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GROUNDWORK



## Applying the Theory of Gendered Organizations to the Lived Experience of Women with Established Careers in Academic Medicine

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### ABSTRACT

**Phenomenon:** The number of women who enter medical school has been on par with the number of men for almost 20 years, but parity in training has not translated to equity in professional life. To capitalize on the perspective of women faculty with established careers in academic medicine and to bring theory to the largely descriptive research on gender inequity in academic medicine, the authors used the Theory of Gendered Organizations to demonstrate how academic medical centers function as inherently gendered organizations. **Approach:** The authors recruited women faculty with established careers at one academic medical center based on purposeful and snowball sampling and interviewed 30 participants in Summer/Fall 2018. They coded and analyzed data inductively. In later stages of analysis they used sensitizing concepts from the Theory of Gendered Organizations to guide our focus on formal expectations of, and informal interactions in, the academic medical center. **Findings:** The disjuncture, i.e., “lip service”, between formal expectations intended to be gender-neutral and informal interactions that advantaged men demonstrated how the academic medical center functioned as a gendered organization. Participants experienced these interactions as being treated differently than men and/or being stereotyped. As their careers progressed, participants recognized gender inequity as embedded in the organization, or as they said, “the way things were stacked”. Subsequent to this recognition, they navigated this gendered organization by advocating for themselves and younger women faculty. **Insights:** Women with established careers in academic medicine experienced gender inequity as embedded in the organization but navigate gendered interactions by advocating for themselves and for younger women. Using the Theory of Gendered Organizations as an analytic lens demonstrates how academic medical centers function as gendered organizations; these findings can inform both theory-based research and pragmatic change strategies.



### KEYWORDS

gender; career mobility; faculty; medical; academic medicine; organizational culture

### Introduction

For almost twenty years, the number of women who enter medical school has been on par with the number of men. Nonetheless, for women who pursue careers in academic medicine after medical school, equity in training has not translated to equity in professional life as a faculty member.<sup>1</sup> In fact, gender inequity in academic medicine is well-described in quantitative research. For example, women faculty are less likely to achieve promotion than their male peers;<sup>2–8</sup> after controlling for factors critical to

promotion, differences in academic rank persist. Women are not financially compensated equal to their male colleagues.<sup>4,5,9–12</sup> Compared to men, women are disadvantaged in other aspects that influence success in academic medicine like authorship,<sup>13,14</sup> mentorship,<sup>15</sup> family responsibilities,<sup>16,17</sup> harassment and discrimination,<sup>18,19</sup> and resource disparities.<sup>20</sup> In addition, the number of women in leadership positions in academic medicine has not increased at rates anticipated by their representation in medical school.<sup>6,21–24</sup>

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Qualitative research complements quantitative findings by providing a rich description of the lived experience of women faculty in academic medicine.<sup>25–31</sup> For example, in studies with women faculty from different specialties,<sup>26,27,29–31</sup> gender inequity is experienced as failing to meet expectations for the “ideal” worker who commits all hours to their profession,<sup>26,29–31</sup> being judged as “less than” in the hierarchy of academic medicine,<sup>26,27,30,31</sup> and lacking support from mentors and role models.<sup>26,29,31</sup> Only three studies, however, have interviewed women with established careers in academic medicine (i.e., full professors, senior leaders, and/or faculty with at least ten years on an academic track).<sup>26,28,30</sup> Each employs the term “coping strategies” (e.g., self-silencing,<sup>30</sup> downplaying gender differences<sup>28</sup>) to describe how women have dealt with gender inequity in academic medicine.

Extant research on gender inequity in academic medicine, be it quantitative or qualitative, is replete with descriptive data, but lacks theoretical grounding.<sup>32</sup> Theory outside of medicine could elucidate gender inequity in the field.<sup>33</sup> In particular, the lived experience of women faculty who have established careers in academic medicine could provide insight into the problem of gender inequity if one takes the perspective that *organizations* like academic medical centers (AMC) are inherently gendered. Acker’s Theory of Gendered Organizations situates gender and associated gendered inequities within and throughout organizations.<sup>34–36</sup>

“To say an organization, or any other analytic unit, is gendered means that advantage and disadvantage, exploitation and control, action and emotion, meaning and identity, are patterned through and in terms of a distinction between men and women, masculinity and femininity.”<sup>34(p. 146)</sup>

The overarching goal of the Theory of Gendered Organizations is to identify common mechanisms across organizations that produce a cumulative disadvantage to career success for women. In the process, the theory provides a useful framework for seeing gender inequity on different levels: individual identities, workplace interactions, organizational structure, and culture.<sup>34–37</sup> Examples of how academic medicine manifests as a gendered organization include the segregation of different disciplines and the construction of faculty roles that are consistent with the “ideal man”.<sup>38–40</sup>

While a comprehensive review of the Theory of Gendered Organizations is beyond the scope of this paper, we capitalize on its capacity to highlight the

embeddedness of gender inequity in organizations, even when organizational structures appear gender neutral.<sup>36,41</sup> To that end, we focus on two levels of Acker’s framework—workplace interactions and organizational structure—because they were salient in our data and provided a lens through which to examine a critical disconnect between these levels. Using interviews conducted with women faculty who had established careers at one AMC, we asked, “How does this AMC function as a gendered organization?” In the end, we demonstrate how informal interactions in this AMC actually maintained and reproduced gender inequity even though the organization had structures (e.g., formal expectations and policies) in place to promote for gender equity.

## Methods

### Qualitative approach and reflexivity

We began with an inductive approach to qualitative research, aiming to explore the lived experience of women who had established careers in academic medicine at one AMC. We maintained our research aim but narrowed our focus—based on the undercurrent of gender inequity in the stories we heard—and used the Theory of Gendered Organizations as an analytic lens to examine how the study AMC functioned as a gendered organization.<sup>34–36</sup>

From the start, our research was informed by social constructionism; that is, we viewed the social world as constructed through social interactions and changing social structures.<sup>42</sup> Within this paradigm, we conceptualized gender as socially constructed and acknowledged that our views on gender influenced the conceptualizations presented in this manuscript. SA (faculty/physician) and LT (faculty/non-physician) had leadership roles in a faculty development program for women at the study AMC while BD served as its coordinator. DB (faculty/non-physician) was also employed at the study AMC but did not work in the faculty development program or with any of the participants. To maintain confidentiality and to provide distance from leadership of the faculty development program, only DB and KC collected the data, knew the identity of the participants, and had access to the data and led the analysis. LH partnered with the research team throughout the analysis as an expert in sociology and gender studies. KC and LH were not employed at the study AMC.

**Table 1.** Characteristics of the 30 women faculty who participated in interviews, summer/fall 2018.

		No
Rank	Associate	5
	Full	25
Specialty	Basic sciences (e.g., Genetics)	4
	Medicine	12
	Pediatrics	9
	Radiology	2
	Surgery	3
Track	Associated faculty	6
	Standing faculty (including tenure, non-tenure)	24
Age	40-50 years	5
	51-60 years	7
	61-70 years	17
	>70 years	1

### Context and data sources

The AMC we studied was an urban, private institution in northeast United States. It has over 2,600 faculty working full time, with 40% women faculty; of all full and associate professors, approximately 27% and 38% are women respectively. Most faculty are on a standing faculty track with voting rights, scholarly leave benefits, a probationary period, and an up-out-promotion decision. Others are on an associated faculty track with no probationary period or up-and-out promotion. AMC has a track record of supporting women faculty. For example, it has had a dean-funded, faculty development program for women for over two decades. Moreover, the health system affiliated with AMC was recognized recently as a “top ten” employer for women in a national ranking.

In the summer and fall of 2018, we recruited women faculty (MD or PhD) who attended a cohort, 4-session workshop series entitled “Envisioning the Later Stages of Your Career”, which was offered by the faculty development program for women. We anticipated that these women might know things about academic medicine in general, and AMC in particular, by being insiders for at least two decades. We expanded our purposeful sample by snowball sampling. That is, we asked participants who attended the workshop series to identify female colleagues of similar seniority who did not attend the workshop series.

We ended data collection after the second round of snowball sampling. Of 45 women invited, 30 (67%) agreed to participate in this study. Eleven of the 30 participants (37%) attended the workshop series (see table 1 for sample characteristics). Clinical, teaching, research, and administrative responsibilities varied among study participants; for example, participants employed as associated faculty had primary clinical responsibilities whereas those employed as standing faculty typically had more diverse roles. We obtained approval from our institutional review board and

verbal consent before the interviews. To maintain confidentiality, we removed information that could disclose the identity of participants during the transcription process and assigned a participant identification code to each transcript.

We designed our initial interview guide to elicit women’s career experiences in academic medicine, with a focus on the later stage. For example, we asked, “In this later stage of careers, women tend to talk about wanting to be true to themselves; how does that resonate with you, if at all?” In these semi-structured interviews, we did not explicitly ask about gender inequity because we did not assume that it would necessarily reflect participants’ experience at AMC. Nonetheless, they consistently brought gender inequity into the conversation. Therefore, in later interviews, we added probing questions such as, “How might it have been different if you were a man?” DB and KC conducted in-depth interviews, either alone or as a dyad; 27 interviews were in person and three by phone. Interviews lasted 55 min on average (range, 25-110 min); they were audio-taped and transcribed verbatim by either DB, KC, or a professional transcriptionist.

### Data analysis

DB and KC led the analysis. They collected and analyzed data iteratively. Using incoming data to guide the coding process, they created descriptive codes and repeatedly compared codes and data with one another so that codes parsimoniously fit the data.<sup>43</sup> They also compared codes against codes to identify overlap and substantive differences.<sup>43,44</sup> Throughout the coding process, they wrote memos to describe different dimensions of a code (see appendix). DB and KC managed qualitative data and memos in ATLAS.ti. They also created profiles for each participant and reviewed profiles to balance the participant’s unique story with commonalities across participants. DB and KC connected with the research team twice a month for updates and peer critique.

An advantage of our inductive approach to research was its flexibility and permission to follow leads that we saw in our earlier broad sweep of the data.<sup>43</sup> Recognizing that the Theory of Gendered Organizations provided a lens through which to understand the stories of our participants, we moved up a level of abstraction later in our analysis.<sup>44</sup> To that end, DB and KC clustered similar codes into categories that were informed by sensitizing concepts from two levels of the Theory of Gendered

Organizations: informal workplace interactions and organizational structure.<sup>35,36</sup> Following Acker's lead, they conceptualized informal interactions as workplace conversations and inferences that are intentionally or unintentionally gendered – typically being treated differently or being stereotyped. They conceptualized organizational structure (or “organizational logic” in Acker's terms<sup>34(p. 147)</sup>) as formal expectations and policies in place at AMC because they speak to organizational arrangements. As Acker notes, organizational structures have material forms such as written rules about work, labor contracts, managerial directives and the like.<sup>34,37</sup> In addition to codes categorized around these two levels of Acker's framework, DB and KC constructed a third category of codes from the data pertaining to how participants actually navigated informal workplace interactions. The research team did not observe substantive differences in code categories between women who participated in the workshop series and those who did not. Therefore, they analyzed the dataset as a whole.

## Findings

Thirty women faculty at the study AMC participated in this research. As displayed in Table 1, participant age, rank, department, and academic track (80% were on a standing faculty track) varied. Despite this diversity, all participants spoke from at least two decades of experience in academic medicine.

In the following section we illustrate how AMC functioned as a gendered organization at two levels: (a) formal expectations and policy and (b) informal workplace interactions. We focus on how gender inequity was experienced in the disjuncture between these two levels as it relates promotion and salary. We also describe how women navigated gender inequity in ways that leveled the playing field for women.

### Functioning of a gendered organization

#### Promotion in standing faculty academic tracks

Similar to academia at large, scholarship was the main criteria for the promotion of standing faculty positions in the school of medicine housed at AMC. As AMC's promotions guidelines detailed, administrative, service, and clinical contributions were thoughtfully considered but scholarly merit was primary. Nonetheless, participants experienced informal interactions that privileged the promotion of men, even though formal expectations and promotion policies were intended to be solely merit-based.

*I never really paid much attention [to academic tracks] because they stuck me on a non-tenure track even though I had all these NIH grants and everything else. All the men whose CVs looked like mine went from non-tenure to tenure, but every time I would talk to someone like maybe you should put me up for tenure, they looked at me like I was crazy. (ID 315)*

This participant experienced her gender, not her merit, as prohibiting her from being on the tenure track. Another participant encountered the stereotype that women needed to be cared for and given well-intended but gender-specific advice about the timing of promotion – “bias masquerading as paternalism” as she said. Being married to a male faculty of similar seniority at AMC, she had a unique perspective on gendered promotion practices.

*Every year I'd meet with [promotions officer] who'd say, “Oh, you're close. You just need a couple more publications.” I'd say, “No, you told me that last year and I did it.” And every year, the bar would get a little bit higher. I knew where I was at compared to peer institutions, too... But here's the thing: my husband never had any of that. He went up on time for promotion and there was no problem at all. (ID 318)*

As their careers progressed, participants navigated informal interactions by advocating for their own promotion. For instance, the participant who compared her situation to her husband's advocated for herself by collecting data about promotions at peer institutions, something her husband did not need to do. Participants also advocated for the promotion of younger women. For example, those who now sat on promotions committees took a stance for junior women faculty:

*I rock the boat on the promotions committee all the time, and people are looking at me. I will tell you as recently as two years ago, I was reading the CV of an incredible woman. I didn't know if she was tenure or not, but she was a fabulous researcher. Her CV looked incredible. I was reading her letter for promotion written by her division chief. Her CV stood alone; it didn't matter what sex she was. But this promotion letter talked about what a lovely woman she was, how many children she had, and that despite all of this, she was a PTA mother... I said to the committee, “Have you ever read a letter about a man that says he coaches Little League when he's got 50 first author papers in the field?” (ID 302)*

In sum, formal expectations for promotion were intended to be gender neutral, but participants experienced informal interactions related to promotion as being treated differently than men and/or being stereotyped. This disconnect is an example of how AMC functions as a gendered organization; in other words,



how gender inequity is maintained and reproduced. Nonetheless, participants worked to disrupt this reproduction of inequity and act as levers for change when they used their seniority to influence the promotion process for other women.

### **Salary of women faculty across academic tracks**

Like most organizations within academia, AMC had equal opportunity policies in place to prohibit unlawful discrimination based on gender and was committed to equitable opportunities for employment. Nonetheless, participants spoke of salary differentials as characteristic of misalignment between formal expectations and informal interactions. One participant recalled a conversation about her starting salary where she confronted the stereotype that married women should not be paid more than their husbands:

*I met with the Chair and said, "What does the person who gets \$175,000 versus \$170,000 look like? Where did I go wrong?" He didn't have a good answer. He was like, "Well, you know, we would only give that for assistant professor, not instructor." I said, "Good news, I'll be appointed as assistant professor." ... Then he said, "Well, what does your husband make?" I almost fell off my chair. I said, "I'm not married and it's irrelevant". (ID 313)*

Faculty salaries were not disclosed at AMC, thus salary differentials often came as a surprise to women who inadvertently found out how much their male colleagues were paid. One participant shared her story about the discrepancy between formal expectations and policy on one hand and her own experience on the other.

*I had a colleague who was finishing off paperwork, and I was finishing my notes. We were just wrapping up and he brought up something about his salary. He was five years junior to me and he tells me his salary and, in this big organization, salaries are a hidden deal here. When he told me his salary, I started shaking because he was paid \$15,000 more than me ... How can you talk about being fair if you're not paying the woman the same as the man? (ID 316)*

Participants navigated informal interactions by having difficult conversations with leadership, even if that put them in a precarious position of threatening to leave the institution and uproot their family. The participant quoted above advocated for herself when she mustered the courage to "demand an increase" in salary from her department chair. She advocated for others when she called for salary transparency: *I think empowering women is fake unless you bring transparency and bring their salaries in par ... How can you talk about being fair if you're not paying the woman*

*the same as the man?* Other participants acted on behalf of younger women faculty when they were in positions to address salaries. Recalling her own experience of salary inequity, one participant said:

*There were people who said they cared about equity and pay, and when I got all the salaries, I realized my salary for years was way lower than tons of other people ... So one of the first things I did [in leadership position] was give some women a raise. (ID 312)*

In sum, although formal expectations related to salary were intended to be gender-neutral, informal interactions advantaged men. Again, this disjunction is an example of the maintenance and reproduction of gender inequity within AMC. Participants navigated these interactions by advocating for equitable salaries for themselves and for other women and calling for salary transparency.

**Shifting perspectives.** Recalling their earlier careers, participants often described themselves as being naïve or too busy with the demands of work and family to notice gender inequity: *It wasn't anything that I suspected or felt early my career. I was so focused on being that junior faculty member, on doing these things, and meeting these milestones that who even thought about it?* (ID 106) However, perspectives shifted over the course of careers. Another participant observed:

*I don't know whether I was just like asleep for the first 20 years of my career or what, but I had always felt that my own career path had not been impeded by the fact that I'm a woman ... It's almost embarrassing to say but I didn't even see it; you get socialized to think that it's normal behavior. (ID 305)*

This perspective shift typically occurred after a period of self-doubt, the veracity of which was rarely discussed or explored with their peers. One shared, *"I kept asking myself, is it just me, or is there gender bias? The worst part is that women don't talk about it because nobody wants to be in that place."* (ID 106) The persistent discrepancy between formal expectations and policies, and informal interactions within the organization, provoked a gradual recognition of AMC as a gendered organization. Participants became aware of *"the way things are stacked"* within the organization. Subsequent to that shift, they advocated for themselves and younger women.

*I have gotten better over time at speaking up, because now I'm in positions where there are people who I think need to hear what I have to say and they're not necessarily hearing it ... I find I still have to be careful in terms of when I start to introduce that and how I introduce it. But I think I'm starting to have some impact in the rooms I'm in. (ID 317)*

In sum, participants shifted from baseline unawareness to a recognition of AMC as a gendered organization when they moved through their careers. More than coping, participants advocated to level the playing field for themselves and other women faculty.

## Insights

We used interview data from women with established careers in academic medicine to demonstrate the ways in which AMCs function as gendered organizations. Although we did not set out to explore such inequity, all but two of our participants shared career experiences in academic medicine that provided evidence that gender inequity was embedded in the organization. Guided by the Theory of Gendered Organizations, we offer two primary insights. First, gender inequity at the AMC we studied functioned via a disjuncture between formal expectations and informal workplace interactions. Second, for our participants, a recognition of AMC as a gendered organization developed over the course of their careers.

In our study, formal expectations, which were intended to be gender neutral, left intact informal interactions that were experienced as inequitable. Consistent with the Theory of Gendered Organizations,<sup>34–36</sup> this disjuncture contributes to the maintenance and reproduction of gender inequity. For promotions, merit was the presumed gender-neutralizer that appeared in formal expectations and policy. But participants described informal interactions that detached the promotion process from merit: that is, they experienced differential treatment (e.g., not being considered for tenure despite equivalent scholarship) or stereotypes (e.g., needing to be cared for). For salary, the policy language of nondiscrimination made it seem as if salaries were equitable. Yet here too, participants experienced informal interactions in which they were treated differently than men (e.g., being paid less than junior colleagues who were male) or stereotyped (e.g., making a lower salary than one's husband). Importantly, formal expectations and policies that are incongruous with informal workplace interactions can create an organizational culture that distinguishes between men and women and allows masculine values to perpetuate, even if that is not the intent of organizational leadership. The disjuncture between formal expectations and informal interaction that perpetuates inequity must be made visible for organizational culture to change.

We add to the literature on gender inequity in academic medicine by leveraging a theory from Gender

Studies. Specifically, the Theory of Gendered Organizations has been applied to academia and could be instructive for academic medicine in a US context.<sup>38,40,41,45–49</sup> Our findings echo the few studies that use this same theory in the context of Dutch academic medicine, where gender inequity was evident in instances like exclusive male networks that negatively impact the hiring of women, even when national legislation requires open, transparent recruitment practices.<sup>40,50</sup> Using the Theory of Gendered Organizations embeds our research within a larger body of knowledge. We add to the literature informed by this theory by demonstrating that awareness of gendered organizations grows over the course of a woman's career, at least in the context of academic medicine. As more senior faculty, the women in our study experienced marked shifts in the socio-cultural landscape in general and organizational culture in particular. As a result, their ability to describe their experiences of gender inequity was especially robust. Subsequent to increased awareness, they acted in ways that reduced gender inequity. Our data suggest that women with established careers in academic medicine do not simply cope as other studies suggest.<sup>26,28,30</sup> Instead, they advocate for themselves and junior women faculty by trying to counteract or offset the impacts of gendered systems.

There have been multiple calls to address gender inequity in academic medicine by implementing change at the level of the organization, rather than “fixing” women.<sup>1,51–63</sup> Our study illustrates the complex undertaking of organizational change. To be successful, change strategies must resonate with women's experiences.<sup>64</sup> Revising policy statements can be part of a plan to communicate an organization's formal expectations for gender equity,<sup>65</sup> but it is not enough. An important lesson learned from our data is this: unless consideration is given to how formal expectations and policies are enacted, the problem of inequity is pushed underground where it persists. Therefore, strategies to promote gender equity must be implemented across multiple levels of the organization.<sup>64,66,67</sup>

Our study also illustrates the power of counter-narratives: stories that splinter what has been widely accepted as truth. Sharing these types of stories could be instructive for trainees and younger faculty, to the extent that they provide a narrative that runs counter to what has often been reported about women coping with the existing systems.<sup>68,69</sup> To this end, future research should explore how women play pivotal roles in restructuring gendered organizations like the AMC.

We hope our qualitative study is a starting point for more theory-based research on gender in academic medicine, particularly theories from Gender Studies. At the same time, we acknowledge that findings from a single institution (one with a track record of supporting women faculty) can limit transferability of findings. Future research should go beyond exploring the formal expectations and workplace interactions of a gendered organization; an institutional ethnographic approach that captures things like individual identities and organizational culture, as well as formal expectations and informal workplace interactions, might be the next step. A greater limitation may be that for reasons of confidentiality in a single site study, we did not ask participants about their gender or other social identities. Going forward, research informed by the Theory of Gendered Organizations must engage with the messiness of intersectionality and differences in how women understand being a woman.<sup>52,70</sup>

Using interviews from 30 women faculty with established careers in academic medicine at one AMC, we demonstrate how informal workplace interactions misaligned with formal expectations. The latter were gender-neutral, the former were not. These women came to understand gender inequity as embedded in the organization and navigated gendered interactions by advocating for themselves and for junior women faculty. Using the Theory of Gendered Organizations as an analytic lens, we demonstrate how AMCs function as gendered organizations and provide insight into mechanisms that can make AMCs more equitable for women.

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## Ethical approval

The study was approved by the institutional review board at The Children's Hospital of Philadelphia, May 3, 2018, IRB 18-015059.

## Previous presentations

This research was presented at the Northeast Group on Educational Affairs Annual Conference, April 5, 2019, Philadelphia, Pennsylvania; Association of American Medical Colleges, November 12, 2019, Phoenix, Arizona.

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**Appendix.** Sample of codes and corresponding memo.

Code	Excerpts of memo
Advocating for women	Code created [date] – <i>Advocating for women</i> signals instances when women advocate for each other, when they take a stand either locally or nationally. For instance, one participant gives “#MeToo talks” at her specialties’ national conference. Another works one-on-one with male colleagues in her department to help them understand of how their evaluations of post-doctoral trainees may be biased in favor of men, if they expect all trainees to be “self-assured”. Unlike coping, advocating is an active and outward process. Advocating for women is not without risk. Women can “speak up” but not so much that they are dismissed by male colleagues
Lip Service	Code created [date] – <i>Lip service</i> was created in response to participants’ use of the actual phrase. It signals when what is explicitly stated in policy or formal documentation does not match one’s experience. For example, one participant talked about an email that described AMC as a female-supportive institution. She responded sarcastically, “Really? Are you serious? I guess I did not get that memo.” <i>Lip service</i> gained salience in light of Sharon Bird’s work on incongruous bureaucratic structures. She points out the disjuncture between formal policies in academia that intend to “undo gender” or promote equity on the one hand, and the trickle down, informal practices that “do gender” or promote inequity on the other.