

Burnout in Female Faculty Members: A Statistic or an Opportunity?

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Abstract

Despite approximately equal numbers of male and female medical school graduates, women are entering academic medicine at a lower rate than their male colleagues. Of those who do assume a faculty position, female faculty members report higher levels of burnout, often attributable to gender-specific difficulties in clinical expectations and maintenance of work-life balance. Many of these struggles are attributable to issues that are amenable to supportive policies, but these policies are inconsistent in their availability and practice. This commentary presents evidence for inconsistencies in the day-to-day experience of female faculty members, and proposes solutions for the mitigation of the challenges experienced more often by female faculty members with the goal of diversifying and strengthening academic medicine.

Keywords

academic medicine, equity, gender, policy, burnout

Despite the fact that women are now graduating medical school at a similar rate to males,¹ fewer are entering academic medicine, and those women who enter academic medicine report high rates of burnout.² This burnout appears to originate from a reported inability to maintain a satisfactory work-life balance.³ Three components that have been reported to negatively affect a female academic physician's ability to establish and/or maintain work-life balance—child rearing responsibilities, patient demographics/patient access, and promotion/tenure—appear to affect women differently than their male counterparts. It is necessary to examine each of these components in order to understand the divergence of academic career paths when comparing men with women.

Approximately 75% of female physicians have children,⁴ and historically, women have more child rearing and home-making responsibilities than men.⁵ More commonly than not, it is the mother who brings the children in for well or sick visits, keeps the school agenda, and plans for after-school activities and child care. At the end of the work day, the mother is often the parent rushing home to make sure dinner is prepared, and homework is done on time. This is not to say that working fathers do not share in the working mother's stressors, or that the working fathers do not take part in child rearing and housekeeping. However, the working mother commonly takes a greater share of the burden.

This is true for the female academic physician as well. Striving for success at home while climbing the academic ladder at work can lead to greater fatigue and a lesser sense of well-being.⁵

The fatigue female academic physicians feel from striving toward this work-life balance is then compounded by the stress of caring for patients in the digital era while not forsaking the nurturing qualities many women naturally possess. The face of primary care is changing with all the advances in electronic medical records, patient adeptness at surfing the Internet, and smartphone applications. As a result, one can access their physician as easily as one can buy a pair of shoes on the internet, enabling patients to immediately consult with their family's primary care provider on every emerging health issue, no matter how minor. Although as a patient this is very desirable, the instant access puts a larger burden on primary care physicians. Female physicians, with their often predominantly female patient panel,² may carry an even greater burden because these

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female patients often contact their physician more readily and seek help more frequently than male patients do. Often socialized as women to communicate more verbosely, female physicians tend to “parent” their patients and build relationships,⁶ taking time to thoroughly reply to patients during visits and via electronic portals versus their male counterparts who more likely reply in brief messages thereby saving time that can then be spent on leisurely activities after hours. As a result, female physicians tend to spend more time working after hours—either returning to the office in the evening after their children have been cared for, or working remotely once other responsibilities have been fulfilled.

As the fatigue of maintaining a work-life balance combines with the stress and time consuming nature of taking care of patients in today’s world, working toward promotion/tenure often falls to the wayside for many female faculty. Although the number of women entering medicine is the same or greater than the number of men, the Association of American Medical Colleges (AAMC) notes that only 38% chose a career in academics and 32% of those hold the rank of associate professor or professor.¹ Women also only represented on 30% of new tenures between 2009 and 2014, indicating a disparity relative to their male counterparts.¹ This leaves those who seek more gender balance in academic medicine left to wonder; why is there such a gender difference in entry and promotion of those within academic medicine? In one survey, female faculty at the assistant professor level indicated that they thought promotion would not be of benefit to them and, more importantly, did not feel encouraged to request promotion.⁷ Furthermore, a greater number of female faculty members work part-time or at a reduced full time rate (75%-80% full time equivalent; FTE), and many take these reduced-time faculty positions to perform child care duties.¹ As such, they may not feel they can earn promotion as quickly as a full-time worker. More commonly, part-time faculty do not have the time or flexibility in their schedule to commit time to research and institutional committees, key requirements for tenure at most schools, thereby disadvantaging them relative to their full-time counterparts when being considered for promotion.

What Can Be Done to Make Female Faculty More Successful?

Women have been shown to be just as productive as their male counterparts⁸ and have been shown to be more effective in physician-patient communication,⁶ suggesting that the reduced number of women in academic medicine is undesirable for the practice of medicine. To increase the proportion of women in academic medicine, and in turn improve medical practice, more policies could be developed and implemented to reduce the stressors that female faculty face and barriers to their recruitment, promotion, and retention.

Some of these could include benefits for part-time faculty similar to those of their full-time colleagues, child care benefits, and greater flexibility in work schedules and in promotion timing.

Academic physicians and other full-time faculty work more than 50 hours per week,⁹ and these long hours are associated with burnout.² However, it is ethically and financially justifiable to provide full-time benefits to a faculty member working 40 hours a week, even if they are a 0.7 FTE. These benefits should include free, or subsidized, on-site child care with flexible hours of operations that mirror those worked by hospital employees who often work second or third shifts. While this benefit should be made available to male and female faculty alike, it could potentially help reduce stressors which manifest from traditional gender roles in child rearing. Investing resources for teaching and mentoring faculty on how to care for patients in this new digital age could also be of benefit. Time management training and even job counseling might help female faculty learn how to place value on certain aspects of their work, and help to set reasonable goals and expectations that are obtainable and even bestow positive reinforcement on the faculty member. Having flexibility in an institution’s tenure clock could also help female faculty be more successful in achieving promotion and tenure. For example, if the expectation is 10 years for promotion from assistant to associate professor, a faculty member at 80% time might be allowed 12 years to advance. Pairing female faculty with a male or female mentor who is more experienced might help guide that faculty member as she grows to become a successful clinician-scientist who presents regularly at scientific meetings or who publishes in scholarly journals. Finally, the creation of more specialized tenure tracks that put more emphasis on clinical and teaching effectiveness for physician faculty might prove to be a more reasonable standard for promotion versus a strong emphasis on research for physicians who lack the training, skills, and time to commit to an independent line of research.

Research thus far has proven that there is a significant disparity between the number of women and the number of men in academic medicine. It has also shown that the women who choose careers in academic medicine do not climb the promotion ladder as readily. Only recently has an effort emerged to determine the reason for this disparity, but most of the existing research is observational, cross-sectional, and lacking in scientific rigor. By bringing more attention to this disparity, we hope to encourage others to begin brainstorming ways to mitigate the disparity between men and women in the academic workforce. The AAMC has recognized this as a concern deserving of recognition and we have hope that these next few years will see an increase in rigorous scientific examinations of this pressing issue and policy solutions in an area where they are desperately needed.

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