Development and implementation of the Women Leaders in Medicine Program at a multispecialty health care system

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ABSTRACT

Physicians in the USA are experiencing burnout symptoms at alarming rates, with women surpassing men. Many modalities are used to combat burnout. Leadership training is one proven strategy. Baylor Scott & White Health developed a program of systematic leadership development with quantitative and qualitative surveys and feedback from the 200 female participants of the pilot year. The Women Leaders in Medicine Program invited all Baylor Scott & White Health female physicians in both Central and North Texas to leadership training, which focused on (1) peer networking, (2) leadership skill building, and (3) mentoring, advocacy, and sponsorship with system leaders. The program was well received and highlighted the need for more in-person networking and skill-building opportunities for this demographic. Based on the data collected, the investigators are confident that this program is feasible for replication in diverse clinical settings for all female physicians.

KEYWORDS Burnout; female physicians; leadership

According to a recent report, 19.8% of physicians plan to reduce their clinical work hours within the next year.¹ Female physicians are experiencing job burnout at a higher level than their male counterparts.^{2,3} Regardless, female physicians' lower patient mortality, complication, and readmission rates^{4,5} demonstrate their understanding and application of high-quality, cost-effective care. Although women represent half of physicians entering practice, their growth in leadership positions lags.⁶ Evidence shows that leadership development programs, peer mentoring, and social support can promote personal and professional growth of female leaders in medicine and reduce burnout.^{2,7–10} Developing leaders with less burnout has a positive effect on teams, as evidenced by a Mayo Clinic study of 2800 physicians that found that each one-point increase in a leadership score resulted in 3.5% less burnout among physicians they supervised.^{11,12} Morahan et al summarized the importance of culture change to long-term sustainability in the advancement of female physician leaders.¹³ Baylor Scott & White Health (BSWH) created a focused leadership development program, Women Leadership in Medicine

(WLiM), as a tool to fight burnout among female physicians. Herein, we describe WLiM's pilot year. Its success was built on female physicians from all specialties formulating collaborative connections, gaining specific leadership skills, and advocating for themselves and their female colleagues.

METHODS

BSWH is among the USA's largest nonprofit integrated health care systems, and its service area is the largest in Texas. The business structure of the organization divides the 6000 employed and affiliated physicians into two units: The Central Division (CTX) has 1261 fully employed physicians (472 women), and the North Division (NTX) has 1124 physicians (546 women) through the HealthTexas Provider Network and 3675 affiliated physicians. No department, division, or specialty was excluded.

A program development survey was delivered before the program launched. Survey items included (1) interest in short- and long-term personal leadership development, (2) interest in WLiM, (3) participation in a private social media

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page, (4) organizational support of leadership development, and (5) barriers to leadership. Survey results aided in preparing the program's agenda and session topics.

The CTX board of directors provided seed funding for the pilot program. All clinical department chairs endorsed the program, and more than 80% of chairs and C-level leaders attended the networking session of the WLiM pilot. Participating physicians received four to six continuing medical education credit hours for participating in the half-day or full-day events and were allowed to utilize education time to attend.

Program development and evaluation surveys collected quantitative and qualitative data on the program and leadership topics. Quantitative data were analyzed with descriptive statistics. Responses to eight open-ended questions were combined in a categorical analysis. Researchers first coded individual responses via the emergent process, then created categories, and finally addressed incongruencies and agreed on final themes/categories for the open-ended questions.

RESULTS

More than 200 female physicians from both divisions attended at least one in-person program (216 in CTX and 26 in NTX) in the pilot year. The initial program development survey, conducted only in CTX, had a 38.7% response rate (184 of 476 female clinicians). The second program evaluation survey 6 months later had response rates of 28% in CTX (132 of 470, all fully employed) and 10% in NTX (95 of 929, including fully employed and affiliated. The denominator changed because these were actual numbers of employed physicians at different points in time.)

Using the survey results, the program was developed around three main objectives: (1) facilitating peer-to-peer support and networking, (2) building leadership skills, and (3) enabling mentorship, advocacy, and relationships with leaders. These objectives were achieved during the leadership summit events.

Post-leadership summit surveys (70% response rate) resulted in ratings of superior and above average for content (96%), facilitator (90%), and venue (69%). Respondents requested future program topics such as maintaining work-life balance, following a roadmap to leadership, managing conflict, dealing with sexual harassment, exploring various paths to leadership, discovering joy in leadership, and working in a male-dominated profession. Evaluation results suggested that enthusiasm and optimism continued to increase from the first instance to the second instance of the program, indicating a short turnaround time on investment.

Response rates varied for the open-ended questions, ranging from approximately 30 to over 80 items to code per question. The resulting categories described, summarized, and captured the essence of participant responses. Responses were coded until saturation, and disparate responses were not categorized. Several categories were shared across questions. Fourteen categories were found in the responses to the eight

questions: (1) assumptions, (2) family, (3) gender bias, (4) opportunities, (5) promotion of what is available, (6) representation, (7) support, (8) changing times, (9) appreciation, (10) skills/knowledge, (11) work-life balance, (12) burnout, (13) camaraderie/networking, and (14) initiative.

In the program development survey, one question asked about support of female leadership: *Do you feel that our institution is supportive of women who wish to advance to leadership positions?* Representation was identified as a category due to the number of participants referring to some aspect of representation to illustrate their feelings of support. For example, more than 25 participants commented on female physician representation within their department or unit. Instances of female representation were noted in comments such as, "Many women in [the institutional leadership program], but not many female medical directors or department heads." Most comments in this category focused on the lack of female representation: "There are no female leaders in my department and it does feel like the leadership is grooming only males." The second category (opportunities) included 17 responses that had both positive and negative connotations. Respondents believed that leadership's support was directly related to opportunities available to women. One respondent commented, "I've been give[n] personal opportunities and taken two of them." Additional categories that surfaced from this question were assumptions, gender bias, family, changing times, and promotion of what is available. Interestingly, fewer than five respondents saw release time from their clinical responsibilities (support) as the largest barrier to participating in leadership.

In the second question analyzed, participants illustrated their stance on whether women in leadership were supported by the organization with specific examples, which yielded similar categories to the previous question. Twenty-four participants focused on representation and 16 on opportunities. Comments about representation centered on a lack of female representation in physician leadership, especially at the highest levels: "While the administrative and C-suite positions at my primary facility are mostly held by women, this is not at all the case on the physician leadership side." The 16 comments on opportunities were mixed: "I feel like I have been given many opportunities. ... However, often when I look around the table at the meetings/committees I attend, I still see older white men as the chosen physician leaders."

In the initial post-program evaluation to determine the program's usefulness, participants were asked to share two take-away points that they would apply to their life or share with others. Many comments were categorized as skills/knowledge. For example, one respondent commented, "Thanks for providing a clear pathway in dealing with sexual harassment/hostile work environment." Other comments emphasized the categories of burnout, initiative, and opportunities.

Another question in the initial post-program evaluation asked respondents to "share what you believe this group does for you either personally or professionally" as a way to

determine the direction of the program. More than 30 responses fell into the camaraderie/networking category. The comments highlighted satisfaction with and inspiration from interacting with other female physicians. One participant noted, "This group does make me want to pursue leadership in the future." The remaining responses included the categories of initiative, burnout, and self-awareness (skills/knowledge).

In considering the future of the program, participants were asked how the program could serve the group. Two major categories emerged: skills/knowledge (26 responses) and camaraderie/networking (18 responses). In terms of skills/knowledge, multiple participants stated that leadership skills training is needed. Subcategories of leadership skills mentioned were management and negotiation skills. Comments placed in the camaraderie/networking category included those that highlighted the need for more networking: "I like these events—they provide connection." Other comments included a request for resources to mitigate burnout and additional mentoring opportunities, which were not grouped into categories.

Finally, in the post-program evaluation, general feedback was sought via three open-ended questions. A total of 39 responses were grouped in the appreciation category: "This is so important for our system. Keep it up to be the catalyst for change." Other comments highlighted gender bias. One respondent commented, "Referencing the 'one' female from past does NOT mean the organization has always been progressive." Another respondent stated, "I'm concerned that setting up a separate 'women's leadership training program' will be seen by the men as somewhat of an affirmative action type joke. ... To truly transform the culture, it's going to take more than a separate for-women-by-women program." The remaining comments highlighted the categories of work-life balance, burnout, and desiring more female mentors, involving younger faculty (representation).

DISCUSSION

The WLIM pilot was strongly supported across the organization. During program development, we identified physician engagement rates, self-identified leadership status, perception of organizational support, and female physicians' personal leadership development goals. The connections to leaders within a large organization that this program facilitated might not have occurred otherwise.

Post-program evaluation categories highlighted the importance of networking and camaraderie as well as practical knowledge and skills in areas such as burnout and leadership that the program provided. Finally, appreciation for the program was evident by the overwhelmingly positive comments and enthusiasm for future sessions. We plan to train 25% of BSWH's female physicians over the next 2 years. Because the goals and structure are relational, the budgetary ask for replicating this program is low. Furthermore, the cost savings in retention, high advocacy, engagement, and decreased burnout are significant.

Few studies describe the impact of interventions intended to improve physician well-being and work-life balance, particularly for female physicians.¹⁴ All BSWH physicians are offered the opportunity to take the Maslach Burnout Inventory, and we are monitoring movement on this scale in association with participation in WLIM and other programs. We are establishing a framework for data-driven anti-burnout program development across employment models. Future plans include (1) expanding the program to all BSWH female physicians across Texas; (2) including trainees; (3) tracking female physicians in leadership roles; (4) monitoring burnout and retention scores; (5) exploring WLIM's impact on female physicians with differing employment models, ages, external burnout forces, and independent leadership training activities; and (6) publishing our guidebook on recreating this program at any institution.

We believe that the initial framework described herein and future programming can be applied and replicated to every practice setting. Given BSWH's characteristics, we have the unique opportunity to measure engagement, burnout, and retention in various practices, geographic areas (from a city of 6 million to communities of 10,000), employment relationships, and specialties. We also believe that WLIM will contribute to leadership development and have a positive impact on female physicians at all levels of experience. Regarding sustainability, we have witnessed a culture change through engagement of administrative and physician leaders as well as a strong commitment to support the development of more female physician leaders. Long-term plans include assessing sustainability of primary outcomes, including career advancement in leadership roles and, ultimately, retention.

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