers, so appraisal must be used effectively, to ensure that promotion criteria and processes are known and that appropriate goals are set.

Those involved with appraisal of women in academic appointments must recognize the period of slower publications and grant acquisition that is associated with childbearing, as acceptable and not detrimental to a long-term career. Examples in the USA were cited, where there is a longer period before appointment review for women who have taken maternity leave or had periods of flexible/part-time working. However, women must recognize and accept that career breaks may slow their career progress, though should not halt it completely. Guidance, supportive departments and good senior leadership can often mitigate against the loss of research momentum that might otherwise seem inevitable.

Where role models for women are still few, direct teaching and discussion about the criteria upon which a successful senior academic career are judged should be encouraged and made transparent. Academic medicine is seen as a personal career choice that requires hard work and competition, and that needs to be acknowledged, but the rewards of the intellectual stimulation and relative autonomy should be emphasized. Personal development can include coaching in skills, such as assertiveness and negotiation, which might seem innate to men, but are often alien even to the brightest of women.

- Networks and mentorship and support should continue beyond the training years and into the time of becoming a Principal Investigator, right through to senior appointments to Head of Department and Dean.

Defending academia

Members of the association with both clinical and academic leadership roles should include in their responsibilities, the protection of their consultant-level academics from the demands of the NHS. The issue of clinical load can be particularly burdensome to those academics working less than full-time.

- Job planning should vigorously defend academic time and ensure that this is valued equally and that personal development, and supporting clinical activities such as governance and audit, and annual leave allowances do not encroach into that time.

How might the membership ensure the personal development of those women continuing to more senior levels of an academic career?

Acknowledgement of career ambitions of women is the key to progress. Personal development, for

example, executive and management coaching can make up for the lack of role models and should be encouraged to prepare women for the higher leadership roles.

- The Association members should support best practice in recruitment in their institutions, with open and wide advertising of vacant senior posts, even to the very highest level. Headhunting through closed networks will prevent full access to the best potential recruits in the workforce.

Other general points participants in the workshop felt should be debated by the membership and considered by the Committee of the APGBI

(i) There is a need to gather data on gender of members of the Association.
(ii) The Association should gather data on, and also publicize the achievements of, women as presenters and members. Methods to do this can be quite simple, e.g. use of full names rather than initials on abstracts.
(iii) The Association should consider opening up membership of the Committee and the appointment of Office Bearers through invitation or self-nomination to apply for vacancies.
(iv) The Association should actively state that it wishes to encourage nominations of women as potential members [note only 4 (15%) of 27 nominations in 2009 were women] and use its membership in supporting senior gender-friendly mentoring networks.
(v) The Association should request and support enquiry and research into the careers of academic Training Fellows. Understanding the time-point of drop-out and considering why men and women leave a potentially rewarding career might help design new ways of improving retention of bright Fellows.

In the future, women will form the majority of the medical workforce in the UK. Those entering academic medicine lead the changes innate to our profession and embrace the wider leadership responsibilities. It is essential that our standards remain high but also that we draw from the widest possible pool of the best candidates, including women, who nevertheless may require encouragement and support to develop their potential. I commend the discussions of the Workshop to the Membership. Embracing the future will ensure the continuance of the Association and its prestige. Readers may also be interested in a recent publication from genSET which reports on a series of Consensus Seminars funded under the Science in Society Programme of the European Union 7th Framework. The aims of this programme include promotion of greater equality of opportunity and treatment in recruitment and advancement of women and men scientists, and in assessment of their performance and work. The report can be found at www.genderinscience.org.

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Conflict of interest: None declared.

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Appendix 1

Present

Jean McEwan (Chair); Alison Condliffe; Anne Dornhurst; Karen Fitzmaurice (introduced, speaker at APAM); Marta Korbonits; William Powderly; Liz Trimble; Anita Holdcroft (introduced, speaker at this session); Irene Leigh; Caroline Savage; Maggie Bassenden; Richard Horton (introduced, speaker at APAM); and Jane Franklyn.