



AN EVOLUTION OF EMPOWERMENT

A Women in Medicine Summit Compendium

Edited by Shikha Jain & David Kim



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WOMEN IN MEDICINE

AN EVOLUTION OF EMPOWERMENT

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AN EVOLUTION OF EMPOWERMENT

A Women in Medicine Summit Compendium

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MISSION STATEMENT OF THE WOMEN IN MEDICINE SUMMIT

Barriers have existed for women in medicine since the first woman entered the healthcare workforce.

The focus of this summit is to identify barriers women in medicine face and create action plans that can be executed at both the local and national level. During the two-day summit, faculty facilitate breakout sessions and presentations given by diverse speakers from various specialties and institutions. Each session delivers evidence-based talks and present tools and solutions to be utilized in working towards fixing the system and closing the gender gap across all specialties and aspects of healthcare. We must empower women in medicine with the tools they need to change the system at their home institutions and in their specialty specific organizations.

This summit is planned and executed by a steering committee comprised of women from each of the major academic institutions in Chicago, and leaders from national organizations from across the country. WIMS is endorsed by local and national organizations.

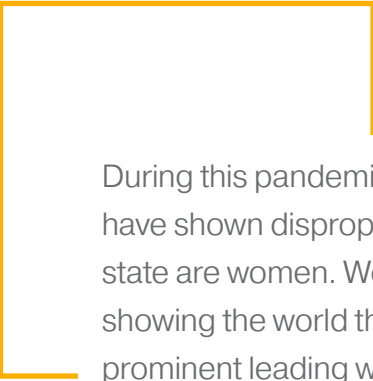
The Summit is a unification of women in healthcare, with the common goal of finding and implementing solutions to gender inequity.

PREFACE

It is a strange time to be in medicine, and an even stranger time to be a woman in medicine. Our nation has been thrown into a pandemic for which we were unprepared where the majority of frontline (Rho, et al, 2020) essential workers are women. Unfortunately, during times of strife, it is easy to fall back into old habits (Agarwal, 2020) and the coronavirus pandemic has exacerbated inequalities (Villarreal, 2020) for women at many levels. The impact of this public health crisis on women has the potential to reverse years of progress towards gender equity.

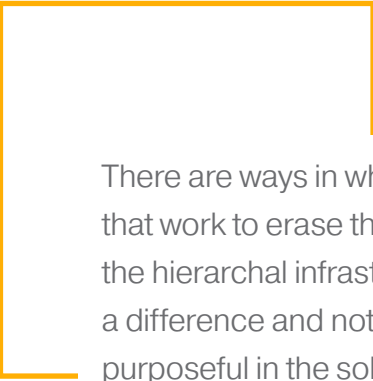
Gender imbalances (Jain, 2019) in healthcare have been well documented and researched for decades and include disparities in award (Silver, et al, 2018) nominations, pay (Paturel, 2019), promotions (Nonnemaker, 2000), publications (Silver, 2018) and the size and number of grants (Oliveira, et al, 2019) awarded to women. The Association of American Medical Colleges (2013-2014) reported that only 21% of full professors, 16% of deans and 15% of department chairs were women in 2014. At that time, women made up 46% of medical school applicants, and 38% of full time academic medicine faculty. These types of inequities have only widened in the wake of the current global pandemic, and the effects of this crisis on women are likely to persist even after it has passed.

Women take on the bulk of unpaid family care at home and with the added challenge of social distancing and the loss of childcare, this burden has only become more exacerbated. In the United States, the majority of unemployment applicants during the COVID-19 pandemic in many states were women (Scharff and Ryley, 2020), coinciding with school closures and stay at home orders. As we eventually emerge from this pandemic, there is concern that with a depleted job market, men in more lucrative industries will compete for roles typically filled by women. Women may also need to wait to start the job search until childcare and care for sick family members has been arranged. Women represent 70% of the global workforce, however as health care resources are depleted, essential services such as maternal care and reproductive health services (United Nations, 2020) may not be available leading to more health problems. Yet despite these barriers, through crisis and challenges, women across the globe have continued to demonstrate resilience, grit and incredible strength and there is hope and a path forward.



During this pandemic, cities, states and countries with women leaders (Anderson, 2020) have shown disproportionate levels of success, despite the fact that only 7% of heads of state are women. Women across the globe are exemplifying authentic leadership and are showing the world that not only do women lead, but women lead exceptionally well. These prominent leading women are a step toward dismantling the implicit biases that have been forged for decades where the default (Biddle, 2018) leader is seen as a man. The path forward towards an equitable system requires identification of these inequities and an intentional plan to address the disparities that permeate our health care system. In order to change the narrative that only men are successful leaders, it is important to celebrate the amazing women leaders (White, 2020) who have emerged in this pandemic and amplify their accomplishments to begin to change the narrative.

The **Women in Medicine Summit**¹ (WIMS) was created to empower women by providing education, opportunities for networking, mentorship and sponsorship, and inspiring women to take control of their futures by learning skills to help them achieve success. The Summit has evolved to now include an annual conference, monthly webinars, take home skills and tool kits, an international social media platform, and tangible results that have helped women from across the country achieve leadership success with personal and professional development. By developing content and specific programming for medical students, trainees and early career physicians, as well as for those already in senior leadership positions, the Summit aims to empower women at all parts of their training and careers. By inspiring, educating and motivating women at different points in their careers, the WIMS is creating networks of women from across the country who are not only equipped to fix the system, but empower and educate others to do the same. By creating specific programming meant for allies, the HeForShe track educates and empowers male allies to work together with their colleagues to fix the system, not the women. The Summit provides toolkits and action plans for attendees to take back to their organizations and institutions with the purpose of making meaningful change. Members of the steering committee, faculty and attendees have published extensively on the topic of gender equity in healthcare. Through continued academic pursuits, with the purpose of further understanding, they work to correct these inequities in medicine. In this compendium are pieces written by invited faculty speakers from the 2019 and 2020 WIMS. These thought leaders share their expertise on the evolution of empowerment that has occurred in medicine, and ways to achieve equity in healthcare utilizing evidence, science, and authentic leadership.



There are ways in which we can emerge from this pandemic with new structures in place that work to erase the systemic sexism and structural inequities that have been built into the hierarchal infrastructure of medicine and healthcare. However, in order to truly make a difference and not lose ground in the equity space, it is essential leaders at all levels are purposeful in the solutions put into place to ensure an equitable and equal environment for all. The evolution of the empowerment of women does not stop with women, it requires male allies, and a thoughtful, well executed path forward to ensure we do not lose ground in addressing the gross inequalities that currently plague our healthcare system. There is hope for an equitable path forward, but we must all do our part to ensure its success.

We invite you to join us virtually at the 2020 Women in Medicine Summit, October 9-10. Be a part of the change that is needed for the future of healthcare by equipping yourself with the leadership skills and tools necessary to make a difference. Connect with leaders from across the globe, sign up for personal mentorship sessions and learn skills to enrich both personal and professional development and work towards closing the gender gap that continues to plague our healthcare system.



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¹ <http://womeninmedicinesummit.org/>

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PERFECT PRESCRIPTION FOR INEQUITY: THE INTERSECTION OF COVID-19 AND THE U.S. HEALTH CARE SYSTEM

By Darilyn V. Moyer

The COVID-19 pandemic is a perfect prescription for exacerbation of current, and creation of new, inequities in our health care system. When we get to the other side, the pandemic will leave unprecedented devastation in its wake, including a disproportionate toll on the aged, those with preexisting conditions, minorities, the poor, the incarcerated, essential workers, healthcare workers, and Native American populations (Woolhandler & Himmelstein, 2020; Bibbins-Domingo, 2020). The existing inequities in the U.S. health care system, including barriers to and social determinants of care, were addressed in the 2020 American College of Physicians' "Better Is Possible" policy papers (Doherty et al., 2020). In the face of the COVID-19 pandemic, this prescient call to action and offer of systemic solutions is more relevant than ever.

Inadequate personal protective equipment and infection control procedures will have a disproportionate impact on health care practitioners, including those with underlying preexisting conditions, which will increase risk of poor outcomes, including hospitalization and death (Ranney, et al., 2020). Concerns about data inadequacies that will underestimate the impact of the pandemic on traditionally marginalized populations must be addressed (Osuji, 2020). This is a moment we cannot ignore.

Additional inequities that have been created or exacerbated in the face of COVID-19 are daunting and innumerable. Front and center is the increased clinical and economic risk of frontline and essential workers in health care and other industries. Many of these low-wage earning individuals are fearful of taking unpaid leave and job loss when they or others they care for are ill. Lack of provision of safe working environments in health care has resulted in several thousand Occupational Safety and Health Administration complaints (Vaidya, 2020). Reports of sanctioning of health care and other workers who are speaking out by their employers is alarming (Stone, 2020). Structural inequities in health care environments which perpetuate lack of diversity, equity, and inclusion, are magnified (Singiser, 2020).

So, how do we gain ground on the inadequate health care system structures that have teed up the astounding and unacceptable outcomes we have seen during this pandemic? In January 2020, the American College of Physicians (ACP) put forth a series of policies, creating a vision for systematic reform of the U.S. health care system. The plan ensures access to health care for all by addressing the inadequacies that created a system that leaves many behind by undervaluing public health and primary care, fostering barriers and discriminating against vulnerable populations, spending too much on administration, and creating perverse incentives. It includes policies that put forth solutions to ensure access to equitable care for all, achieved by overlaying the current employer-based insurance system with a public option, or through a single-payer system, addressing inadequately funded and structured public health systems, addressing social indicators of health, improving health for all, with lower costs and better outcomes (Doherty, 2020).

Our health care system is in critical condition and in need of a rapid, and comprehensive response. Now is not the time for bitter partisanship, but is the time for the communities in health care to work together to address the variety of existing, amplified, and new inequities, created in the face of COVID-19.

While we were woefully unprepared to address the acute consequences of the impact of the first wave of COVID-19, we must be better prepared to address the next waves, as well as the predictable exacerbations of chronic diseases, and the mental health and sociobehavioral consequences that will disproportionately impact traditionally marginalized communities.

We must also use this opportunity to restructure our health care leadership to create a more just, equitable, diverse, and inclusive environment for the benefit all in health care — and especially for our patients.

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ADAPT LEADERSHIP PROGRAM FORMAT, CONTENT TO ADDRESS NEEDS DURING COVID-19 PANDEMIC

By Nancy D. Spector

What happens when an unprecedented global crisis impacts not only the delivery of a program such as Executive Leadership in Academic Medicine® (ELAM®), but also potentially exacerbates the already vast gender disparities in medicine?

ELAM® is a program designed to prepare women in academic medicine, dentistry, public health, and pharmacy for the highest levels of leadership positions. Over the past 25 years, the program has trained more than 1,000 women to lead their institutions through times of growth, financial downturns, and significant institutional changes.

The COVID-19 crisis required quick and decisive internal leadership so that we could ensure the delivery of a robust and transformational ELAM experience — even if the ELAM fellowship couldn't meet in person. Recognizing that many of our current class of fellows were deeply involved with managing the crisis at their home institutions, ELAM leadership saw that there was a need to design a flexible, asynchronous and synchronous version of what would have been a six-day, in-person final session of this year's fellowship.

We tapped into our faculty and extensive network of alumnae to help us think through and redesign parts of the curriculum so that we could provide up-to-the-minute guidance on leading and managing through crisis and address new issues that arose along the way. This included, among other things, adding a section to our negotiation module on how to successfully negotiate through virtual platforms.

Guidance on COVID-19 fallout on research, including issues such as cybersecurity, distance research, and impact on international collaborations,

was added to our managing resources module. And the ELAM team worked with the Director of Coaching to initiate virtual Rapid Response Group Coaching sessions, which were broken out by disciplinary focus, to help our community continue to build its leadership skills during the crisis. The topics of these virtual coaching sessions included Real-Time Leadership in a Live Crisis, Intermediate Leadership Opportunities and Challenges, and Long-term Leadership Dynamics — Evolving the New Normal.

One of the many troubling things that ELAM leadership noticed during this time of crisis was that women were reluctant to leave their institutions for high-level leadership positions and were not joining searches. At the same time, men who were overseeing the searches were requiring that the searches continue. This reluctance could lead to an increased risk that the leadership disparity gap would continue to grow.

To address this, and continue to focus on advancing diversity and ensure parity and equity in leadership searches, ELAM designed a new, interactive webinar for the current class of fellows and alumnae. The webinar was meant to help them consider and find leadership roles in the midst of the current crisis and beyond.

In addition, ELAM has continued to produce scholarly work on gender equity issues so that the imperatives around promoting and sustaining equity don't get lost in the greater crisis.

As we move through the next months of the pandemic, ELAM will continue to stretch, innovate, and learn so that the program can always provide the highest quality leadership learning experience no matter the delivery platform.



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9 THINGS EVERY HEALTH CARE LEADER SHOULD KNOW ABOUT COMPENSATION

By Julie K. Silver

Discussions about compensation, particularly when they are focused on disparities for women and other people who identify with one or more underrepresented groups, often elicit strong emotions from those involved.

For example, current leaders may feel defensive about their decisions and actions involving paying people who work for them, and workers may feel angry or upset if they know or perceive that they are not being paid fairly. Health care leaders should recognize that emotionally charged discussions may cause reasonable people to minimize or even abandon the facts in favor of whatever position they are advocating for.

The truth always matters. And though there is room for some interpretation, emerging and current leaders will be better able to participate in or direct discussions on compensation if they are armed with the facts and develop an evidence-based, data-driven, and rational approach.

To support productive conversations that advance pay equity for women in medicine, I have developed the following list of nine things every health care leader should know about compensation:

- 1. Studies show that, after accounting for co-variables such as part-time work, productivity, and a host of other factors, there is a documented problem of gender-related pay gap disparities for women physicians.** This science sits squarely in a much larger body of literature that overwhelmingly shows pay disparities for women in almost every job and career category in the United States and beyond. While research may show gender disparities, reports cannot be used as evidence of unfair pay at any given institution that has not been specifically studied.
- 2. Women who also identify with one or more other underrepresented groups may be at particularly high risk for inequitable compensation.** Numerous studies and surveys demonstrate that women of color, including women physicians, are paid at lower rates than peers (Marcelin, 2019). Though compensation data on women in medicine who identify with other minority groups such as gender minorities or individuals with disabilities are sparse, leaders should be keenly aware that intersectional identities tend to compound bias and discrimination.
- 3. Published calls to action state that paying women physicians fairly should be a top priority for every dean, chair, health care executive, and business administrator.** For example, the Association of American Medical Colleges (AAMC) published a report on compensation which states, “Empower your chairs to take ownership of the process as part of regular chair responsibilities” (AAMC, 2019). The AAMC also released a gender equity position statement (AAMC, 2020) as a call to action that included a major focus on fair compensation. Many other professional societies and other organizations are making fair pay a top priority as well. Examples include a position paper from the American College of Physicians (Butkus, 2018), a health policy statement from the American College of Cardiology (Douglas, 2019), and a report from the American Surgical Association (West, 2018).
- 4. Expecting new hires to negotiate fair pay, particularly early in their careers, is not considered best practice.** One study noted that even with training in negotiations, “new junior faculty are hardly in a position to ensure their own salary equity” (Jagsi, 2013). Furthermore, the authors stated, “Those doing the hiring and setting the salaries need to be sensitized both to the corrosive impact of salary inequity on faculty morale and to the importance of working to avoid even small inequities early in women’s careers, particularly given evidence that such inequities grow over time.”
- 5. Paying women less than men for the same work is increasingly becoming illegal as states enact fair pay laws.** These laws exist in part because expecting women and other people from underrepresented groups to negotiate their way to fair pay has not been a successful strategy. For example, in 2018 the Massachusetts Equal Pay Act went into effect—prohibiting wage discrimination based on gender. This new law makes it illegal for an employer to pay a woman less than they pay a man who does comparable work (Mass.gov, 2020).
- 6. Paying women less than men for the same work is unethical** (Silver, 2018). The large body of literature documenting pay disparities for women is antithetical to the values, morals, and ethics of medical professionals.
- 7. Paying women physicians unfairly begins with their first position after training, and plagues them throughout their career** (Lo Sasso, 2020; Mensah, 2020). For an individual woman physician, this may result in millions of dollars in lost income, retirement, and investments (Silver, 2020).

- 8. Women may be at a disadvantage for fair pay due to a host of nuanced issues that are documented in the literature (but are often left out of discussions).** For example, gender bias may inform relative value units (RVUs) (Benoit, 2017). Many studies show that gender bias (subjectively rating women's performance lower than male counterparts) creeps into evaluations completed by patients, peers, and supervisors, and lower evaluation scores begin in training for women physicians. (Klein, 2019) At top leadership positions, women may be absent altogether or be present in less authoritative roles than male colleagues (Schor, 2018).
- 9. People who dismiss or minimize pay disparities may not be knowledgeable about the evidence-base on physician compensation.** For example, my colleagues and I analyzed physician compensation studies published over a recent 6-year period (2013-2019), and we found that these studies were disproportionately produced, cited, and disseminated by women (Larson, 2020). Interestingly, we also

discovered that most of these studies were not funded—suggesting that many women are doing compensation research on their own time and at their own expense.

There is an urgent need to address gender-related pay disparities for women in medicine. Progress may be hindered or even derailed altogether if participants in the process (or other stakeholders) are not knowledgeable about the compensation-related evidence-base and relevant facts. The nine tips I highlight here are not intended to be all-inclusive; rather they are aimed at helping to prepare leaders prepare for challenging conversations about pay equity.

Importantly, during this time when misinformation and disinformation is common, good health care leaders can distinguish themselves by educating others about what is known to be true. Great leaders, regardless of their gender, will be ethical and use science and facts to drive change—even when they encounter resistance—to ensure that women are paid fairly.

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Follow Dr. Silver

BUILD LEADERSHIP CAPACITY FROM WITHIN

By Linda Ginzel

Given that I've worked as a business school professor teaching executives for the last 30 years, one might suppose I could make a list of qualities all leaders should demonstrate.

Instead, when asked to speak to a group of women in medicine about becoming leaders in their profession, my response is, "The first thing to do is dismiss all the myths about leadership in the medical community. Throw away the impression that a leader looks a certain way, is a certain gender, has a certain degree, is a certain age, or behaves in a certain manner. When you think a leader has to fit certain parameters, you limit your ability to lead."

In my workbook, *Choosing Leadership*, I recommend we discard the word "leader" all together. Instead, we should focus on the verb "lead." I prefer to see leading as action and leadership as something demonstrated by individuals engaged in finding ways to champion a better tomorrow.

To increase your capacity to do this, I recommend exploring a few simple activities designed to help you understand your own strengths, tap into your personal courage, develop leadership capital, and become wiser, younger. You are never going to be younger than you are today, but you can be wiser tomorrow. It doesn't happen by chance, though. You have to work on it.

Start with writing down your earliest leadership story. Go beyond experiences such as becoming class president. Thinking about when you have engaged in leadership behavior, small and large—those are the ways you have taken steps into the unknowable future. Next, write down your most recent leadership story. Can you find a common thread? When you do, you are articulating your personal take on leadership.

From there, write out what is called your zero draft leadership definition. I say zero draft because this is simply an invitation to brainstorm in writing. Throw out default definitions and preconceived notions. Your definition of leadership reflects you, and your zero draft is a place to start. It is not fully-formed. In fact, it will evolve as you continue to understand yourself and the ways and times you have had the courage to lead.

Compare this to the times when you see yourself firmly grounded in the present, not envisioning the future. I think of this like being on a journey and needing both a map and a compass. A map is useful when the terrain has been charted. A compass gives you a sense of direction. This is the difference between managing and leading. We all do both in our lives.

As you explore these activities through writing down your thoughts and reflections in a journal or in the *Choosing Leadership* workbook, you'll begin to grow your own point of view about leadership. This is important. Your perspective will evolve with experience and understanding of your own identity. You determine what matters most to you. As my friend, Dr. Joon K. Shim, Assistant Professor of Surgery at Wright State University's Boonshoft School of Medicine said so eloquently, "Writing is thinking made visible." If you don't write down your ideas, they don't exist. Once an idea exists, it becomes data that you can use to find the pearls of wisdom in your own experience.

Leadership development is all about personal responsibility. As a social psychologist, I believe building leadership skills is essentially a process of self-discovery. I want to help each individual uncover, articulate, and understand his or her own definitions of leading, managing, and even following. Through this process, you gain leadership capital and the capacity to choose to lead, manage, or follow, depending on the situation and your role in it.

As you develop leadership capital, you become stronger inside. It's like a skyscraper. Architects and engineers had to understand that if they built from a solid internal core, then their buildings could soar toward the sky.

The same is true for you. Your structural integrity determines how high you can go. For people practicing medicine, there's so much pressure, and there are so many demands. How do you build resilience? Build from within. I suggest that if you are strong inside, you can face what comes from outside.



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Follow Dr. Ginzel

FIND YOUR LEADERSHIP STYLE, COMMUNICATE IT WELL

By Karen J. Nichols

“I’m the doctor, of course I’m the leader!”

Who hasn’t heard that comment — or even thought it personally? The truth is we all have a leadership style even if we’ve never thought about it. There are several testing instruments for you to use to identify your own style and what it means. You may be a leader with a natural style that leans toward being democratic, autocratic, laissez-faire, strategic, transformational, transactional, coaching, or bureaucratic. And seldom is one person functioning in just one style.

“And why is my leadership style so important?” That’s a good question. Because while you have a natural style, different situations call for different styles. Not knowing that there are different styles and not employing the most effective style for the specific situation hampers the opportunity to achieve the desired result.

For example, in a crisis situation, a leader may choose to employ an autocratic approach when the same leader would usually prefer a more democratic style for routine matters. It’s also important to recognize that other people likely have different styles that also contribute to or hinder progress in the situation. (Don’t assume that they’re just being difficult.)

So, what does communicating well have to do with leadership when you communicate with your patients all the time? William H. Whyte said it best: “The single biggest problem in communication is the illusion that it has occurred.”

The first steps in communicating well are to ask questions and clarify definitions. We do this all the time as physicians. Unfortunately, we often forget to do so when in a leadership role.

For example, I was meeting with leaders in the nursing profession, and they made the comment that as nurses, they were independent. The physicians in the room, including me, challenged that statement. After some rather heated comments, the facilitator of the meeting asked the nurses for their definition of the word “independent.”

It turns out that they were referring to the fact that they each had an independent license to function as a nurse. That was not the definition of the word “independent” from the physician perspective. Clarifying that definition was critical to making progress in the meeting. Asking questions and thereby clarifying definitions is the basis of good communication for us as physicians and as leaders.

Doctors are naturally cast in leadership roles. We can be more effective by learning about our leadership style and also by employing well-accepted principles of communication.

Leadership Style Resources

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Follow Dr. Nichols

CULTIVATING INTENTIONAL SUCCESS: 5 KEY STEPPINGSTONES

By Stacy Wood

Have you ever hungered for success?

The best type of success, the kind that is based on intention and the process of working toward goals that you define for yourself, is usually enjoyed by women who have embraced certain skills.

Based on my years of coaching and researching successful women from a variety of industries, I recommend focusing on these 5 key steppingstones to support your journey towards success:

1. Develop a Poised Voice

“Poised Voice” is the ability to someone to understand the messages in an effective manner, so that they are heard.

The process begins internally; one must understand what you really want to share with the world. Then the process becomes more external by listening carefully to others and sharing your thoughts in a clear and impactful way.

2. Cultivate Confidence

A lack of confidence can stifle your success. Doubt often begins with a tiny voice in our head saying, “You aren’t enough”.

By simply pausing to ask, “What is the evidence for that?” we can begin to re-position ourselves back on track toward success.

Lack of confidence prevents us from putting our best ideas, thoughts, and solutions out into the world.

3. Face Fears

The most common fears that we harbor are fear of failure, rejection, and embarrassment. These powerful thoughts keep us cautious and hold us back. By learning to lean into the feelings of fear with logic and thoughtful tactics, we push beyond our boundaries.

4. Balance Grit, Grace & Space

Grit is the ability to keep going when things get hard. Grittiness allows you to stay in the game when times get tough.

Grace is the concept of extending a moment of understanding and gentleness towards yourself or others.

It’s vital to strike a balance between grace and grit (both internally and externally).

Space is the literal room to breathe, escape negativity, and rejuvenate. We must be willing to allow ourselves, and those around us, the space to re-set both physically and mentally when times are stressful.

Together, [grit + grace + space] allows us to be tenacious, patient, focused, and refreshed.

5. Establish Caregiver Priorities

The term “caregiver” encompasses a variety of roles including traditional motherhood, caring for a parent or spouse in need, pet parents, foster parents, or many more. And as a caregiver, you will at some point feel the strain of the extra responsibility clashing with your plans for professional growth... this is OK.

Being honest about personal priorities and limitations makes it easier to put plans in place to care for our loved ones and our career in a more harmonious fashion.

If you desire to intentionally plan for future success, begin with the basics. Embrace these 5 steppingstones and use them as tools along your journey!



STACY WOOD



Follow Ms. Wood



Follow The WILDwood Project

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She provides executive coaching, interactive workshops, nature-based retreats, and motivational speaking. Beyond working with private coaching clients, her clientele list boasts national and international firms such as KPMG, Mede Analytics, Keiter, and more.

Stacy brings a wealth of leadership, training, and sales experience into her boutique coaching practice from years as a successful medical sales consultant, time as an adjunct professor with the University of Richmond, and as a former training manager for Novartis Animal Health. Her B.S. in Animal and Equine Sciences from Virginia Polytechnic Institute has led her to develop the “Equine Factor”, a unique equine assisted coaching program.

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HACK YOUR BRAIN TO LET THE LEADER IN YOU EMERGE

By Alison Escalante

Efforts to promote gender equity in medicine focus on training women in leadership and assertiveness skills. Once that inspiring conference ends and women return to the workplace, many of them experience a stress response and feel too uncomfortable to use the techniques they've learned.

One of the problems with the current approach to leadership training is that no one discusses how a person's ability to regulate her autonomic nervous system can play a role in her ability to lead. But, this skill is every bit as important as understanding the basics of being a good leader.

How do we decide who is a leader? Confidence and clarity in thought, and communication are social identifiers that mark a leader. These features make us feel safe — whether a leader is truly competent or not. And more than anything, we accept leaders because of the way they make us feel.

Research studies have provided evidence that both men and women possess an unconscious bias against assertive women (Madsen & Andrade, 2018). That experience of discrimination (Hill, 2017; Oliver, 2017) feels like a threat and activates (Rozenman, 2016) the sympathetic nervous system (an unconscious process (Escalante, 2020) that results in predictable physiologic changes).

Sympathetic activation turns the brain toward a particular type of thinking and impairs higher level cognition. Thinking becomes more rigid, lacking clarity and creativity. The stress response also changes our social signaling. Voices and facial expressions become flatter and eyes stare intensely.

Research studies have also provided evidence that human nervous systems co-regulate (EurekAlert!, 2020) That means stress is contagious; other people feel it and do not feel safe.

The consequence is this: an excellent leader may not appear so to others because the social identifiers of leadership are inhibited by stress. Our brains only have access to that effortless confidence and clarity of thought when the social nervous system is dominant (Porges, 2006). That system is activated by the vagus nerve, which puts us in an open and connected state of regulation very different from the fight or flight response of the sympathetic nerve.

Even under stress, there are ways that we can access that vagal activation. But, we have to recognize what is happening to us. Once we stimulate the social nervous system, our voices become musical, our demeanor engaging, our thinking clear, and our leadership shows.

To activate the social nervous system under pressure, try the following strategies:

Engage with allies whenever possible. Make eye contact and amplify each other's opinions. Friendly eye contact and feeling social connection with an ally both activate the vagus nerve.

Use deep pressure to stimulate the vagus nerve (Reynolds, 2015). For example, squeeze the fleshy part of your hand or tap on your thigh under the table. Or for more sustained regulation, wear a deep pressure therapy vest under your clothing.

Breathe deeply and intentionally to make your voice more musical. Long slow outbreaths are a quick way to activate the vagus nerve. Many methods emphasize counting as you breath, but it is how we breath out that sends a message of safety or danger to the autonomic nervous system. And not having to worry about counting keeps you focused on the meeting.

Participate in activities that decrease sympathetic arousal. For example, yoga, meditation, and interacting with friends all promoted flexibility in the autonomic response. Everything gets easier with practice, and working on autonomic flexibility when not under pressure comes in handy when we are.

Readers may be concerned that this discussion implies that it's women who need to do the changing. Yet these skills will help individual women's leadership shine, even as they continued to advocate for broader equity in the workplace.



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CORONAVIRUS: CALLING ON WOMEN IN MEDICINE TO LEAD IN PLACE

By Neelum T. Aggarwal

At the 2019 Women in Medicine (WIM) Summit held in Chicago, I delivered a breakout session encouraging women physicians to expand their leadership skills by actively participating in professional organizations that may not be traditional to their respective areas of specialty. The goal of my presentation was to argue that networking within your specialty (medicine) with colleagues that are similar to you, your goals, career trajectories, will not be enough as you move through your career.

My presentation noted that an engagement that focused on the importance of intentionally building teams with diverse members, learning how different organizations and their “organizational cultures” approached negotiation skills (work schedules, pay, promotion), and how to deliver clear messaging and direction, would lead to increased resiliency and skill development that one day would be of importance to them in their careers.

No one would have predicted that the COVID-19 pandemic - with its unexpected challenges that highlighted underlying health, social, economic, and structural disparities - would jolt us to wake up and challenge the very nature of how we practiced medicine and conducted our day to day activities (Lewis, 2020).

Furthermore, no one would have predicted that the pandemic was also poised to hasten the widening of the gender gap already prevalent in the U.S. health care system and threaten our employment with potential layoffs or reduced hours (van Biesen, 2020).

Physicians across the country have been thrust into a new reality of continuing to provide non-urgent medical care through video and phone telehealth visits, while also organizing (in parallel fashion) virtual classrooms and homeschooling, managing elder care, and negotiating a new normal of maintaining productivity with no separation of work from home life.

This juggling or multi-tasking of activities, once worn as a proud badge has now become more of a never ending, weary management activity that has left both sexes exhausted, but has disproportionately affected women.

Although the impact of the pandemic has been dominated and acutely felt by women, we continue to make 80 cents on the dollar vs. our male colleagues (McCray & Ebanks, 2020).

This is despite the data that reported (prior to the pandemic) 49% of employed women in the United States, including 42% of working mothers, were the family’s main breadwinner (Barrett, 2020).

In addition, women were also eight times more likely than men to care for sick children or manage their children’s schedules, spend more time caring for sick or elderly family members, and spend time on domestic responsibilities when compared to their male counterparts (Barrett, 2020).

As compared to men, women reported more stress around the COVID-19 pandemic, were more likely to be worried that their income would suffer, and were more concerned that they would have to put themselves at risk due to an inability to afford to stay at home (Gamble, 2020).

Social media posts calling for increased productivity during times of a shutdown and working from home do not take into account these issues, nor the increasingly reported racial and ethnic disparities related to care and responsibilities. However, the decrease in productivity — arguably related to split attention during this pandemic with childcare and domestic responsibilities (Bennet, 2020)— has already been noted by several academic journals.

Editors of journals in several fields have noticed a significant difference in the number of journal submissions from men vs. women, with submissions from men having increased by 50% and those from women staying the same or declining. Data has supported this noting that research productivity from women and mainly women of color has also decreased (compared to men (Patino, N.D.; Viglione, 2020)

This brings me back to the messaging from my WIM breakout session where I challenged my attendees to actively and intentionally become engaged with diverse professional groups to equip them to lead. The messages delivered then - that highlighted the importance of mentorship and sponsorship, the support of women in projects that exemplify collaboration and team science, and advocating for policy that eliminates the tenure clock - are even more relevant now.

Women need to learn how to engage effectively, build networks, to support themselves and their varied gender roles that will be present in both good and relatively calm environments, in addition to chaotic environments akin to the present COVID-19 era.

COVID-19 has challenged us to critically assess its toll on our workforce, continue to champion robust diversity of thought and action, and focus our energies on teamwork for support to ensure that we as women physicians do not lose the gains that we have made in medicine.

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ENGAGE MEN AS ALLIES TO CREATE GENDER EQUITY IN HEALTH CARE

By David G. Smith and W. Brad Johnson

Women are at a disadvantage in the workplace. They deal with unequal pay, sexual harassment, lack of credit for their contributions, and more. And while organizations are looking to address these issues, too many gender-inclusion initiatives focus exclusively on how women should respond, leaving men out of the equation. Such efforts reinforce the perception that these are women's issues and that men — often occupying crucial leadership roles in most organizations — don't need to be involved.

The mentoring landscape is also unequal. Although strong mentoring relationships have the capacity to transform individuals and entire organizations, evidence consistently shows that women face more barriers in securing mentorships than men (Kalbfleisch & Keyton, 1995). And when they do find a mentor, they may reap a narrower range of both career and psychological benefits.

When men lean into the roles of ally and mentor for women, demonstrating awareness, commitment, and gender humility (for example, being willing to admit mistakes and ask for feedback), they stand to help level the playing field for women at work, encouraging female colleagues to achieve their highest potential.

Men have a crucial opportunity to promote gender equality at work. Research shows that when men are deliberately engaged in gender-inclusion programs, 96% of women in those organizations perceive real progress in gender equality, compared with only 30% percent of women in organizations without strong male engagement (Krentz, et al, 2017).

We find several common themes when working with senior male leaders. These themes relate to men with various motivations and understanding of gender inequities. A few men are threatened by gender diversity and see the workplace as a zero-sum game. Some men are just not aware, or perhaps don't believe or take seriously the challenges women face in the workplace. Others believe that gender equality has been achieved and don't understand why this conversation is important. And still others are aware of the challenges and understand the importance. But, they think they are already doing enough or don't see that it is their place to take action or speak up.

Linking gender equity to leadership is vital. To create a culture in which men can be allies, we find it's essential to reframe gender equality as a leadership issue instead of a women's issue.

Forward-leaning and successful organizations cultivate a culture of allyship and equip men to succeed in mentoring women and thrive as public allies for gender equity. Male allies advocate for policies and practices that improve the workplace for everyone — especially those who don't look like them. Allies also step up when it comes to recruiting, hiring, and promotion practices.

Finally, it is imperative that leaders create a work environment that supports allyship itself, a workplace where curiosity, courage, confidence, caring, and commitment are valued traits. In this environment, men can support each other on the path to becoming an ally — acknowledging mistakes, holding each other accountable, and maintaining a learning orientation along the way.



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CREATE THE LIFE IN MEDICINE THAT WORKS FOR YOU

By Nisha Mehta

Nearly 40% of female physicians cut back clinically or leave medicine entirely within their first five years of finishing training (Paturel, 2019). This statistic is staggering and poses real policy issues when considering the worsening physician shortage, particularly now that women comprise a little more than half of currently enrolled medical students.

Contributing factors are complex, but there are several common themes. One of these is the tendency we all have as physicians to follow in the footsteps of our mentors. For many, this results in self-imposed expectations related to what it means to be a physician, which are often at odds with other life goals. The time at which female physicians are forced to choose between these competing priorities is a common exit point.

As the makeup of the physician population changes, we are increasingly realizing that the lives of recent graduates — male or female — demonstrate obvious differences from the lives of those whose portraits lined our medical school hallways. Accordingly, stereotypes about what it takes to be considered successful in medicine must be challenged.

Many physicians are fearful of being perceived as weak or less serious about their careers if they express a desire to deviate from the norm. Women physicians in particular, who battle gender biases throughout their career, feel this disproportionately. While many privately acknowledge obstacles to work-life integration and wish for change, most continue to mold their lives to reflect antiquated stereotypes. Substantial debt burden faced by many recent graduates can further discourage physicians from pursuing alternative options.

Unfortunately, the end result is to threaten a physician's willingness and faith in the ability to fight for a career that emphasizes both career longevity and career satisfaction. Combined with increasing challenges in the health care landscape, this has contributed to widespread acknowledgment of burnout. In conjunction with pressures imposed by societal gender roles, many female physicians eventually conclude that a substantial reduction in clinical responsibilities or an exit from medicine entirely is necessary.

I would argue, however, that empowering and enabling women physicians to shape careers in medicine that reflect their individual goals could prevent many physicians from coming to these conclusions. This starts by not apologizing

for differences, thinking outside of the box, and knowing our worth. Women physicians will eventually comprise half of the physician workforce. Supply and demand economics will lead to a willingness to change the way jobs can be structured. While templates are convenient, they are not usually necessary.

It is imperative for women physicians to share stories and provide each other with mentorship and support. Increasing business, finance, and leadership skills lead to a stronger position at the bargaining table, as well as the ability to walk away from a bad situation and pivot towards a more favorable one. Alternative income streams can ease financial pressures and allow for more creative options.

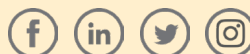
Collectively, women physicians can change the culture of medicine and enhance career longevity amongst physicians. Whether it's increased flexibility, more equitable pay, or more leadership positions that we are pushing for, we need to embolden women in medicine to unapologetically go after their goals. It may be that the only limiting factor in our success will be how much we are willing to ask for.



NISHA MEHTA

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Dr. Mehta is a radiologist, keynote speaker, writer, and physician advocate. Her missions include addressing the physician burnout epidemic through physician empowerment and cultural change in medicine, as well as increasing business and financial literacy amongst physicians in order to promote career longevity and career satisfaction. She is a strong proponent of creating physician communities to achieve these goals, with over 100k members in her online communities, Physician Side Gigs and Physician Community. Her work has been featured in numerous international media outlets, including Forbes, CNN, the Washington Post, Bloomberg, and PBS NewsHour, as well as several prominent physician focused outlets. She was named a 2020 Top Voice in Healthcare by LinkedIn. She lives and works in Charlotte, NC with her husband, who is a plastic surgeon, and her two sons.



Follow Dr. Mehta

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FOLLOW THESE 5 STEPS TO DEVELOP A MENTORING TEAM

By Ruth Gotian

Those who are mentored outperform and out earn those who are not (Eby, et al, 2008). They get promoted more often and report lower burnout rates. However, having just one mentor is limiting. Having a team of mentors puts you in charge of your future.

Women in particular benefit from strategic mentoring teams (Gotian, 2019) that have their best interest at heart (Johnson & Smith, 2016). The challenge is that there are few women in leadership roles. As such, the development of a mentoring team for women needs to be purposeful.

Unlike having a single mentor, an entire team offers diversity of perspectives and skills, and increases your network. The reach and impact of your team is directly proportional to its breadth and depth. This is critical for women, as there is a limited number of female leaders in any particular industry.

By having a broad range of mentors, you could leverage the types of skills you learn and people you meet. Imagine having a mentoring team with a lawyer who can provide negotiation tips, a salesperson who will help you optimize your networking, a public speaker who can help you hone your speaking skills, an editor who could help you with your writing, an educator who can help you improve your teaching skills, and a marketing expert who could help you develop your brand. You are the common denominator among your team. While you can reach out to any and all members on the team, they don't all need to meet together.

Just because someone has an impressive title, doesn't mean they should be a mentor (Gotian, 2016). A five-step process can help you strategically consider who should be on your mentoring team.

Step 1: Name your goal

What is your immediate goal? Is it to get promoted to Associate Professor or Senior Vice President? It's important to identify and name your attainable short-term goal. Labeling what you hope to achieve will help identify a path forward.

Step 2: Devise your plan

Naming your goal is a pivotal first step. In order to prevent your goal from becoming a fantasy, identify what you need to accomplish in order to achieve your goal. Do you need to publish in a major journal or build a new curriculum? Be very explicit about what the next steps are. Once you've pinpointed your next steps, you can start constructing your mentoring team. This intentionally selected group of people will aid you in actualizing your plan, provide insight, and introduce you to the right people. Envision a bullseye, with three circles, one inside the other.

Step 3: Identify your inner circle

Who are the people who know you best, even when you are not at your finest? Consider your partner, family, friends, or even your children. These people will tell you the unfiltered truth, even if it hurts. They know the personal you.

Step 4: Identify your middle circle

The next circle includes your closest work colleagues. They know your work ethic and reputation. They might be at any level of the organization. They know the professional you.

Step 5: Identify your outer circle

The final circle takes the most effort. It includes people in or outside of your field. You may not know them directly, but you know of them. This includes those you've heard speak or whose work, position, or reputation you admire. If appropriate, ask for introductions to your outer circle.

The circles are permeable as the role of a mentor is not a life sentence. Add and subtract names of mentors as circumstances change. Over time, those in the outer circle will transition toward the middle circle, and new names will become part of the outer circle as you advance.

If strategically constructed, your mentoring team will help you ascend and achieve your goal.



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Dr. Ruth Gotian is a leadership and executive coach, keynote speaker, and author. She is the former assistant dean for mentoring and executive director of the Mentoring Academy at Weill Cornell Medicine and the current chief learning officer in its department of anesthesiology where she is also an assistant professor of education. She studies, teaches, and writes about optimizing success, leadership, and networking based on her work and interviews with the most successful people of our generation including Nobel laureates, Olympians, and astronauts. She is a contributor to Forbes, has a doctorate in adult learning and leadership from Columbia University, and has been hailed as a leadership expert by Nature and Columbia University.



Follow Dr. Gotian

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BECOME ACTIVE IN ORGANIZED MEDICINE TO IMPACT CHANGE

By Katherine Tynus

If you're like me, you're probably frustrated by the dysfunction in our health care system.

This pandemic magnifies and brings into focus how leadership has failed to enact health care policy that serves us, our colleagues, and our patients — particularly those who are most vulnerable.

It's disheartening and depressing to think about the massive financial expenditure on U.S. health care and how large the gaps and failures are. It's hard to know what to do with all of that frustration and rage.

We live in a world of spin and clickbait, and it's tempting to think that posting, sharing, or signing an online petition is a means of action. Unfortunately, social media posts don't really accomplish much aside from soothing our bruised souls.

So, what can we do? Well, think about where policy is created and by whom. Most policies that affect your daily practice come from Washington, D.C., and your respective state capitols. Legislation controls your reimbursement, insurance oversight, and access to care.

Short of running for office (which I think women physicians should do, too), the best way you can influence legislation is through grassroots efforts and lobbying. And unless you're willing to quit your practice and start a grassroots movement, the most effective lobbying comes from state and national organized medicine.

You may argue that your employer and/or your specialty society hire lobbyists on your behalf; you would be partially right. Your employer's lobbyist's main concern is providing for their health system, that is, their reimbursement, tax liability, and ability to expand their market. Their concerns may overlap with yours, but not always.

Similarly, your specialty society's concerns are to protect the interests of your specialty, not your colleagues in other specialties or in other health professions. And most specialty societies have a strong national, but not a statewide, presence. Many laws that affect your daily practice are local, not federal.

The only organizations that provide comprehensive policies and lobbying for all specialties at the state and national levels are your state medical societies and the American Medical Association (AMA). You might view your state medical society, as an old boys' club. In many cases it is.

But the truth is that many, if not most, state medical societies are losing membership and therefore are ripe for new members like women physicians. Similarly, you may believe the AMA doesn't represent your views. However, it will never represent your views if you don't make them heard. The AMA functions as a democracy, a real opportunity for direct involvement and advocacy to make your unique positions heard.

These institutions of organized medicine are our best hope to amplify our voices. If we don't like what they're doing, then we need to change them from within.



KATHERINE M. TYNUS

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A Primary care physician with Northwestern Medical Group and an Assistant Professor in the Department of Medicine at the Feinberg School of Medicine. She is a leader in academic and organized medicine.

After graduating from Northwestern University, where she majored in communication studies, Dr. Tynus earned her medical degree at the University of Illinois and completed her internal medicine residency at Loyola University.

She's had a long career in academic medicine, leading a successful transitional year residency program for 14 years and earning Gold and Silver Apple teaching awards at MacNeal Hospital in Berwyn, IL. Dr. Tynus serves on the ACGME Transitional Year Review Committee since 2017 and is former co-chair of the Council of Transitional Year Program directors. She wrote board exam questions as a member of the American Board of Internal Medicine Test Writing Committee from 2010 to 2018.

Active in organized medicine, Dr. Tynus is Past President of both the Illinois State Medical Society and Chicago Medical Society. She is an alternate delegate to the AMA's House of Delegates and is on the AMA's Speaker's Panel for Practice Transformation and the STEPS Forward™ Program. She is a Fellow of the American College of Physicians and has served as chair of the Education Committee for the ACP's Northern Illinois Chapter.

She is married, has two children, five step-children, two dogs, a cockatoo and a guinea pig. She appeared monthly on the Patti Vasquez show on WGN radio 720 AM for Wellness Wednesdays from 2017 to 2019.

ADVANCE THE MISSION OF YOUR WOMEN'S LEADERSHIP COMMITTEE

By Sheila A. Dugan

Women's leadership groups are key to cultivating female leaders in our profession. But, what if your group could also serve a vital role in promoting women's equity efforts and participate as a strategic partner to your institutional leadership?

Read on to learn more about how you can accomplish this at your organization.

Understand the history

Women's leadership groups seek gender equity. Women in academia face inequities in, among others areas, leadership, promotion, and NIH funding by gender (Ash, et al, 2004; Carr, et al, 1993; Kaplan, et al, 1996; Poulhaus, et al, 2011). Strategies to address actual or perceived inequities are created and implemented. Many times these strategies include training or networking events, but impact metrics (such as subsequent changes in job status or grant achievement) are not monitored.

While the group may glean power from a few wins, it's not clear how these changes impact overall gender bias in the institution's culture or result in sustainable change (which might include improved talent acquisition and retention). Many times, the women's group acts in isolation from the greater institution, given employee resource groups (ERGs) are employee-led and offer a welcoming environment — in particular to underrepresented groups (Welbourne, et al, 2015). This may result in ERGs functioning outside of mainstream workflows. Sometimes they can even be seen as confrontational.

Identify opportunities for change

Understanding how your mission ties into the mission of the larger institution is key when it comes to increasing financial support, improving reach of your message, and changing policies. Your women's group can't function in a silo. It must engage senior leaders and infuse institutional strategy with diversity,

equity, and inclusion (DEI) efforts. Isolated initiatives often falter when it would be possible to grow impact and reach by combining with other's work in the DEI space, such as the office of the Chief Diversity Officer (Gillespie, et al, 2018).

Data is also key to your success. There are many resources that provide useful external data, including the American Academy of Medical Colleges (AAMC) salary by gender tool. But, using your internal data is the most effective way to frame the problem and your suggested response. Senior leaders are likely to respond to internal quantitative and qualitative data, as the information helps them see factual evidence that there is a problem.

Making the ethical and business case is tantamount to the integration of the women's group strategic plan into the larger strategic plan of the institution.

Not only does your health care organization want to fit the descriptor of "doing well by doing good," leaders of the organization need to understand DEI advantages including improved finances, increased opportunity for innovation and community engagement, improved recruitment and retention, and enhanced brand and reputation (Gillespie, et al, 2018).

Build an institutional movement

First, take inventory of your group; diverse membership representation is key. Next, articulate your goals and priorities, based on internal data. Communicate the findings, develop shared short- and long-term goals, and hold leaders accountable. Further, include women's leadership goals on the strategic scorecard. This is a powerful message to all stakeholders, including the board. In addition, providing monetary programmatic support, including an office space where your group has visibility for members and all women in the organization, sends an undeniable message about institutional readiness for change.

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Follow Dr. Dugan

CREATE COMMUNITY BY STARTING A WOMEN IN MEDICINE AND SCIENCE GROUP

By Vidhya Prakash and Najwa Pervin

The menu was simple: French toast, quiche, and fresh fruit. The small group of women faculty and residents were at the home of Vidhya Prakash, an Infectious Diseases physician at Southern Illinois University (SIU) School of Medicine and they didn't know what to expect.

In true physician-style fashion, they organized themselves symmetrically around the room (two per couch), an even number on each side of the coffee table, and two seated an equal distance apart by the fireplace. Nervous laughter came from the residents, with expressions of, "What am I doing here?" etched across their faces.

After a somewhat awkward silence, Prakash asked the group, "Who's burned out?" What ensued was a raw and cathartic discussion about work-life integration, living up to society's impossible expectations, and career stagnancy in a safe space. The once symmetric room transformed into a perfectly imperfect cluster of women in medicine huddled together around the coffee table, finding strength through their shared experiences and truths.

From this group, which began gathering in 2015, an executive committee formed with dedicated chairs organizing educational sessions on topics such as gender equity, community activities (to include fundraising for domestic violence organizations), and social events (to include international potlucks).

In 2018, SIU Department of Medicine's Women in Medicine group, co-founded by Vidhya Prakash and Susan Hingle, Internal Medicine faculty at SIU School of Medicine, became the Alliance for Women in Medicine and Science (AWIMS) under the guidance of Wendi El-Amin, Associate Dean for Equity, Diversity and Inclusion at SIU School of Medicine.

The mission of AWIMS includes honest discussion and positive change in the realms of gender equity, career advancement, work-life balance, community service, and professional development of women in medicine and science. There is an advisory board that includes key stakeholders from across SIU School of Medicine and an executive committee that leads the following five initiatives: education, community engagement, research, mentorship and career advancement, and mindfulness and wellness.

Events from each initiative are open to all members of the campus community, as the group aims to create an inclusive environment. The AWIMS list serv contains over three hundred members. The entire community is invited to quarterly educational sessions on topics such as gender equity and sexual harassment. The mentorship program includes mentorship mixers every six months. Wellness initiatives from retreats to wellness forums occur quarterly. Monthly journal and book clubs stimulate powerful discussion and regular community engagement activities help members connect to one another and society. Initially, engaging all members of the SIU community was a challenge. Men did not feel welcome, and many carried the misconception that the group was only open to physicians. Taking the feedback seriously, AWIMS leadership became very intentional in underscoring the importance of inclusion, and the need for diverse viewpoints to fulfill the AWIMS mission.

Personal communication in the form of private conversations and emails with stakeholders to amplify the message of inclusion was the key to success.

From members to leadership, the composition of AWIMS reflects the core tenets of equity, diversity, and inclusion, as people of all genders, scientists, educators and researchers have a seat at the table.



VIDHTA PRAKASH MD

Vidhya Prakash is an Infectious Diseases physician and Professor of Clinical Medicine at Southern Illinois University School of Medicine. She also serves as Vice Chair of Clinical Affairs in the Department of Internal Medicine. Dr. Prakash is founder and director of SIU Medicine's Alliance for Women in Medicine and Science. She is chair of the Health and Health Care Committee on the Illinois Council on Women and Girls.

Dr. Prakash received her BA in English from The Ohio State University in 2000 and her MD from the University of Cincinnati College of Medicine in 2004. She completed her Internal Medicine residency in 2007 and her Infectious Diseases fellowship in 2009 at the San Antonio Uniformed Services Health Education Consortium. She served as an Infectious Diseases physician in the United States Air Force until 2014. She joined Southern Illinois University School of Medicine in 2014.



Follow Dr. Prakash



NAJWA PERVID MD

Najwa Pervin is an Assistant Professor of Clinical medicine and an Infectious Disease physician at Southern Illinois University School of medicine. She received her bachelors in medicine and surgery from Dow Medical College, Pakistan, in 2013. She completed her Internal medicine residency in 2017, and Infectious Disease Fellowship in June 2020, from Southern Illinois University. As a resident she was actively involved in the grass root beginnings of Women in medicine at SIU and continues to play an active role in the SIU Medicine's Alliance for Women in Medicine and Science.



Follow Dr. Pervin

BLACK WOMEN MAKING STRIDES AND STRIVING FOR MORE

By Niva Lubin-Johnson

As the 119th President of the National Medical Association (NMA), I am the thirteenth woman to hold this position in the organization's 124-year history. Also, I've been the third woman to hold this position in four years. NMA was founded because African American physicians were not allowed to join the AMA. We are the collective force for African American physicians for parity, justice and medicine.

We are making strides in other areas, also. The 2018 change in the majority of the U.S. Congress was due to Black women voting at a higher rate of all other groups. We are a larger percentage in the workforce (62.2% of us are employees), and between 2004 and 2014 the number of Black women with a bachelor's degrees increased 23.9%. Also, the numbers of businesses owned by Black women increased by 178% between 2002 and 2012 — the largest increase among all racial and ethnic groups of women.

We also know that there are many areas that need improvement. For example, 16.5% of Black women lack health insurance coverage. Our incidence of AIDS is five times higher than other racial and ethnic groups of women. And we have a 24.6% incidence of poverty, which is higher than all groups of men and women, except Native American women (24.8%).

Recent statistics also show that women and African American physicians have lower incomes than men and whites. As women progress in academia, fewer of us are associate and full professors. African American female medical students are also more likely to be victims of sexual harassment.

I write about our successes and our struggles to remind everyone that despite the urgency and crisis that is going on with Black men (which includes issues such as the lack of Black men in medicine and higher mortality rates for Black men for many diseases) we need to address some challenging and different issues for our women also.

We are dealing with lower pay, slow to no advancement in academia, and sexual harassment. Suicide is higher for physicians and even higher for female physicians. Addressing these issues during and after my presidency helped to achieve progress in the awareness of the problem and solutions. The Pandemic has accentuated some of these issues and the recent episodes of racial strife gives hope that things will change for the better, if not in my lifetime, hopefully for the next generation.

It will take Black men and women physicians to find answers to the crisis of the lack of Black men in medicine. And it will take both groups to eliminate the sexual harassment of medical students.

As NMA President, I spoke, hosted programs, and attended meetings that stressed collaboration with other organizations to achieve our organizational goals. We must continue to work together to survive and thrive, as we have for the past 400 years. And as Black physicians united, we celebrate 125 years as our National Medical Association.



**NIVA
LUBIN-JOHNSON**
MD, FACP

Dr. Lubin-Johnson has been an advocate of quality healthcare for all and is the 119th President of the National Medical Association. In its 123-year history, she is the third President and first woman to have served as President, Speaker of the House Delegates and Chair of the Board of Trustees.

She was in the last class to finish her Medical Degree in 3 years from Southern Illinois University and completed Internal Medicine at St. Joseph's Hospital in Chicago. Dr. Lubin-Johnson was in private practice for 29 years and served on various committees at 2 hospitals on the Southside of Chicago.

Dr. Lubin-Johnson is Chair of the Women's Physician Section and has been Chair of the Minority Affairs Section of the American Medical Association. She is a member of the American College of Physicians, Life-member of the Student National Medical Association and Alpha Kappa Alpha Sorority, Inc. and a founding advisory member of TimesUp Healthcare. With the pandemic, she felt a need to serve and is a member of the Illinois Department of Public Health COVID-19 Equity Team and the Illinois Lieutenant Governor Health Equity Task Force.

She believes in the need for wellness and preventive care to prevent physician burnout and is laser-focused on increasing the numbers of African Americans entering and completing medical school and completing residency.

OVERCOMING GENDER AND AFFINITY BIASES IN THE MEDICAL PROFESSION

By Andie Kramer and Al Harris

The medical profession is predominately led by men and operates in accordance with masculine norms, values, and expectations. As a result, although half of all U.S. medical school students are women, only 16% of deans, 18% of department chairs, and 25% of full professors in those schools are women (Paturel, 2019). Women are only 18% of hospital CEOs, 10% of senior authors on peer-reviewed medical papers, and 7% of editors-in-chief at prestigious medical journals (Mangurian, et al, 2018).

And, of course, there is the issue of pay. Not only are women physicians paid less than their male counterparts, but that pay gap is widening. While some of this gap is accounted for by choice of specialty and hours worked, 39% of the total gap is unexplained by objective factors (Lo Sasso, et al, 2020).

The most effective strategies for combatting women’s systematic discrimination in the medical profession is to directly confront the affinity and gender biases (Kramer & Harris, 2019) that underlie this discrimination.

Affinity bias is people’s natural preference to associate with, advance the interests of, and coach and mentor people who are like them. This means that the men currently at the top of the medical profession instinctively—and generally unconsciously—favor other men when allocating career-enhancing opportunities. This favoritism is compounded by gender bias—the stereotype-driven assumption (also generally unconscious) that men are superior to women at leadership and challenging career-related tasks.

The adverse consequences of these biases for women physicians’ careers are starkly revealed in a 2019 Merritt Hawkins survey (2019).

Key Takeaways from the 2019 Merrit Hawkins Survey

- 74% of women physicians believe they are paid less than comparably situated men.
- 76% of those women have personally experienced gender discrimination.
- 75% of those women who experienced gender discrimination have also experienced offensive or inappropriate comments from fellow physicians.
- 79% of all women physicians believe that gender discrimination is a serious or somewhat serious problem in medicine.
- 73% of women physicians report feeling a diminished sense of career motivation and satisfaction because of gender discrimination.

This pattern of discrimination against female physicians is reflected in the lack of respect they are often shown. For example, half of the time when female physicians are introduced by men, they are not identified as “doctor.” On the other hand, women almost always introduce both female and male physicians as “doctor” (Files, et al, 2017). Blatant recent examples of this disrespect were frequently on display in Donald Trump’s introductions of Dr. Deborah Birx and Dr. Anthony Fauci at the coronavirus task force briefings. Trump frequently introduced Birx as “Deborah” but Fauci as “Dr. Fauci.”

Another manifestation of the disrespect often shown female physicians is that more than 50% of the women faculty in teaching hospitals has experienced sexual harassment — a far higher percentage than the comparable percentage for female faculty in science or engineering departments (Johnson, et al, 2018).

The lack of respect frequently shown to women physicians is perfectly captured in a story recounted by a female surgeon in *Physician’s Weekly* (Salles, 2019). She writes, “When a male anesthetist walked into a surgeon’s lounge that happened to have several women in it at the time, he said, ‘Look at this! It looks like a goddamned Tupperware party in here.’”

There are concrete steps that can be taken to deal with the affinity and gender biases underlying the discrimination and lack of respect women physicians so often experience. For example, the stereotype driven nature of gender bias results in women physicians often being seen as either too communal — nice, kind, and sweet — to be effective leaders or too agentic — dominant, forceful, and assertive — to be likable. We call this too soft, too hard, rarely just right phenomenon, the “Goldilocks Dilemma.” Women, however, can escape the Goldilocks Dilemma by combining both communal and agentic qualities so they are perceived as forceful and caring; dominate, and welcoming; competent and empathetic (Kramer & Harris, 2016).

Women physicians also need to understand that the medical profession, like all other professions, is not a meritocracy. While providing high-quality medical care is a necessary condition for fulfilling their primary responsibility as physicians, it is not sufficient to assure career advancement. Advancement depends on women continually raising their hands, looking for opportunities to take on ever more important responsibilities, and not being shy about owning their own accomplishments.

In addition to individual efforts to overcome affinity and gender biases, women physicians need to recognize the importance of collaborative efforts. Strong female-dominated networks — such as the Women in Medicine Summit — are essential to female physicians’ successful and satisfied professional lives.

And, seeking the active support, mentorship, and sponsorship of senior male physicians is also important. To increase the likelihood of such support, women should genuinely acknowledge their senior colleagues' accomplishments, express their desire to learn leadership skills from them, and display a willingness to accommodate themselves to their colleagues' schedules.

Finally, organizations must change their policies and practices to ensure more inclusive, bias free, and respectful medical workplaces (Kramer & Harris, 2019).

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These policies and practices must explicitly foster transparency, flexibility, and gender-neutral processes for assignments, evaluations, compensation, and promotions. Achieving these goals will depend in large part on organizations implementing objective metrics to track the results of policy changes.

The medical profession has a long way to go before it will achieve gender neutrality. If it starts now, it can get there in the foreseeable future.



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Follow Ms. Kramer

IMPLICIT BIAS IN MEDICINE: INDIVIDUAL-LEVEL INTERVENTIONS MAY DISEMPOWER VS. EMPOWER

By Cheryl Pritlove and Elizabeth Métraux

For more than two decades, institutions seeking to address gender and other inequities have used the concept of implicit bias (IB) and implicit association testing (IAT) to welcome more diversity in their ranks (FitzGerald, et al, 2019). There is some evidence to suggest these efforts have been effective in raising individual and collective awareness of implicit gender bias, and have encouraged individuals to take action to reduce those biases (Carnes, et al, 2015; Payne & Gawronski, 2015; Girod, et al, 2016). However, the focus on individuals has produced minimal overall improvements in gender equity, particularly in the workplace (Bezrukova, et al, 2016). Indeed, the emphasis on individual-level interventions may distract from the need to implement system-level reforms necessary for progress (Pritlove, et al, 2019).

When it comes to IB and IAT enhancing equity in the workplace, there are numerous limitations (FitzGerald, et al, 2019; Bezrukova, et al, 2016; Pritlove, et al, 2019). However, the ways that these interventions can actually disempower women are discussed much less frequently.

For instance, by making individuals the root of the problem and site of the solution, we ignore the deeply political and historical issues that guide system-level operations in ways that produce and reproduce gender inequity.

We can see this in the masculinized nature of many employment spheres, including the organization of healthcare systems (e.g. meritocratic principles, hierarchical ranking of healthcare providers like doctors vs. nurses, and so on), as well as in the written and unwritten policies that situate women as the primary unpaid caregivers for children and elders, with implications for their involvement in the employment sphere (Pritlove, et al, 2019; Morgan, et al, 2018).

Through IAT and other individual-level interventions, people are primed to accept more responsibility in changing norms, but lack the power to make those changes at a system-level. By asking individuals to behave in more equitable ways, while neglecting hegemonic and patriarchal structures, we are setting them up for failure (Pritlove, et al, 2019).

Another problem is that IAT interventions are often targeted at predominantly white, heterosexual men, whose gender identity aligns with their biological

sex. These interventions, therefore, are further financial investments in men's "awakening," rather than women's advancement. When we do invest in women, the focus tends to be on "fixing" women, grooming them for success in what remain masculine employment structures. For example, women's leadership programs provide women with tools to be "effective" leaders (Hopkins, et al, 2008). It's a charge that carries a number of assumptions with it, including that women's difficulty climbing ladders hinges on a lack of capacity, training, or the characteristics necessary for success.

It's important to recognize that many forms of leadership training favor stereotypical male traits (e.g., authority, decisiveness, and completion of tasks vs. collaboration, empathy, and consensus-driven decision-making) (Vial & Napier, 2018; Gutiérrez y Muhs, 2012). Instead of teaching women skills deemed critical on the individual level, the better approach might be to question why masculine norms have been permitted to define leadership in the first place. Then, more focus could be placed on providing greater opportunities to redefine the concept in ways that promote greater diversity of skills.

Finally, not all women in the workforce are similarly marginalized (Gutiérrez y Muhs, 2012). So, strategies to empower must account for the individualized nature of a woman's experience, as gender intersects with race, ethnicity, class, identity, and countless combinations thereof. The ways in which these intersections impact oppression is overlooked in IB and IAT interventions (Pritlove, 2019), projecting instead the experiences of predominantly white, heterosexual women. Adopting a universal approach to women's experiences may empower women who belong to the dominant group. For the rest, their voices and struggles are often silenced.

Currently, feminist theories are largely absent from conversations about gender equity in medicine, the inclusion of which are necessary for producing meaningful and lasting change (Sharma, 2019). According to many feminist theories, empowerment relies on an individual's opportunity to challenge and contribute to change in existing power relations and on gaining greater control over the sources of power (Cornwall, 2016). Providing women with opportunities to contribute to system-level changes, rather than focusing exclusively on individual-interventions, can only enhance their sense of empowerment, and offer more opportunities for inclusive and diverse workplaces.



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SUPPORT WOMEN MEDICAL PROFESSIONALS BY TEACHING ADVOCACY SKILLS

By Isobel Marks

Being young and female is often not a powerful combination. A young woman will frequently have her authority questioned and will struggle to be heard. What's more, the undertone of comments can do extreme damage to self-esteem, goals, and ambitions.

People judge women through a range of suppositions. For example, they might say "oh, so you're married." But, they mean, "you're going to have kids soon," Or, they might say, "oh, you're pregnant." But, they mean, "you're going to quit your career soon."

These pre-judgements can impact us from the very start of our medical careers, and can stop us from being taken seriously in the workplace. But, there are ways we can act to support not only ourselves, but our entire community.

Advocacy is the tool and method that is needed to take ideas beyond ourselves, making our fight everybody's fight, and enlisting a much wider support network to achieve our aims.

As young professionals, we are in an excellent position to achieve this, with strong skills in social networking and technology, and the creative flare to try new things. What's more, before we become too entrenched within a health system already full of biases against women, we have the power to speak out more freely and openly against such oppressive systems, without necessarily risking our careers.

There are many different ways to advocate, and not all of them involve shouting and making a scene.

Looking strategically at your goals, figuring out who has the power, ability, and foresight to make changes, and understanding who that person listens to and respects can be more powerful than an all-out demonstration.

These skills, although not necessarily honed in medical school, can be taught on a peer-to-peer basis — and can achieve real and lasting change.

Women and men who want to achieve this may have to look beyond their own community, to groups that have previously been successful. Within the political world of global health and diplomacy, there are many such groups who have run highly successful advocacy campaigns and made changes at the highest levels of government, and to international law (Padamsee, 2020; Alcalde, 2009). One example of such student-led innovation, is the open access button, which tracks globally when academics and students cannot access important research due to pay wall restrictions, and has been key in providing evidence to encourage the creation of open access journals and research. A second group is the Universities Allied for Essential Medicines (UAEM), who campaign directly to universities to add clauses to their medicine patents in order to allow the development of drugs for use in low and middle income countries without restrictions. From the standpoint of women in medicine, we too must think big and look at the methods that they used, from media strategy to research, innovation and policy.

Another thing to keep in mind is the diversity and strengths of our community. While being female has always held its own challenges, these challenges can be multiplied many times ethnic or religious minority status are added to the equation. We must recognize the heterogeneity of our experiences and our struggles — and accept that being female alone does not mean that we understand one another's experiences.

Remember, young female professionals have the ability and power to make a real difference. But, to do so, they must be strategic, work together, and most importantly, be brave.



ISOBEL MARKS

Isobel Marks completed her foundation training in North West London and is currently working in Major Trauma at St Mary's Hospital, Paddington. Whilst training at Barts & the London Medical School, she worked as a paediatric surgical outcomes fellow at Massachusetts General Hospital, and a research associate with the Program for Global Surgery and Social Change (PGSSC) at Harvard Medical School. Issy coordinated the International Federation of Medical Students' Association (IFMSA's) Global Surgery Working Group for two years, and was a founding member and chair of InciSioN, the International Student Surgical Network, afterwards chairing the InciSioN Board of Trustees. Issy worked as a WHO policy officer for the UK Department of Health and delivered advocacy training for the G4 Alliance at the 2016 World Health Assembly. Issy has led a number of international projects, including the 2017 surgical indicator collection for the World Bank's World Development Indicators. She has also worked on several baseline assessments of surgical capacity in Nicaragua and Kenya.



Follow Ms. Marks

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A SURGEON'S APPROACH TO ERGONOMIC MODIFICATIONS IN THE O.R.

By Audrey Tsao and Marissa Pentico

The challenges female surgeons experience with using surgical instruments that have historically been designed for use by male surgeons with taller, stronger physiques — and often larger-sized hands — have been well documented (Sutton, et al, 2014).

For example, in one study involving laparoscopic surgeons, a majority of the participants identified instrument design as a source of their physical symptoms, which included discomfort in the neck as well as the shoulder area.

In another article, the authors cited concerns regarding the negative impacts that result from the discrepancies between hand and medical device sizes (Stellon, et al, 2017). To accommodate a wider range of surgeons, they recommended that medical device manufacturers refer to anthropometric data and the population when designing devices, utilizing data of physical measurements of the human body such as hand span, height and arm reach.

Finally, another study highlighted the importance of involving surgeons in the design process, as this can help with surgeon acceptance of a new device and improve performance, and the safety of the patient and surgeon (Santos-Carreras, et al, 2011). The Centers for Disease Controls also makes recommendations on tool design (CDC, 2004). Although generally indicated for nonpowered tools, it can be relevant for surgical instruments, as well. Features of ideal tools include reducing applied forces, fitting the hand well, and positioning the body in more neutral postures during usage.

From Dr. Tsao's perspective, hand size and grip strength is a consistent factor for a smaller surgeon. For example, instruments that use a wider hand span are difficult for her to use. Therefore, she either use two hands and positions her assistants to help, or she uses a different instrument with a pistol grip. She has changed almost all of her rongeurs from standard ones to a pistol-grip pituitary rongeurs.

Another approach she uses is to grasp an instrument in a different position, which may trigger the need for a stronger grasp strength but allows reasonable excursion of her hand span. However, resulting awkward postures should be monitored for and not maintained.

She will also often use a larger pick-up to allow for greater mechanical strength and decrease her hand fatigue. Surgeon awareness of the mechanical force exerted at the tip of the forceps is important when using potentially oversized instruments.

Since she is unable to palm instruments due to her smaller hand size, she often

uses sterile rubber bands to attach her forceps and place her fingers through the loop so her hands are not trying to tie and grip the forceps. This allows her to avoid repetitively putting down and picking up the instrument while tying sutures.

To increase the friction between her gloved hand and an instrument, she wraps coban around a grip, which increases the stickiness of the handle, requiring less power to grip it.

In addition to instrument designers adjusting their approach to designing tools, surgeons can also adapt their operating environment to improve ergonomics.

One of the things she is very aware of is that, given her height, there is an advantage to focus the work she does so that it is below shoulder level. This reduces strain on the muscles around her shoulders and allows for less fatigue throughout the day.

To accomplish this she:

Uses two risers, side by side, to provide larger platforms to work on (if she is unable to lower the table further), and always adjust the equipment in the operating room to avoid awkward postures.

Ask a taller assistant to move the overhead surgical lights — but always in the same trajectory that he/she pre-positioned them so that no light obstruction occurs.

Remove the elevated platforms on the operating room table that are designed to allow for placement of radiographic plates, as this decreases the height of the space she is operating in.

She also prefers to pick up her own instruments instead of waiting for an assistant to hand them to her. She modified her workspace to accommodate this approach to surgery in the following ways:

She uses a second mayo stand and allows large instruments to be placed on and off, with handles positioned for her. She also standardizes where the instruments are on the mayo stand for muscle memory.

She uses additional surgical pockets and places her pickups and cautery into these pockets directly across from her. She provides her assistants with additional pockets and allow them to maintain their own commonly used instruments.

AUDREY TSAO MD

Dr. Tsao is currently in practice with the Mid-Atlantic Group of Permanente Medicine in the DCSM group located in the District of Columbia and Southern Maryland. Previously she was in private practice in Arizona after relocating there from her academic practice at the University of Mississippi Medical Center in 2006. She has worked in the field of total joint arthroplasty and been involved in full time academics as a professor of Orthopedic Surgery. Her special interests included the design of total knee and hip implants, design of surgical instrumentation and the wear of materials involved in total joint replacement. She has also been involved in the international AO trauma as a faculty member and alumnus. Currently, she is the chair of the Women in Arthroplasty Committee for the American Association of Hip & Knee Surgeons known as AAHKS. Her special interests include innovation methods for bioengineering within orthopedics, implant and instrument design. She is an advocate for women in orthopedic surgery and enjoys teaching and mentoring women at all stages of their career. In her spare time, she continues her work as a founding member of WOGO, Women Orthopedic Global Outreach in an effort to enhance mentorship and provide role models for young women all over the world. WOGO as an Op Walk team has done multiple medical mission trips performing total knee replacements for those without access to including Nepal, Tanzania, the Democratic Republic of Congo and Cuba. She continues to practice the 4 G's: Be giving of yourself, generous with your praise, gracious in your thanks and gentle in your feedback.

MARISSA PENTICO

Marissa Pentico had practiced as an occupational therapist for 14 years, and as an ergonomist for 15 years. In addition to the surgical ergonomics program, she has developed and/or managed lab/office/material handling ergonomic programs within the Duke University Health System. She also conducts ergonomic evaluations, provides departmental education and training as well as consultative services within the organization.

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UNDERSTAND THE BASICS OF TRUST FOR LEADERSHIP SUCCESS

By Omayra Mansfield

We know that individuals with strong trusting relationships live longer, healthier lives, and have a greater sense of fulfillment and peace. Professional environments with high levels of trust have greater employee satisfaction, lower rates of turnover, and in the clinical setting, demonstrate better clinical outcomes and higher levels of teamwork.

In the trust transformation, we focus on the importance of taking time and identifying strategies to help us start with ourselves and do everything possible to become a trustworthy individual. This is not an act of selfishness. If you are to live up to your maximum potential, caring for your physical and mental well-being is essential. Give yourself permission to reflect and grow.

As a place to begin this reflection, look at the relationships in your life. We were made for relationships; they are essential to our lives. Relationships contribute to our physical and emotional well-being, and they contribute to an organizational culture of professionalism.

How often do you stop to reflect on whether the relationships in your life are filled with trust or where trust may be lacking? Think of someone in your life that is particularly close to you, that you trust. Why do you trust that person? Are they reliable, authentic, honest, respectful? Now consider someone who you distrust. What are the qualities they lack that inform that opinion? Once you look at relationships through the lens of trust, whether it is present or absent, it is difficult to undo.

There are four attributes of trust: trustworthiness, authenticity, dependability, and influence. Each of these attributes is aligned with a guiding principle. We must build trust from the inside out, take responsibility for our relationships,

communicate consistently and keep our promises, and be good stewards of our trust. It moves from *me* where you first work on trusting yourself, then to *we* where you cultivate a strong relationship with another person, and finally to *us* that involves building relationships and extending trust and influencing a group.

There are several characteristics of trustworthiness that are foundational to growing as an individual. Of these, the two most important are integrity and attitude.

Without integrity, there can never be trust. This implies a firm adherence to a set of moral standards, and always doing the right and honest thing. Attitude is paramount to communicating a message effectively, and as leaders to our ability to successfully lead. Psychologist Carol Dweck has observed that your attitude is a greater predictor of success than your IQ. Being cognizant of our attitude and behaving with integrity are essential first steps in achieving transformational trust.

Once we are trustworthy, we can then focus on fostering authentic relationships. The ultimate goal of authenticity, where we can be our most sincere selves, is transparency. To achieve this we must be present, use active listening, demonstrate candor and respect, be willing to forgive and have a clear purpose. Every day we are faced with opportunities to either strengthen or weaken our one on one relationships. Being intentional about focusing on these elements of authenticity will build and solidify these relationships.



OMAYRA MANSFIELD

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Dr. Omayra Mansfield is an emergency medicine physician. She is the Chief Medical Officer at AdventHealth Apopka and AdventHealth Winter Garden. She is the immediate past Chief of Staff of AdventHealth Celebration and is a proud graduate of the AdventHealth Physician Leadership and REACH Leadership courses.

Dr. Mansfield co-authored *The Trust Transformation*, a workshop that helps participants transform and improve the relationships in their lives by building a foundation of trust. Her primary areas of interest are improving the physician and patient experience as it relates to improving provider wellbeing, patient adherence to care, and clinical outcomes, and she has lectured extensively on these topics. She is married to Frederick, a pediatric anesthesiologist with USAP-Florida. Together they enjoy the adventure that is raising their daughter Elizabeth and son Alexander who regularly remind them to savor the little joys in life. They stay healthy doing Crossfit and running together.



Follow Dr. Mansfield

GETTING THE MOST FROM ALL PHYSICIAN LEADERS

By Mark Hertling

During a four-decade career in the Army, I trained for and practiced the art of leadership while commanding at various levels. It was a rewarding career, filled with interesting people, a variety of cultures, and dynamic challenges. Then in 2013, after retiring from the Army, I was recruited by a large healthcare system. One day, the chief medical officer of our hospital asked if I could take on an “additional duty” in helping him train our physicians in the art of leadership. I accepted the challenge, and today the seminars we developed and the classes we designed have become my passion.

Over the last six years, 700 physicians, nurses and administrators have graduated from our eight-month long development program. The graduates have begun to take on the mantle of leadership, and we have seen proof of cultural change in our hospital. We also have conducted research showing how participants have changed in their leadership style and ability, and how that change has affected the organization.

In our classes, interprofessional teams of doctors, nurses, and administrators come together to learn about themselves, discover the dynamics of leadership dyads, and acquire tips for building and influencing teams. They also begin to understand how they might better contribute to their organization and their profession. The approach to our seminars consists of the participants learning about themselves, understanding how to influence others, and finding ways to develop teams.

In learning about themselves, leaders must assess their own character and define their personal values. In discovering the dynamics of dyads, leaders realize there is power in proper and succinct communication.

To build successful teams focused on strategic objectives, leaders must first understand how their ingrained (and polished) personal traits, exhibited behaviors, and application of various influence techniques contribute to their success.

My former colleagues wearing the uniform learn these tricks during required military professional development courses and in the operational environment where they function. Most soldiers would say my summary of the factors of leadership are simplistic and might even state these building blocks represent a “BFO” (“blinding flash of the obvious”). They should, because the military receives repeated iterations of these basic leadership approaches and applies them at different levels. But those who have not studied these *attributes*, *competencies* and *influence techniques* that are associated with successful leadership might find the tools we teach in our seminars useful.

Leading is hard, but the elements necessary for good leadership can be learned and practiced. Only those who assess, possess and then further develop the attitudes, behaviors, and influence techniques will make great leaders. And, great leaders are needed in healthcare.



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MARK HERTLING**

DBA

Served for 38 years in the US Army. He has a BS from West Point, three Masters degrees, and is a Doctor of Business Administration. He spent over three years in combat, and his last posting was leading the 60,000 soldiers of US Army, Europe. Since 2013 he has been with AdventHealth, based in Orlando. He is married to his best friend, Sue, and they have two children and five grandsons.



Follow Dr. Hertling

FOLLOW THIS ROADMAP TO SET UP YOUR PRIVATE PRACTICE

By Krishna Jain

The world of medicine continues to change. In a 2018 American Medical Association (AMA) survey, 47.4% of the physicians were employed by various health organizations, while 45.9% owned their own practice. Ten percent of physicians were employed by physicians owned practices. Overall, 54% of physicians worked in a practice owned by physicians (AMA, 2019).

Graduating residents and fellows have a hard time starting their own practices for multiple reasons, including student loan burden, family obligations, lifestyle issues like being on call, and lack of management training. As a result of these challenges they look for an employment opportunity.

Starting and running a practice is a lot easier than getting into a medical school, graduating from medical school and surviving a grueling training program. Go into private practice, be your own boss and enjoy.

In this article I present a road map to go into solo practice.

Under the right circumstances the private practice model can be immensely satisfying. You can be your own boss. You can choose who to work with, build a respectable business, provide excellent patient care, and have more control when it comes to time management. It's empowering to deliver patient care without external interference.

Get buy-in from family

Having a private practice means that you are committing to a small business — complete with its risks and rewards. Before committing to this option, talk to your spouse or significant other about the pros and cons of starting the practice.

For example, it will take time to build a practice, and as a result, it will take time to build a satisfactory revenue stream. Work-life balance also needs to be addressed. This may be even more pertinent to a female physician because of possible pregnancy and childcare. The private practice is a business and may encroach on personal time.

Frank discussion about these things is crucial. Your spouse or significant other may not be part of the practice, but the practice will be a part of his or her life, because patient care and business needs don't automatically stop at 5 p.m.

Develop a business plan

You will need to develop a pro forma, or a document that demonstrates that your business will be financially viable. As you develop it, be conservative vs. overly optimistic, because you do not want to make financial commitments based on unrealistic expectations. If you're looking to get a loan, keep in mind that the bank will need to see this.

The following information should be included in this document:

Location. It's critical to start a practice in an area where there is need vs. competing with existing successful practices.

Hospital privileges. If the practice involves inpatient care, you should apply for hospital privileges. It may take several months to get privileges, so start this process early. There are very few hospitals with closed staff models, and with proper documentation about your medical license, medical training and letters of recommendations, etc., it shouldn't be too challenging to get privileges.

Staff. The office will need a variety of staff members, including an office manager who can manage day-to-day operations. Also, the duties performed by your staff will depend on the type of practice you have. In primary care you may need staff to manage many more patient encounters than in a surgical practice.

Equipment and supplies. You will need to furnish the space and depending on your specialty, procure necessary equipment needed to support patient care. For example, if you are a vascular surgeon you may need an ultrasound machine to image vessels. The clinical and clerical supplies will need to be ordered.

Insurance. Various types of insurance will be needed to run the practice and mitigate the risk, including professional liability to defend you in case of a malpractice lawsuit; workers compensation insurance since it is the law; business interruption which would be pertinent right now with COVID-19 interrupting business; practice overhead insurance in case you are not able to work for a period of time; and cybersecurity insurance in case patient records are compromised. On the personal side, life insurance and disability insurance should be obtained.

Credentialing and contracts. As soon as the location has been decided upon, you should apply for a Medicare number for the practice. After receiving this number, approach other insurance companies for contracts. Without a Medicare number you will not be able to have contracts with other insurance companies. The credentialing with various insurance companies can be time consuming and can take several months.

Regulatory compliance. It's important to be compliant with OSHA and HIPAA and any other state regulations. There are published guidelines that should be followed.

EMR. Under the Affordable Care Act it was mandated that all practices use an EMR. These can be expensive and difficult to operate. Consider using the same EMR as the one being used in the hospital where you are planning to have privileges. This will make data sharing much easier.

Practice management software. Along with the EMR, software is needed for practice management issues, including scheduling, billing, and collections. Most of the EMR systems also offer this module.

Billing and collections. Billing and collections can be done in house or can be contracted out to a billing company with a good track record. Outside company usually charge between 4-8% depending on the services being used by the practice.

Marketing. Good communication with referring physicians and excellent patient care are the best marketing tools. Also, consider using digital, print, audiovisual, and social media to market your practice. A comprehensive website is crucial

to the success of the practice. You can write articles for local newspaper and appear on local TV and radio stations. Social media like Facebook can be used to promote the practice. Presentation to local physicians can be very helpful in developing the practice.

Managing the office. An employee manual should be created and made available to all employees. Job descriptions should be written and followed. Also, in a small practice, employees should learn one another's jobs, as sometimes they will need to substitute for each other. For example if the front desk person falls ill, the medical assistant responsible for getting the patient ready to be seen by the doctor can also work at the front desk.

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Follow Dr. Jain

WHY WOMEN PHYSICIANS NEED TO BE INVOLVED IN POLITICS

By Joanna T. Bisgrove

We're at an interesting point in American history. One hundred years after women finally won the right to vote, there are 126 women in Congress, 90 in statewide offices (including nine governors), and 2,152 female state legislators. And come January 2021, we could have our very first female vice president.

Why does any of this matter? Because all of these women have fought glass ceilings to get to where they are. No matter their politics, they all want and need to hear from their constituents. Furthermore, they trust physicians — and are much more apt to trust women physicians.

They listen to us because we not only have expertise in our field, but we've fought the same fights against the proverbial glass ceiling. Women in medicine and women in politics are often subject to the same roadblocks toward career advancement.

As our political leaders get to know us, they realize quickly they can trust us. In turn, we are able to offer crucial advice to help shape government policy to be better for women.

Understanding health care policy, as well as how to shape it, is key to being able to be an effective advocate and policy advisor. Moreover, having a network of fellow physician advocates to work with is both fulfilling and critical to this work.

Organized medicine is a key pathway for women physicians to learn how to shape both local and national policy, as well as build those all-important networks. It is also a fertile training ground to learn how to make those connections with your local and national legislative leaders to build those long-term relationships. Through organized medicine, women physicians can gain experience, training, and access to support networks and resources to run for office themselves.

There are many ways to get involved, as organized medicine exists in many forms, including national organizations such as the American Medical Women's Association, American Medical Association, and National Medical Association. Each specialty also has its own national society, as does each state.

For some, the idea of getting involved can be daunting. Politics can seem like a bloodless sport at times. But, it is also a place where we can make a difference in the lives of so many.



JOANNA T. BISGROVE

MD, FFAFP

Family physician near Madison, the state capitol of Wisconsin. She has been co-chair of the Legislative Committee for the Wisconsin Academy of Family Physicians since 2014, and has built relationships with several state legislators and their staff. She has testified before the state legislature on several occasions, including lead testimony for legislation to simplify prior authorizations for medications that later became law.

At the national level, Dr. Bisgrove is a delegate for the American Academy of Family Physicians to the American Medical Association's House of Delegates, the AMA's policy making body. She is also a member of the AMA's Women Physicians Section Governing Council, which has joined with other women physician groups to help lead the charge for gender equity in healthcare. She works regularly with her US Senator, Tammy Baldwin, and her US representative, Mark Pocan.



Follow Dr. Bisgrove

WIMS Chair:

SHIKHA JAIN, MD, FACP

Editor



Dr. Shikha Jain is a board-certified hematology and oncology physician. She is an assistant professor of medicine in the Division of Hematology and Oncology at the University of Illinois in Chicago. She is the Director of Communications Strategies in Medicine and the Associate Director of Oncology Communication and Digital Innovation for the University of Illinois Cancer Center. Dr. Jain is the Chief Operating Officer and Co-Founder of the action, advocacy and amplification organization IMPACT and Co-Founder and Chair of the Women in Medicine Summit. Dr. Jain was named one of Modern Healthcare's Top 25 Emerging Leaders in 2019, and was also awarded the Rising Star award by the LEAD Oncology Conference in 2019. She was selected as a ResearchHERS ambassador by the American Cancer Society, and was honored by 500 Women in Medicine. She has been appointed to the 2020 American Society for Clinical Oncology Women's Networking Center taskforce and

appointed to the Council on Communications and Membership Advocacy as well as the COVID19 taskforce for the Illinois State Medical Society. She was recently appointed to the editorial board of Healio HemOnc Today and is the consulting medical editor for Healio Women in Oncology. She is also the host of the podcast Oncology Overdrive, and the founder and former host of the podcast The Rush Cast. Dr. Jain's mentorship and sponsorship have resulted in the advancement of numerous young women and men in medicine across the country. She works tirelessly to promote the dissemination of evidence based scientific information through numerous mediums including social media and has been recognized as a thought leader by Doximity and the OpEd project. She lectures nationally on the importance of social media and communication strategies in healthcare. She is also the founder of the social media group Dual Physician Families.

Dr. Jain gave a TEDx talk in 2019 on the gender moonshot and the importance of gender parity in healthcare. She is a nationally renowned speaker and writes for several national publications including Scientific American, The Hill, US News, Physician's Weekly, Doximity, KevinMD, and ASCO Connection.

In her clinical practice as an oncologist she tries to incorporate patient education and outreach as often as possible. With the proper tools and guidance, she works with her patients as a team to treat the disease and helps them move through an often difficult process together with as little stress as possible. She believes in personalized and individualized care, and also feels the more knowledge a patient has about their own disease, the more informed a decision they are able to make.



<https://shikhajainmd.com>



<https://www.womeninmedicinesummit.org>



<https://www.impact4hc.com>

Assistant Chair:

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WIMS HeForShe Track



Laurie Baedke is a faculty member and Director of Healthcare Leadership Programs at Creighton University.

A sought-after speaker and author with broad experience building companies, and leading organizational change, Laurie has specific expertise in healthcare management, emotional intelligence, and strengths based leadership. She is an active mentor and advisor to senior executives, physician leaders, early careerists, and entrepreneurs.

Laurie holds a bachelor's degree in human services and business administration and a master's degree in healthcare administration. At age 26, she became the youngest individual to achieve board certification as a Fellow of the American College of Healthcare Executives (ACHE), and is also a board certified Fellow of the American College of Medical Practice Executives. Laurie has been certified by The Gallup Organization as a Strengths Performance Coach since 2006.

Laurie is the recipient of numerous awards. Professionally, she has served on four national committees for ACHE, and is a current member of the ACHE of Nebraska and Western Iowa Chapter board of directors. She also serves a variety of civic and community organizations, including current appointments on the Omaha Bridges Out of Poverty Board of Directors Executive Committee and the Leadership Omaha Curriculum Committee.

Laurie holds a faculty appointment at Creighton University's Heider College of Business, where she serves as director of the Executive MBA in Healthcare Management program.

Her first book, titled *The Emerging Healthcare Leader: A Field Guide*, was published by ACHE's Health Administration Press in 2015. She contributed a chapter; *The Clinician Entrepreneur*, to a book published by Oxford Press in April, 2017 titled *The Handbook of Private Practice*. And, most recently, a second edition of her book, *The Emerging Healthcare Leader: A Field Guide*, was published ACHE's Health Administration Press in March, 2018.

Laurie lives just outside of Omaha, Nebraska with her husband and two children.

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WIMS HeForShe Track



Dr. Thomas Varghese Jr. is the Executive Medical Director at Huntsman Cancer Institute, Head of the Section of General Thoracic Surgery, Program Director of the Cardiothoracic Surgery Fellowship, and an Associate Professor (Tenure-track) in the department of Surgery at the University of Utah.

Dr. Varghese holds national leadership positions in the Society of Thoracic Surgeons, Thoracic Surgery Directors Association, American College of Surgeons, Society of University Surgeons, and Surgical Outcomes Club. He is co-chair of the Association of Women Surgeons #HeforShe Taskforce, and a health services researcher who helped create the American College of Surgeons Strong for Surgery program (<https://www.facs.org/quality-programs/strong-for-surgery>) and has RO1 funding from the National Cancer Institute on the role of Precision Exercise Prescription (PEP) for elective lung cancer surgical resection.

Tom spends his free time with his family, as well as actively engaging on social media via Twitter.

You can follow him on social media:



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David C. Kim is Business Development Manager of Career Center Publishing for Wiley. He is responsible for building partnerships with scientific, scholarly and professional societies in North America, and specializes in leveraging Wiley's global scientific communications and disciplinary expertise to help societies deliver high-impact professional development resources and career opportunities, improve membership engagement and increase non-dues revenue generation. He leads Wiley's Career Center Diversity, Equity & Inclusion initiatives, involving strategic efforts to improve career opportunities for underrepresented communities. David was formerly Associate Editor & Journal Publishing Manager at Wiley, overseeing the strategic development and management of high-profile peer-reviewed journal portfolios in Finance, Economics, Statistics, Geography, Demography, Consumer Sciences and Health Policy. He is a 2020 Fellow of the Society for Scholarly Publishing and serves as the Board Advisor of Women In Science At Columbia.

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