A Longitudinal Curriculum to Address the Gender Gap in Physician Leadership

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Setting and Problem

While women make up more than half of entering medical school classes, the majority of leadership positions in academic medicine are held by men, including 85% of medical school deans and department chairs and 75% of residency program directors. There are many theories to explain the gender gap in leadership, including timeline and pipeline issues, a dearth of female role models and mentors, and women prioritizing family obligations. The authors sought to understand the underlying issues better and address these challenges.

Intervention

The authors' family medicine residency program accepts 12 residents per class, with 5 to 7 women per class over the past 3 years. The Growing and Inspiring Resident Leadership (GIRL) curriculum was created and evaluated as a part of a 2010–2015 US Health Resources and Services Administration (HRSA) training grant. The curriculum promotes development of leadership skills in residents of both genders, but specifically targets female residents. Focal areas included awareness of leadership opportunities, understanding organizational dynamics, conflict resolution, negotiation skills, mentoring, and personal wellness.

The curriculum also includes:

1. A yearly networking event: Female faculty and residents are invited to an annual informal social event at the home of a faculty member. The goals include introducing incoming residents to potential faculty mentors and increasing relationship-building in the nonprofessional setting.
2. Longitudinal leadership workshops: Led by female faculty, these 1-hour workshops include role playing, simulation scenarios, panel discussions with local expertise, and networking opportunities.
3. Faculty mentoring: Faculty members are asked to intentionally seek out residents who share their aspirations and offer career counseling and skill development.

While the curriculum is especially tailored for female residents, male residents are also encouraged to attend the workshops.

Outcomes to Date

Attendance at group events has ranged from 15 to 21 residents (55% to 65% women at the workshops). Women and men have added valuable personal reflections and discussion points at all sessions. Faculty members have estimated their time commitment to be 4 to 6 hours per year, considering preparation, presentation, and mentoring efforts. Although faculty participation is essentially voluntary, the HRSA grant provides some salary support for faculty.

As part of a survey of all graduating residents administered since 2011, residents were asked about the GIRL curriculum. We asked residents about their agreement with 9 questions asked about leadership training and use of leadership skills during residency. Residents indicated strong agreement with statements about the adequacy of leadership training, availability of female leadership models (4.7, Likert 1–5), comparable effectiveness of male and female leaders (4.9), and male and female leaders being equally represented at the institution (4.9). The sole question with which respondents disagreed asked whether they wished they had received more leadership training during their residency (1.4).

We also asked open-ended questions regarding desired leadership skills, whether they received adequate training in these areas, and valuable lessons learned from their role models in residency. Responses were used to refine the curriculum, including content identified by the residents, such as public speaking, listening skills, burnout prevention, and conflict resolution. Feedback from residents has been uniformly positive, and we plan to extend a similar program to junior faculty.

Conclusions

To address the leadership gap in medicine, it is critical that interventions be evaluated to determine their impact. We continue to evaluate this program with various measures and larger samples of graduates, and we will explore whether this training has lasting effects among alumni several years after graduation. We hope to collaborate with other specialties within our institution, where gender gaps

are even more pronounced, as well as other departments of family medicine across the country.

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New Ideas

Morbidity, Mortality, and Improvement—Moving Ideas Into Action

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Setting and Problem

The morbidity and mortality conference has a long-standing tradition in internal medicine training. Cases are typically dissected in an open forum with instructions that the discussion must not leave the room. Unfortunately, it is quite common to encounter the same type of cases repeatedly through the years. In these instances neither the discussion nor an actionable plan for improvement likely has left the room. Without a driving force connecting academic discussions to improvement, the traditional morbidity and mortality conference format may not prevent errors from recurring.

Intervention

At the University of Cincinnati Internal Medicine residency, we have rebranded the traditional format into a focus on Morbidity, Mortality, and Improvement (MMI). Residents rotate at the University of Cincinnati Medical Center and Veterans Affairs Medical Center, and chief residents hold MMI conferences at both sites. After each conference, the chief residents gather residents, faculty members, quality improvement/patient safety experts, and other interprofessional team members to determine an action plan to improve the problem discovered during the conference. The chief residents emphasize improvement concepts throughout the MMI case discussion, and share initial plans for improvement after the case is reviewed. At the subsequent MMI conference the following month, chief residents share

their work and the initial improvement results. Many projects take longer than a month to complete, and the chief residents typically provide updates of multiple projects at each MMI conference.

Outcomes to Date

The MMI process has led to multiple improvement projects (TABLE). In 1 example, the problem consisted of a code blue situation that was conducted suboptimally with regard to advanced cardiac life support protocol use, poor communication used by the senior resident leading the code, and poor overall team interaction. In response, we designed and implemented the Emergency Response Rapid Review Course (ERRRC). After analysis of the MMI case, it was felt that although each interprofessional team member knew his or her role, the team functioned poorly because they had not actually practiced together as a team, a common problem for code teams in teaching hospitals. The ERRRC was created to rectify this. On the first day of every month, the chief residents gather resident ward team members, nurses, respiratory therapists, and ancillary staff in the simulation lab to navigate a code/rapid patient simulation and practice together as a team. The chief residents also conduct mock codes on the floor that include residents and other members of the interprofessional team.

In another example, the MMI conference reviewed medication order errors made by resident teams. After review, it was felt these errors could have been prevented had there been a daily standardized review of patient medications by providers. In response, the improvement team implemented a “Medication Review is the 5th Vital Sign” program that uses a checklist technique to assist team members in reviewing a patient’s