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EDITORIAL

Identifying the barriers to female leadership in Paramedicine

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The main message is clear: women are not making it to the top in any profession, anywhere in the world, and the field of prehospital and academic medicine is not immune. Whether in the public or private sphere, from the highest levels of government decision-making to common households, women continue to be denied equal opportunity with men (1,2).

In the past, paramedicine has typically been a male dominated role. As it stands now, women represent only 25% of paramedics across Canada, and the number of women that hold leadership positions is less than 5% (3). The goal of our current research project regarding female leadership in paramedicine aims to uncover the reasons behind this stagnation, and the barriers that females seeking leadership face. Current literature in female leadership in the medical community focuses mainly on leadership representation in academic positions at medical schools. This body of work has identified several recurring patterns that seek to explain barriers women face in the professional, medical and academic worlds.

One study conducted by Kvaerner and colleagues on female medical leadership found that the medical career structure itself has been slow to adapt to the changing profile of medicine and that there exists deficiencies in career advice and counseling from patrons and colleagues. They suggest that these deficiencies may contribute to a "glass ceiling" effect on women's upward mobility (4). They discovered that the gradient of existing sex ratio in a corporation is a strong predictor for career opportunities for women. If women are in the minority, they are exposed to exaggerated attention and lack of integration (reactions that do not appear in groups with less variable sex ratios). Furthermore, they found the probability of women achieving senior positions seems to increase with the proportion of women in the specialty (4). Organizations must take it upon themselves to be self-aware of the deficiencies within their societies that are contributing to the lack of upward mobility for female employees.

Mayer found similar results almost ten years later when they investigated the academic advancement of women in medicine, searching for the answer to whether or not socialized gender differences have a role in mentoring. Through their investigations they recognized that demands of clinical practice, family obligations, and lack of mentoring have all been identified as factors influencing the lack of advancement of women to upper levels of management (5). Mentorship in academic medicine was reported to increase personal and career development, as well as research productivity, including publications and grant awards. Previous research has proven that formal and informal traditional mentoring models have been shown to increase advancement of mentees, however, it is more difficult to establish informal mentors in the minority groups (i.e. women in this case). Traditional mentoring styles often emphasize separation over integration, independence over relationships, and competitive task over collaboration. Interestingly, Mayer found that women are more inclined to engage in "leveling" or equalizing behaviour, even with their obvious subordinates (suggesting that the traditional model of mentoring does not appeal to the types of relationships women are more likely to engage in) (5). Mayer also found that academic promotion is less likely for female faculty than for their male colleagues of similar duration of appointment (5). Gender-matched mentoring can establish mentoring pairs that maximize the opportunity for psychosocial support with insight into work-life balance, work relationships, and work politics (5).

A recent study on the inadequate progress for women in academic medicine sought to explore the opinions of individuals who have leadership roles to address the current "climate" that professional women face. The team conducted qualitative interviews in 24 US medical schools to explore the gender climate for women in academic medicine. Of the respondents, several patterns emerged demonstrating little recognition of women's accomplishments and a persistence of unintentional gender bias. Women were more frequently found in the clinical tracks versus the tenured research tracks with higher perceived prestige and there existed a lack of transparency around salary issues (6).

Furthermore, a study conducted by an internal medicine resident with her colleagues recreated an experiment that was previously conducted with business students. Researchers were asked to read a case, half of the group reading the original story about a female subject, the others reading a story that was changed to a male subject. Both the male and female were perceived to be equally capable, but the female was perceived as political, calculated, and unlikeable. The male was perceived to be more hirable and the superior colleague (7). This analysis demonstrates how success and likeability remain positively correlated for men, and negatively correlated for women (8). Repeatedly it is shown that women face distinct social penalties for doing the very things that lead to success (8). Cooper states, "high-achieving women experience social backlash because their very success – and specifically the behaviours that created that success – violates our expectations about how women are supposed to behave" (8).

It is imperative that professional women seeking leadership opportunities are presented with mentorship/

sponsorship prospects and are exposed to a coaching relationship. It is crucial that young women are exposed to self-promotion techniques to combat the trend that women systematically underestimate their own abilities (9). Many employers have taken steps to reduce gender gaps by adopting policies against discrimination and sexual harassment and introducing family friendly benefits and incentives for longer parental leave. Hiring committees must have defined criteria in advance of evaluating candidates to avoid unconsciously redefining what they are seeking to match the attributes of male candidates.

Opinions in the medical community are still tainted by unconscious bias at best, and active discrimination at worst (10). It is time that the culture of gender bias in the field of paramedicine changes, and it is imperative that all levels of employees recognize that culture does not make people, people make culture. As the ratio of men to women in the field of paramedicine continues to balance, it is apparent that there is no longer a "supply" issue affecting female opportunities for leadership positions. It is time to move beyond the point of continuing to describe the problem and begin to develop and institute concrete solutions.

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Editor's note: Paige Mason is a paramedic and researcher in Ontario, Canada. She is the principal investigator of a mixed-methods studied entitled "Female Leadership In Paramedicine (FLIP)" which is currently underway.

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