Women, Minorities, and Leadership in Anesthesiology: Take the Pledge

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Diversity in the workforce is associated with improved organizational performance in the corporate world[1] and is considered vital to improving outcomes in health care.[2] Although diversity has increased in medical schools and residency programs in the United States, the "pipeline" to senior academic positions in American universities for women and members of underrepresented minorities is "leaky," with few women or minority members reaching the top.[3] This parlous situation applies to academic positions in anesthesiology as well.[4] However, it is unclear whether this block in the leadership pipeline applies only to academia.

In this edition of the Journal, Toledo et al[5] report on a survey about diversity in the leadership group of the American Society of Anesthesiologists (ASA), a member-based organization dedicated to education, research, and advocacy. A total of 595 house of delegates members and state society officers were surveyed, with a response rate of 54%. Fewer women (21.1%) were members of the ASA house of delegates or were state society officers, than were members of the national medical workforce (38.0%) or national population (51.0%), although the percentage of women was similar to the ASA membership (23.0%) and the national anesthesia workforce (24.8%). Underrepresented minorities comprised 6.0% of the ASA leadership, 8.6% of the anesthesia workforce, 8.9% of the national medical workforce, and 32% of the national population (the ASA does not collect racial/ethnic information on its members). Toledo et al[5] concluded that "Efforts should be made to increase the diversity of the ASA leadership with the goal to reducing overall anesthesia workforce disparities." In other words, the leadership should model gender and racial diversity rather than just reflect it. We applaud this suggestion.

The purpose of this editorial is to put the results of Toledo et al's survey into an international context and to suggest solutions. We take a broad view on leadership, considering it to include many visible and influential roles, such as elected office in a member-based organization; tenure in the higher ranks of an academic institution; a management role in an anesthesia group or health care facility; prominence in conducting, reviewing, and speaking about research; as a champion for quality and safety; and in educational leadership roles. Our main focus is on gender diversity because each nation has a unique mix of indigenous and immigrant people, and data on race/ethnicity are not uniformly collected or reported.

The participation of women in medical and anesthesia education, and in leadership, is similar in the United States and 5 comparable nations (Australia, Canada, Ireland, New Zealand, and the United Kingdom) (Table). The percentage of women in primary medical education is 47% to 55% in these countries. However, anesthesiology recruits a smaller proportion of women than the proportion that graduates from medical school (37%–48%). Few women reach the rank of professor or become department chairs (6%–17%), or are elected to the boards of representative anesthesia organizations (13%–36%). So the leadership pipeline is blocked internationally. What can be done to improve this situation?

Our suggestions for change are a modification of the work of Jennifer L. Martin,[6] who proposed "Ten simple rules to achieve conference speaker gender balance" after a basic science conference published a program without a female keynote speaker. Lack of female keynote speakers has been noted at major anesthesiology meetings as well,[7] and at least one organizing committee in Australia has adopted Martin's rules to remedy the problem.[8] Similarly, a major grant body in the United Kingdom now requires applicants to demonstrate employment practices that promote women in science.[9] These rules for increasing participation in anesthesiology leadership are:

1. *Collect the data*: Collect gender and minority status data, not only on the general membership of the organization, but also on members who stand for election and who are elected to the governance bodies of the organization.

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Table. Participation of Women in Medicine and Anesthesia Education and Leadership in 6 Comparable Nations

Country	Medical Students	Anesthesia Trainees	Academic Leaders	Board Members
Australia	51%[a]	47%[a]	12.5%[b] Full professors	14%[c] ANZCA council
Canada	55%[d]	39%[e]	6%[f] Department chairs	36%[g] CAS board
Ireland	52%[h]	38%[h]	17%[i] Full professors	13%[j] CAI council
New Zealand	54%[k]	47%[l]	17% [b] Full professors	14%[c] ANZCA council
United Kingdom	55%[m]	48% [n]	9.5% [o] Full professors	25%[p] RCoA
United States	47%[q]	37%[q]	13%[q] Department chairs	25%[r] ASA Officers

% women holding the role nationally.

Abbreviations: ANZCA, Australian and New Zealand College of Anaesthetists; ASA, American Society of Anesthesiologists; CAI, College of Anaesthetists of Ireland; CAS, Canadian Anesthesiologists Society; RCoA, Royal College of Anaesthetists.

[a]Commonwealth Department of Health. *Medical Training Review Panel 19th Report*. Canberra: Commonwealth of Australia, 2016.

[b]Leslie K. Personal communication.

[c]Australian and New Zealand College of Anaesthetists (ANZCA). Available at http://www.anzca.edu.au/about-anzca/council,-committees-and-representatives. Accessed January 3, 2017.

[d]Association of Faculties of Medicine of Canada. *Canadian Medical Education Statistics, 2016*. Ottawa: Association of Faculties of Medicine of Canada. Available at https://afmc.ca/publications/canadian-medical-education-statistics-cmes. Accessed January 3, 2017.

[e]Association of Faculties of Medicine of Canada. *CAPER Annual Census of Post-M.D. Trainees, 2015–2016*. Ottawa: Association of Faculties of Medicine of Canada. Available at http://caper.ca/en/post-graduate-medical-education/annual-census. Accessed January 3, 2017.

[f]Association of Canadian University Departments of Anesthesia. Available at http://www.cas.ca/English/ACUDA-Membership-Universities. Accessed January 3, 2017.

[g]Canadian Anesthesiologists' Society (CAS). Available at http://www.cas.ca/English/CAS-Organizational-Chart.

[h]National Doctors Training and Planning. *Sixth Annual Assessment of NCHD Posts 2015–2016*. Available at http://www.hse.ie/eng/staff/leadership_education_development/met/ed/rep/annual-assessment-of-nchd-posts-2015–161.pdf. Accessed January 3, 2017.

[i]O'Sullivan E. Personal communication.

[j]College of Anaesthetists of Ireland (CAI). Available at https://www.anaesthesia.ie/index.php/about-us/college-council. Accessed January 3, 2017.

[k]Medical Deans Australia and New Zealand. Available at http://www.medicaldeans.org.au/wp-content/uploads/Table2.pdf. Accessed January 3, 2017.

[l]Medical Council of New Zealand. Available at https://www.mcnz.org.nz/assets/News-and-Publications/Workforce-Surveys/2013–2014.pdf. Accessed January 3, 2017.

[m]General Medical Council. *The State of Medical Education and Practice in UK 2016*. Available at http://www.gmc-uk.org/publications/somep2016.asp. Accessed January 3, 2017.

[n]Royal College of Anaesthetists. *Medical Workforce Census Report 2015*. Available at https://www.rcoa.ac.uk/census2015. Accessed January 3, 2017.

[o]Medical Schools Council. *A Survey of Staffing Levels of Medical Clinical Academics in UK Medical Schools as at 31 July 2015*. London: Medical Schools Council, 2016. Available at http://www.medschools.ac.uk/SiteCollectionDocuments/MSC-survey-2016.pdf. Accessed January 3, 2017.

[p]Royal College of Anaesthetists (RCoA). Available at https://rcoa.ac.uk/college-council. Accessed January 3, 2017.

[q]Association of American Medical Colleges. *The State of Women in Academic Medicine 2014*. Available at https://www.aamc.org/members/gwims/statistics/. Accessed January 3, 2017.

[r]American Society of Anesthesiologists (ASA). Available at https://www.asahq.org/about-asa/governance-and-committees/asa-officers. Accessed January 3, 2017.

2. *Develop a policy*: Develop a policy regarding gender and minority balance in the governance structure of the organization. Depending on the context, it may be important to recognize the profound underrepresentation of women from underrepresented minorities.[10] This policy will need to include contingencies (such as co-option) for situations when insufficient women apply for or are elected to the office. This may be complex where component groups make individual choices in silos, as the component societies of the ASA do. Goal-setting has also been shown to be effective.[1]
3. *Make the policy visible*: Make the policy publicly available but also provide links to it from committee membership pages and make sure that all office bearers are aware of it. Consider providing training to office bearers to help them understand why the policy is necessary, particularly how unconscious bias can influence decision-making about leadership.[11,12]
4. *Establish an informed and balanced recruitment advisory group:* Deliberative, rather than reflexive, identification of candidates increases diversity.[11] Therefore, establish a diverse group who can identify suitable women and members of underrepresented minorities to mentor and sponsor. Members are often encouraged to stand for office by people on the leadership team. If this team does not include women and members of unrepresented minorities, then the result will be continued lack of diversity. Commitment by men to increased participation of women in leadership is crucial.[13]
5. *Report the data:* Report on the gender and minority balance in the membership overall and among the office bearers in the regular reporting of the organization to its members, jurisdictions, and the public. Highlight and celebrate advances in representation in publications and online.
6. *Build and use databases:* Compile a list of women with a track record or potential for leadership. The group that compiles and updates this list should be as diverse as possible and may overlap with the recruitment advisory group.[14]

7. *Respond to resistance:* Expect resistance from women and men alike. Respond by highlighting that gender and minority diversity is not inconsistent with high-quality governance because of the large number of eligible and qualified candidates.
8. *Support female and minority office bearers:* Provide mentorship to female and minority office bearers in addition to the leadership and cultural competence training offered to all members of the team. Consider the ecosystem of the role: if it was designed for a male leader (whether consciously or unconsciously), consider a redesign.
9. *Be family-friendly:* For leaders with primary responsibility for children or older relatives, the timing and location of committee meetings can be problematic. Perhaps it is time to radically rethink the need to leave home for large national meetings and for teleconferences during peak family times. Availability of childcare at meetings may also promote participation.
10. *Take the pledge:* Whatever your gender or minority status, when thinking about standing for office, ask for the policy and the data and see whether this is an organization that takes diversity seriously. If it is not, then you have a choice—reconsider your involvement or seek election and change the organization from within. We strongly recommend the latter.

Although our suggestions for change relate to diversity of elected office bearers, because this was the focus of Toledo et al's study, they may and should be applied to other leadership roles to ensure the inclusion of women and minorities in the leadership of our profession.

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