Which Meritocracy? An Exploration of Gender Differences in Meritocracy Belief and Experiences in Relation to Advancement in Academic Medicine

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Abstract

This research contributes to the gender and medical sociology literature with two explorations: 1) a comparison of how men and women perceive the institution of academic medicine as a meritocracy and 2) linking these perceptions with a gendered comparison of academic physician's experiences with opportunities and challenges toward full promotion. In-depth oral history interviews with 30 tenured full professors at a large midwestern medical school were compared by gender. Both groups expressed a shared belief in meritocracy as the basis for advancement in academic medicine. Both groups described the culture of academic medicine as a male model. An informal internal social control mechanism used by physicians signaled the institution of academic medicine as a meritocracy by policing deviance regarding time spent at work as the notion of "hard work" as well as an ability to devote oneself solely to academic medicine. Using Reskins's (2002) critique of previous sociological research's inability to find mechanisms of how organizations reproduce inequality, this study establishes a mechanism of meritocracy belief coupled with vast gender differences in expectation for success, preferential treatment and sponsored access to advancement opportunities in academic medicine. This mechanism reproduces male dominance structurally and culturally in the institution of academic medicine. Male physicians claim academic medicine is a meritocracy but describe experiences in which they were given more advantages, such as easier access to mentors and sponsors, and put in positions of leadership in ad hoc ways. Male physicians reported few, if any, challenges in their experiences with promotion to Full Professor. Conversely, while female professors also made statements that academic medicine is a meritocracy, their experiences belied an institution in which they still struggle to persist against an assumption that they are culturally ill fit for success in academic medicine. They experienced far fewer advantages and

many more challenges. Male physician perceptions and experiences in tandem with female physician perceptions and experiences work together to reinforce academic medicine as a male dominated organization. Importantly, each gender perceives that what is happening to them is equivalent to what is happening to the others. Neither men nor women expressed recognition of the gendered differences in allocation of resources and the unequal opportunities for advancement.

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Chapter One: Introduction

I. Introduction and Statement of the Problem

Despite improvements in gender equity, a gendered hierarchy and a lack of equality as one moves up the academic rank continue to exist in academic medicine (Carr et al 2015; Jena et al 2015; Lewis et al. 2020; Pingleton et al. 2016; Richter et al. 2020; Riska 2001; Zimmerman 2000). Disparities in retention and the advancement of women persist. Moreover, there continues to be a gender gradient as one moves up in rank. Although women now make up over fifty percent of many medical school classes, parity to men at the full professor rank is stagnant at twenty-five percent (Bonsall, Bertram, and Cofrancesco 2020; Jeffee, Yan Yan and Andriole 2019; AAMC 2020). Entry to medical school for women rose sharply in the 1970s and 80s, and women reached equitable medical school graduation rates in the 2000s (AAMC 2020). Yet the disparity of fully promoted women is a stubborn trend. Over 20 years have passed where the rates of women should equal men based on time to full promotion alone. And yet, this gap in promotion continues.

Social researchers consider the causes for the scarcity of women among full professors and in medical school leadership positions to be a combination of multiple factors. The sexual harassment of women in medical school and as academic faculty creates hostile environments, putting additional pressure on women (Camargo, Liu, and Yousem 2017; Martinez, OBrian and Hebl 2017; NAS 2018). A dearth of representation of women in leadership roles in medical academia presents advancement challenges for women when they serve as tokens in male incumbent roles. Having more women in senior positions in an institution can encourage and provide increased opportunities for junior women (Carr et al 2018; Carr et al 2015; Pingleton et

al 2016). A deficiency of opportunities for women to be mentored in medical school and as junior faculty coincides with difficulty navigating the promotion process as well as fewer research experiences and publications (Cross et al 2019; DeCastro et al. 2013; Pincgleton et al. 2016). Additionally, inadequate preparation for leadership roles and negotiation (Ayyala et al. 2019; Sambuco et al 2013), unequal compensation (Carr et al 2015; Jagsi et al 2013), women's culturally expected role in childcare and family matters (Carr et al 2015; Halley et al 2018), as well as their subspecialty choice (Lorber 2002) have been cited as major contributors to gender disparities at the full professor level. For an extensive review of women in medicine, see LaPierre, Hill, and Jones (2016).

The medical field's espoused tenet of meritocracy is another factor that may be contributing to the gender disparity in positions of leadership in academic medicine. Meritocracy is a cultural idea, holding that a person will succeed if they work vigorously toward their goals (Lorber 1984; Razack et al 2020; Starr 1982). Confirmation that cultural support for the concept of meritocracy in academic medicine continues to be in evidence (see Frishman and Alpert 2019). Razack et al (2020) offer the opinion that gender was typically excluded from academic physician's narratives about merit. They contend that women's gender difference was seen as a problem to be fixed in order to align with merit because a male model stands in for an individual's achievements. Their argument is that what is called meritocracy in medicine is really just a proxy for the combination of ability, resources, and a variety of cultural, social, and class capital. Thus, it is argued, the concept of meritocracy in academic medicine is based on an implicit assumption of male-typed behavior and, as such, it is ascribed and not achieved. This supports Pingleton et al.'s (2016) assertion that women have to work harder in medicine to gain the same advantages in the male dominated environment. In their report on senior level women in academic medicine they

showcased how female professors of medicine negotiated the fine line between medicine as a meritocracy and medicine as an "old boys club." This term is used to connote a system of advantages based on gender favoritism instead of merit. Women are told that they will succeed if they work hard; however, the institutional environment, potentially without conscious recognition, confers advantages to men based on privileged networks and untested assumptions of competence. In such circumstances it is possible that women will see their failure to advance in the same numbers as men as personal, instead of institutional, failings. Given these hypothesized dynamics, it is important to consider the role of meritocracy beliefs in relation to the comparative advancement of men and women in medicine.

As an investigative topic, meritocracy has received less attention in academic medicine even though it is widely adopted as a cornerstone of institutional processes. Therefore, meritocracy as a gendered concept in academic medicine is an unexplored area of sociological research on gender inequity in academic medicine. Social psychological research suggests that women who experience a gender discrimination event are more likely to persist if they possess a belief in meritocracy (Foster and Tsarfati 2005). Knowing this presents an opportunity to advance the sociological literature by looking at the impact of how men and women in the medical academy view meritocracy as a process in their success as well as whether their career experiences bear out the principle assumptions of meritocracy. In other words, since academic women physicians have failed to advance to the same extent as men physicians, it seems reasonable to compare them on the basis of 1) the concept of meritocracy (e.g., Do male and female physicians perceive meritocracy similarly or differently?) and 2) how they have experienced meritocracy in their careers (Have men and women physicians experienced work conditions, work opportunities and advancement/rewards for work similarly or differently?). While there is increasing scholarly interest in gender and

meritocracy, it is difficult to find evidence of studies focusing on the profession of medicine. Therefore, in this study I conduct such an investigation, comparing male and female physicians in terms of both meritocracy beliefs and meritocracy related behavior and experiences. Exploring these questions may uncover, first, if there are parallel yet distinct processes of "meritocracy" that women and men experience in academic medicine and, secondly, if this can contribute to explaining the gap of achievement for women compared to men. It should be noted that while other intersections such as race, class, and sexuality are likely important, this study focuses on gender.

The investigation of meritocracy practices and beliefs vis a vis gender presents a potentially valuable research strategy given the apparent persistent gender differences in the career trajectories of men and women in academic medicine and the inability of the explanations offered to date to identify a compelling explanation for them. So far, no sociological studies surveyed have taken up this issue. We therefore have a limited understanding of why gender inequity and diversity in leadership operates in the trajectory of careers and how senior professors of both genders align with the idea that the medical academy is a rational meritocracy. Much of our current understanding has come from research focusing solely on the experiences of women, particularly those who left academia (Brod et al, 2017; Levine et al 2011; Martinez et al 2017). I have found no sociological studies comparing male and female narratives of challenges and obstacles to promotion, whether from junior professors or from those who have persisted and achieved full promotion rank. Most research on the persistence of women in academic medicine focuses on doctors at junior levels or those who have left academia altogether. This leaves the sociological literature lacking in understanding what those who have achieved full promotion say about their own experience. Additionally, no studies have yet investigated meritocracy as an ideology that possibly affects the reproduction of gender inequalities

in leadership for academic medical faculty. Without studying the compared narratives and perspectives of men and women who have succeeded, the ways in which the ideology of meritocracy may drive the reproduction of gender inequalities in academic medicine remain unanswered.

In sum, my study accomplishes two central objectives. It contributes to the gender literature on physicians by exploring and comparing the meritocracy beliefs and experiences of successful men and women professors of medicine. Second, it adds and examines an important dimension—meritocracy-- to research on the lack of advancement of women in academic medicine.

II. Conceptual Framework for the Study

This research is grounded in the Theory of Gendered Organizations (Balmer et al 2020). Organizational theorists such as Kanter (1977), Acker (1990), and Williams et al. (2012) posit that organizational structure is itself gendered, including the idea that the ideal worker is considered to be "gender neutral" but actually reads as "male". Even though organizations are seen as institutions that any person could interact within, expectations for workers form an abstract ideal type freed from family and community responsibilities, which historically conform to male as opposed to female roles. Some have argued that it is not a glass ceiling that discriminates and holds women back, but a "glass firewall" that permeates every part of the structure of an organization (Bendl and Schmidt 2010). Britton's (2000) question is relevant when she asks, "What does it really mean to say that an organization is gendered?" (pg 419). Britton (2000) agrees with Acker (1990) that organizations are gendered in that their ideal-type is constructed as male, but she also argues that organizations are gendered in that, most times, they

are gender *dominated*. Medicine is gendered both in the male ideal type and by male domination (Zimmerman and Hill 2006). Medicine has, like any other public professional realm, been touted as the rational, competitive, non-emotional and independent field well suited for men, as the cultural idea of what is masculine has coincided with these institutional traits (Lorber 1984; Sallee 2011). Medicine is male dominated precisely because of these assumed traits that are considered necessary for success (Balmer et al 2020).

Kanter's (1977) classic work on corporations and their structural organization of power relations and lack of gender equity in leadership positions illustrates how an organization can be labeled as a meritocracy yet contain hidden dynamics that result in inequitable valuation of workers, work, and subsequent gender disparity. Kanter found that women in the 1970s were considered (by men) to be inept for careers as high-level managers, and explanations given for this were that the men considered women to be one of three archetypes: the mother, the seductress, or the pet. In her study women were not considered ideal type workers but an interruption of business as usual and thus needing categorization as an "other". This kind of othering of women showed the lack of inclusion they experienced. Kanter's study also illuminated how women experienced a lack of opportunity for interesting or valued work assignments, and thus lacked the experience needed for promotion. Women who did receive promotions to coveted positions experienced the stress of being a token in that they were simultaneously a representative of their entire gender and an exception to it. Women who enter the "masculine" spaces of medicine today still experience this same type of tokenism (Sallee 2011). Varpio et al. (2020) found that men described their experiences toward full promotion in academic medicine as inevitable, while women described their experience toward full promotion as a "tenuous navigation" of challenges and obstacles. Acker (1990) states that even the

"meaning and identity (in the organization) are patterned through and in terms of distinction between male and female" thus echoing Kanter's (1977) findings that there are distinctions based on gender influencing outcomes of diversity in the organization. Evidence for these patterns and distinctions are reproduced in academic medicine.

Taken further, Acker's (1990) and Kanter's (1977) arguments explain how women are disenfranchised in the field of medicine and thus need to work against that disenfranchisement. Acker in her later article on inequality regimes (2006) outlines the ways in which an analytic approach to the intersections of race, class and gender is needed in order to subvert such regimes. Her argument that organizations are built on processes that reproduce race, gender, and class inequalities is a poignant one, and one we must utilize when understanding the organization and institution of modern academic medicine. She posits that the general requirements of the work are based on practices that obfuscate gender, race and class. Specifically, hiring and network practices of an organization reproduce inequality regimes because these practices are based on the idea that the best fit worker is one who can complete the work unabated and arrives highly regarded by others in the organization. Because "competent" is itself a judgement made by those already in power, the best fit worker will usually be a male (Acker 2006). Lorber (1984) names the underlying prejudices against women (that they are more family centered than work centered, or that they are mentally and emotionally weaker than men) in medicine an "informal discrimination" and states that this type of discrimination is harder to challenge as an individual. She outlined in her study of women physicians how they had to circumvent gendered expectations and sex role demands on their time and efforts. The female physicians had to negotiate the second shift and the expectations of their spouses and family, had to prove themselves competent in medical school, and mostly succeeded when they were sponsored by

well-established men. Subsequent feminist sociological work has identified and documented evidence in the labor force for a "motherhood penalty" (Budig and Hodges 2010) where women of all income levels experience a disadvantage in lifetime earnings due to lost wages during their child bearing years. For higher wage-earning women, such as medical academics, the evidence points to the contributing factor of lost human capital, which Budig and Hodges explain to be, in essence, missed opportunities for advancement. Varpio et al. (2020) found in comparative male and female narratives about medical faculty careers that women, but not men, discussed parenting as a challenging factor for their careers. In addition, that women in health professions still apparently need a male sponsor of their competency has also been established. LaPierre and Zimmerman's (2012) findings that male mentorship was a significant predictor of career advancement for women in healthcare management lays bare how men still hold the cultural and institutional power in the male dominated field of academic medicine. If a male colleague vets a female colleague, the signaling is that she is worthy of entre.

The gender effects of this invisible and informal discrimination are based on the pattern that men have been entrenched in networks for more time, have less competing family demands, have historically received an enhanced access to higher education, and, because of higher starting pay (Jagsi et al. 2013), they receive steeper pay grades throughout their careers. Lorber (1984) was less optimistic than Kanter (1977) that more numbers of women occupying a setting (in this case academic medicine) would directly translate to an increase in leadership positions for women. Despite her hope that things might change, the lack of gender parity in medicine has persisted well into the 21st century. This warrants a new understanding of existing gender mechanisms and how they work to affect the advancement trajectories and experiences of medical faculty.

Reskin (2002) argued for work inequality researchers to develop an understanding of how mechanisms of inequality at the organizational level of society reproduce differential treatment and allocations of favor. Work inequality research has focused on the *effects* of inequal treatment (like women's attrition in academic medicine); thus, the findings do more to describe the inequality based on sex and less so how the organization is built to confer privilege to dominant groups. She called on researchers to stop focusing on the *motives* that may contribute to inequality and instead seek out the processes by which these inequalities are reproduced and persist. Auster and Prasad (2016) argued that dominant organizational biases are to blame for women's inability to be promoted in institutions. Studying how a belief in meritocracy contributes to organizational inequality and bias may uncover parallel gender experiences in academic medicine.

Meritocracy as an American Cultural Ideal

Meritocracy has long been an American cultural driver (McNamee 2014; Mijs 2018) but the term, however, is relatively new. Even though it draws on a historical precedent in the North American culture of the belief in the American Dream, it was first used in 1958 by British sociologist Michael Young (Kim and Choi 2017; Young 1958). In Kim and Choi's (2017) comprehensive review of the how the term is used, conceptualized, and comprised they find that it is overwhelmingly considered a positive feature of the American national ideology. Often, the term is used as a proxy for the lack of discrimination (Lippert-Rasmussen, Kasper 2009). Specifically, Mcnamee and Miller (2014) identifies cultural attitudes about meritocracy to be about "innate talent, hard work, proper attitude, and playing by the rules." In the United States, the cultural idea of meritocracy is that when one steps into any setting, a person's status is not ascribed, it has to be

achieved. The added ingredient will be one's effort, and the outcome will be success based on the amount of effort. Thus, research that shows that a belief in meritocracy specifically correlates with a "lower engagement" with programs and efforts to create equitable outcomes for disadvantaged groups is unsettling yet unsurprising (Darnon, Smeding, and Redersdorff 2018). This can explain why researchers have also sought to explore how the cultural value of meritocracy has been used to circumvent diversity in the status quo of society's institutions. Often, the drum beat of meritocracy in the culture drowns out institutional attempts to put in place programs that would give marginalized groups an equitable toehold in institutions where a dominant group persists. A search for meritocracy in the sociological literature yields results mostly targeting race and admissions to higher education (Liu 2011). This is unsurprising, as the 20th century debate in higher education of affirmative action policies was paramount. As such an important cultural driver, it is important work to also look for the ways in which the ideology of meritocracy affects gender inequity in other institutions.

Alarmingly, Castillo and Bernard (2010) found evidence that when meritocracy was an explicitly stated ideology, male managers gave greater rewards to male employees over women with identical performance evaluations. They did not find this inequal treatment when meritocracy was not an explicitly stated ideology of the organization. This might render a clue to how meritocracy as an ideology can create dual gendered processes and create gendered outcomes. If one considers the meritocratic process of the organization to be value free, one will have no need to check their own hidden biases.

Meritocracy in Academic Medicine

If we seek to understand the link between meritocracy as an ideology and gendered outcomes in academic medicine, an understanding of previous work brings us to a starting point. While I have argued above that the concept of meritocracy is a fundamental element of the culture of medicine, meritocracy as a "sensitizing concept" (Blumer 1969) is woefully underdeveloped in the sociological literature on social behavior in academic medicine. However, Varpio et al. (2020) found while comparing male and female narratives of experiences with promotion to full that both male and female physicians described promotion as a result of "hard work". What *has* been established is how medicine has long been cultivated culturally by the male model (Zimmerman and Hill 2006). We can link medicine as a gendered organization built on the male cultural model with medicine as a meritocracy by examining a study on the academic medicine setting in which simple hard work does not exactly or automatically translate into success.

In an exploration of gendered processes in academic medicine search committees Van Den Brink and Benschop (2012) found that the search committees emphasized amount and prestige of publications alongside their assumption that women valued teaching more than research. Subjects in their interviews stated that they felt that men prefer to recruit, promote, and support "younger versions of themselves" because they see a likeness in the junior male medical academics. They also found that interviewees would state that a woman's niceness, her likeability, could either hurt her or bolster her in the medical professor recruitment process. Women must have likeability, as in, an ability to 'play well with others.' But, conversely, being "nice" made women seem like they weren't the type to "fight" for grants, promotion, etc. the way "a man would." In essence, a woman's efforts are being filtered through the male cultural model. Woman are stereotyped in this study to care more about teaching and less about prestige

research publications, are othered because they don't resemble the male dominant search committee, and are given impossible standards of likeability of nice, but not too nice. These findings by Van Den Brink and Benschop (2012) showcase not a blank slate playing field, but one that is laid with preconceived notions about a woman's fit in academic medicine.

Yet, it's important to know how women do, in fact, achieve success in the promotion trajectory. While not specifically in academic medicine, a report in the psycho-social literature lays a brick in the foundation for exploring women's success or failure to thrive in academic medicine. Foster and Tsarfati (2005) found compelling evidence of how an individual's belief in meritocracy affected their experience of gender-based discrimination. For the experiment, women were told that their failure on a test was because of their gender. The group of women who believed in meritocracy before their gender-based discrimination fared better afterwards on mental distress. The researchers argue this is because the women who believed in meritocracy saw their discrimination as more of a one-off event. Instead of thinking that gender discrimination is a pervasive experience, their belief in meritocracy enabled them to see the discrimination as one experience in a meritocratic system in which they could simply try again better next time. Conversely, the researchers contend that women who don't believe in meritocracy would likely see no point in trying again and again in a system that is rigged against them.

This finding in the psychosocial literature directly correlates to sociological findings of women in medicine. A handful of papers do explore how women in medicine utilize a belief in meritocracy even when they are faced with gender discrimination. In fact, these particular findings deal specifically with women who succeed in their fields, instead of those who exit before promotion. A survey of female surgeons by Webster et al. (2016) gave evidence for the

same psycho-social phenomena that Foster and Tsarfati (2005) found. They stated that women refused to acknowledge gender as a factor in their professional lives despite acknowledgement of gender differences in treatment (Pingleton et al 2016, Webster et al 2016). Compellingly, they both "affirmed and denied" gender as an influence in their experiences. Pingleton et al (2016) echoed this finding when assessing the oral history narratives of female physicians. In their study, some participants refused gender as a mitigating factor in their experiences, even with discussion of gender-based discrimination in their interviews. Studying women engineers, Carroll et al (2018) found this narrative of gender discrimination coupled with a loyalty to meritocracy. A steadfast commitment to the ideology of meritocratic achievement, then, may be exactly what propels some women in medicine to achieve senior promotion status.

These findings suggest it is imperative to explore meritocracy vis a vis gender in academic medicine, while also comparing the experiences of men in academic medicine. Understanding both how men and women conceive of academic medicine as a meritocracy paired with their experiences of medicine as a meritocracy will hopefully uncover if there are dual processes happening for women and men in academic medicine. While we know that women do have gender and sex-based experiences in academic medicine, we have yet to uncover the root cause of these differences. I argue that comparing meritocracy along-side gender will give possible insight into what is at work in keeping women from achieving equity in promotion.

III. Study Purpose and Research Questions

Despite a number of efforts by scholars to identify the problem and efforts to change the male dominated culture of medicine, problems persist. Much of the existing qualitative work about experiences of the medical academy come from the perspective of women who struggle to

persist or who leave the academy, and we know less about the broader experiences and perspectives of men--those that produce and reproduce the culture and the institution. Without data on their experiences and perspectives and how they differ or not vis a vis woman, we cannot adequately understand the root cause of the gender diversity problem in academic medicine, and we lack the insight to arrive at solutions to the issue. Quantitative work in this area focuses on predetermined problematic aspects of organizational culture, and I argue that qualitative work in this area will be more successful at capturing additional elements of the problem in order for gender diversity efforts to be more successful. Therefore, my study addresses these weaknesses by investigating the gender variance of experiences and perspectives of senior medical faculty to understand how they explain meritocracy and gender diversity in the setting of medical academia. While limited to successful individuals, studying senior faculty allows me to explore the entire trajectory of an individual's experience, comparing men and women up through the academic ranks. Understanding whether or not they see gender disparities as troubling will lend the scholastic body of work more nuanced theorization of Acker's (1990; 2005) abstract worker and whether Kanter's (1977) theorization of the way women are tokenized as organizational leaders still persists in this setting. In short, I again ask Britton's (2000) question, with a twist: what does it really mean to say that academic medicine is gendered?

The cultural message blatantly states: Be a good doctor and you shall get promoted. Yet the proportion of women that do not persist to full professor rank demands a closer look. Comparing the gender variance on how these professors of medicine describe medicine as a meritocracy, describe their own success in this field as based on meritocratic processes or not, and my assessment of the challenges they encountered as well as the institutional and interactional opportunities appointed to them seeks to uncover possible parallel processes working underneath the ideology of meritocracy.

Research questions

In this study, I will examine the following research questions:

1. How do perceptions and accounts of academic medicine as a meritocracy vary among senior men and women physicians?
2. How do career experiences of opportunity and challenge related to training and advancement among senior physicians vary by gender?

IV. Organization of the Dissertation

This introductory chapter lays out the basic focus and questions this study seeks to examine. It introduces the concept of meritocracy as a key sensitizing concept in the study. It also details a background of feminist theories of gender in the workplace and how organizations are gender typed, which can be subsumed under what is called the theory of gendered organizations. These premises guided both my research question and my analysis. After I provide a brief overview of the problems presented in previous literature on women in academic medicine, I state the research questions my study will address.

In chapter two, I outline more fully the historical legacy of the organization of academic medicine as a gendered institution through the historical construction of medicine as a place solely suited for men based on their assumed cultural traits. Next, I survey the literature of empirical studies regarding women faculty experience in academic medicine and the implications therein for the structure of academic medicine.

In chapter three I detail the methodology of this work as well as the sample demographics. A table of participant specialties is included. My interview guides are included in methodological appendices A and C.

In chapter four I report the findings and discuss the implications of how the academic physicians I interviewed see academic medicine as a meritocracy and how that cultural ideology shapes the professors' explanations and experiences of success. I discuss the issues regarding how meritocracy as an ideology in academic medicine creates a setting in which gender disparities dissolve in importance amongst the context of "being a good doctor." I found that these physicians spoke in meritocratic terms by signaling "being a good doctor" and "what it takes to succeed" as gender neutral processes, but when asked to explain how one can be a good doctor and succeed, the processes and experiences were often couched in gendered cues about emotions, availability, and fit.

In chapter five I present data and discussion on how these academic physicians experienced opportunities for mentorship, leadership, training and advancement. Men reported experiencing easier access to leadership and mentor experiences which, in medicine, are an absolute necessity for promotion. I also report data and discussion on the ways in which men and women experienced disadvantages in their careers. Women reported far and above many more and varied challenges in their careers than men. I present findings of the variation of challenges and obstacles experienced by gender. Women reported more experiences with sexism, sexual harassment in medical school and as junior faculty, more difficulty managing family and work responsibilities, and more instances of salary disparities. Women more than men reported medicine as an "old boys' club" that created boundaries around inclusion. Although men and women both reported hierarchical experiences in medicine, only women reported that they felt they had to work harder to overcome their challenges in the hierarchy.

In chapter six I conclude by discussing the theoretical significance of my findings on how gender and meritocracy beliefs produce a mechanism of inequality in academic medicine. I have included the limitations of this work, as well as future research needs on this topic.

Briefly, my findings were that both men and women reported academic medicine as a meritocracy. Both genders stressed the importance of a strong and supportive mentor to guide early professionalization. All participants keenly assessed the hallmarks of success to be access to opportunities for leadership roles, temerity in research goals and integrity as a medical clinician and academician. However, most (but not all) men were seemingly untroubled by the lack of gender diversity of their fully promoted peers. This was less of a disregard for women and more of their conviction that gender diversity had already arrived (or was very near to arriving). To be sure, some women echoed those statements. But in regards to opportunities for advancement in their field, women reported a path more muddied than men. And with respect to challenges to their advancement, women reported more blatant as well as insidious roadblocks than the men.

Chapter Two: Literature Review

I. Introduction

My investigation of the literature begins in section one with a brief historical overview of the sociology of medicine focusing on physicians and the profession of medicine. I then focus in section two on the review of the socio-historic literature on the struggle of women to become physicians in the male dominated profession of medicine. In section three I specifically call on the literature regarding meritocracy as an American cultural ideal, medicine as a meritocracy, as well as gender and meritocracy. In this section I also assess recent attention to the advancement of women in medicine. Section four is a review of the standard explanation given for women's lack of success in academic medicine. I conclude the review by arguing for an examination by gender of the meritocracy beliefs of full professors as a viable strategy for the explanation for the stalled advancement of women in medicine.

II. Brief Historical Overview of Sociology of Medicine Literature

The American Sociological Association created the medical sociology section in 1959 (Hankin and Wright 2010). At its inception, medical sociologists were interested in establishing connections between society and health that physicians found useful so as not to squander their utility to the medical field (Strauss 1957). The sociological perspective on the profession of medicine was dominated by a functionalist explanation for the role of the physician in society (Parsons 1951). Theorists such as Parsons (1951) argued that illness was a threat to the smooth function of the social order. Physicians were agents of social control and legitimization for the norms of what he termed "the sick role."

But the early work in medical sociology was not critical of the field of medicine (House 2000). Sociologists such as Merton (1957) and Becker (1961) focused on examining the institution of medicine and how health care settings were constructed. Merton's study of medical education was the first to examine the socialization of the medical student in the setting of medicine. Fox (1957) focused on how the sheer amount of medical knowledge to be learned as a medical student made mastery prohibitive, thus students of medicine must learn to live with a degree of uncertainty in their profession. Becker et. al's *Boys in White* (1962) followed suit as an ethnography of a cohort of medical students and their socialization. The very fact that this seminal work focused solely on the men in the medical class cohort and completely ignored the few women in the cohort gives a clear starting point to how women were ignored and left out even while existing in the same spaces as men. Bosk (1979), when seeking to understand social control and deviance in physicians, outlined how surgeons manage uncertainty in their profession, which he termed "medical failures." His assertion that physicians use internal informal mechanisms for group control built on Fox's (1957) addition to the conversation of how students are socialized in medicine. Because of the uncertainty in medical decisions, physicians must rely on norms of efficiency about time and work hours in order to manage expectations and the possibly of technical or moral errors in judgement. He found that physicians will reinforce the norms of efficiency in internal (doctor to doctor or attending to student) and informal (conversationally or in department meetings) ways. His study included stereotypes of each medical specialty, setting the stage for the demarcation of fit for a specialty that we still see today. As the investigation of the profession of medicine progressed, Freidson (1988) thoroughly examined how medical *knowledge* is constructed, legitimated, and distributed. He argued that far from being an isolated institution, and with highly developed knowledge apart

from society (and above society), medicine is very much a product of specific social constructions that have been historically and politically created starting with the industrial revolution. Like other professions, the institution of medicine has been delineated into roles (in a hierarchy of power) and has been affected by bureaucratization. The settings of medicine affect the behavior of the practitioners of medicine and the way that patients are seen. Doctors legitimate the act of being sick or well (Parson's 1951 *sick role*), and the behaviors that each status entails. Thus, Freidson's contribution was to elucidate the structure of the profession as a whole and to explain "medical knowledge" in a sociological way, investigating how power and legal authority has shaped the profession and those practicing within it. Following Freidson's lead, Starr's (1982) history of the profession of medicine laid out the historical developments by which physicians gained cultural authority in the United States. Yet as thorough as this text appears to demonstrate the timeline of the construction of institutional and cultural authority of medicine, any discussion in the accounting of this timeline of women's lack of inclusion is starkly absent. A review of these key classic sociological studies of the profession of medicine up to 1980 shows how even the scholars of medicine ignored and excluded women from the narrative of the profession of medicine. This "male only" lens reinforced the notion of medicine as male dominated both in number but also in ideology of fit.

III. The Male Dominance of Medicine 1865-1978

To locate the origins of the male dominance in academic medicine, specifically, it is important to survey the history of academic medicine itself. The American Medical Association (AMA), founded in 1847, was an effort to create a unified professional medical society in the context of secular medicine. This society conferred membership which came with a share of benefits. These

benefits included access to local and national networks of physicians, access to bank loans to establish one's practice, and access to the state licensing facilities.

However, sexism at that time was deeply entrenched in all parts of American society, and medical institutions and science were not immune. Historically, medicine was not a standalone institution as it is today. Healers of both genders were part of every community and had various expertise and specialties. Traditionally, women had been healers for their families, yet as allopathic medicine became a legitimated profession (of men), women were denied access to recognized and authorized roles in the newly minted structure (Morantz-Sanchez 1985; Roth Walsh 1977). As society in the United States and Europe became industrialized, medicine became divorced from the household and was placed under the domain of men only in the public sphere.

The AMA established precedence for the exclusion of women by writing the code of professional ethics such that no one without a formal medical education should be allowed to practice medicine. This ensured that the establishment of the medical field as a whole was a gendered project (Zimmerman and Hill 2006) because women were excluded from the contemporary medical education of the time (Starr 1982). The Flexner report, a nation-wide survey conducted in 1910 of the current medical schools, was an effort to establish a uniformity of professionalization of medical schools. Many of the schools that were shuttered because of Flexnor's recommendation were medical schools that were considered homeopathic and institutionally disorganized. On paper, these professionalization goals looked noble and prudent. However, the latent effect (and some argue, the intended effect) was that the reports caused the shuttering of most of the schools for women. The admittance pool was funneled into schools that were spared. These remaining medical schools admitted men only. Medicine is culturally male in that women are seen as an "other" outside of it,

argues Harrison (1972) so they were not allowed entre. Thus, the creation of the profession of medicine in the United States was a gendered project from its inception (Zimmerman and Hill 2006).

Understanding the cultural and structural societal drivers that propelled the gender bias in the AMA is important work in establishing the historical legacy of sexism in medicine. While women since the dawn of millennia have controlled reproductive activities, have healed their families and kin networks, and generally held vast medical knowledge, with the rise of the industrialized world, women were demarcated as belonging to the home and not to the public sphere. Medicine became a profession dominated by male doctors and paraprofessionals, with the exception of nurses being solely women (for a fascinating account of the way that Florence Nightingale assimilated women nurses into the male medical profession see Freidson (1970). The role of the doctor as the (male) keeper of medical knowledge and privilege was born. This institutional and cultural shift brought on by the construction of vetted medical school participants meant that health and medicine were no longer common knowledge but were now in the purview of a relationship with a male doctor. Doctors (male) were seen as the "supreme experts" in physical and psychological health (Freidson 1988).

Women who *were* able to access medical school were tokens, and the first woman to graduate medical school in 1849, Elizabeth Blackwell, was an anomaly most of her career (Roth Walsh 1977). Roth Walsh's (1977) book on women's denigration in medicine outlines how women in the late 19th and early 20th centuries were systematically excluded from medicine based on the idea that they were physically and mentally unfit for it. She puts forth evidence that women were freely and subjectively slandered in medicine. A physician and "anti-feminist" Dr. Edward Clarke published a series of talks about the problems of women practicing medicine. He argued that women physicians were physically inept to practice medicine because of their

monthly menstruation. To counter this, women physicians completed surveys about their menstruation and, with a representative sample, it was found that Dr. Clarke's claims were preposterous. Yet even with this evidence, women were still not taken seriously as physicians by their male colleagues until much later.

Consistently, women were denied entry into medical school for many years. Women attempted to gain the training and licensure necessary to practice medicine, but it was not until 1945 that every medical school admitted women (Walsh 1977). However, women did not passively accept the gatekeeping efforts of men to keep them out of the institutions of medicine. Barker-Benfield (2000) contends that men were terrified of female encroachment into medicine, and in protest a woman sat silently through the 1982 meeting of the medical society in which men tried to oust her. Many women endured years of harassment, belittlement, and tokenism even as the number of women in medicine grew (Conley 1998). As Riska (2001) says in her study about women in medicine, "Something happens to women during their training to become physicians that does not happen to the same extent to the men" (2001; pg 53). Contemporarily, we have equal medical school graduates but women are less likely than men to reach full senior promotion or to remain in academic careers (Carr et al. 2018; Jeffe, Van and Andriole 2019; Jena et al. 2015).

Following the trend of assessing medical student socialization started by previous scholars (Becker 1969; Freidson 1975; Merton 1957) Quadagno (1976) asked how women were socialized into the occupational structure of a career in medicine. Looking at the occupational culture of physicians, she examined the ways in which values influenced by culture and the social structures people find themselves in work to influence a doctor's choice of subspecialty. Her finding was that experiences in medical school for women in the early to mid-20th century,

when medicine was heavily male dominated, influenced them to choose certain subspecialties based on observations the women reported of other women who attempted to enter male dominated specialties and of women who chose to enter female dominated subspecialties. Female doctors who choose specialties that are amenable to women are given positive feedback from peers, while women are encouraged not to choose more "male" (especially surgical) specialties (Quadagno, 1976). Lorber's (1984) book on women physicians focused on a wider range of social, political, educational and economic barriers for women entering medicine, paving the way for sociological scholarship on women in medicine.

IV. Women's Advancement in Medicine and Meritocracy Beliefs.

Now that the sociological conversation of women's parity is no longer centered around the trend of their exclusion from the institution of medicine, the main concerns are women's advancement given the male dominance of the higher levels of academic medicine. Women have achieved parity in medical school admission and graduation, so the investigation of their slow advancement in leadership roles and the full professor rank is the logical next step for sociological research. It is also necessary to survey here the sociological literature of how the medical academy is constructed as a place of meritorious achievement.

The gendered organization of medicine as an institution has been discussed in chapter one of this dissertation, but a brief recounting of how this literature pertains to the advancement of women in medicine focuses the conversation of how women are othered in this male dominated space. Kanter (1977) and Acker (1990) theorize on male dominated spaces, both numerically and ideologically. Organizations are seen as value free, objective meritocratic spaces that are not inherently discriminatory. Women's attrition from these spaces, then, is seen

as their own uncoerced and independent decision based on faulty personal calculations or lack of fit. Additionally, feminist standpoint theory, first conceptualized by Sandra Harding (1986), posits that one's conceptualization comes from one's experience, and as women are marginalized in society, their perspective will include phenomena of which men are unaware. When men do not experience adversity based on their sex, they do not conceptualize lack of gender diversity as a key problem in the institutions of which they exist.

The second shift, theorized by Hochschild (1989) explains the social paradox of women entering the workforce en masse because of the sexual revolution, but how they are also still considered responsible for the work of the home and child rearing. Women in the medical academy, like so many other professions, have been held to stringent work standards based on the cultural assumptions about their gender roles of sole providers of child care and home maintenance. Benard and Correll (2010) found that women were indeed held to the "normative discrimination hypothesis" of professional women, in which they are seen as professionally competent but interpersonally possessing negative qualities such as being less warm and friendly because they were career driven but not family orientated. Going further, women with children in their study were seen more negatively, while male professionals with children were seen as possessing more warmth, disadvantaging professional women even more. Wynn (2017) found evidence that women with children expected that they would have less of a chance at promotion. Williams (2014) calls discrimination of mothers *descriptive* and *prescriptive* bias. Descriptive is when assumptions are made about working mothers that they are less devoted and competitive workers. Prescriptive is that cultural disproval both at work and in society exists for women who choose not to stay home with their children. And, there's evidence for women themselves constructing their choices between family and work obligations in a zero-sum fashion. Blair-Loy

(2003) found that women executives constructed narratives about their work and family life in an antithetical fashion. Women in her study either constructed themselves as work devoted or family devoted, and usually failed to reconcile both schemas of devotion (though they tried).

And this type of maternal discrimination is alive and well in the medical academy (Halley et al. 2018). Like all professional fields, the "motherhood penalty" (Budig and Hodges 2010) pointed out in chapter one of this dissertation holds true for academic medicine as well. Women miss out on advantageous advancement opportunities during their child bearing years that creates salary disparities their whole career. Crowley (2013) found that women in medicine were asked about future pregnancy plans in the hiring process even before they had children. Periyakoil et al (2020) investigated the microaggressions experienced by female medical faculty, establishing that female medical faculty experience child care and pregnancy related bias microaggressions. For women in academic medicine, there is no good time to have a baby, and they are reproductively policed before they even begin their careers.

As stated in the introduction, the sociological literature on meritocracy has focused more on race and education. But some research conducted has shown evidence of meritocracy belief in various groups in society. When testing who is more likely to hold meritocratic belief, Xian, He, and Reynolds (2017) found that minorities and older people were less likely to believe in a meritocracy, while those with more education and women were more likely to believe in a meritocracy. Additionally, Khan and Jerolmack (2013) found that private high schoolers in their ethnographic study would profess a strong belief in meritocratic processes but the authors found during observation that the same students often did not do very much work at all. And given the economic, cultural, and social capitals of Khan and Jerolmack's sample, research by Mcnamee and Miller (2014) nuances the conversation further. They found that "playing by the rules" may

actually be detrimental to getting ahead for professionals. In their book they gave evidence that it is consistently one's starting position in an organization that determines their success. Given these compelling findings on the importance of beliefs about meritocracy in a conversation of professional success, but also the unclarity of how successful people experience meritocracy, it is important to study the perceptions and experiences of successful medical academics to compare both aspects and whether they are similar or different among men compared to women.

V. Women's Lack of Advancement to the Leadership Rank in Academic Medicine

The sociological literature that explores women's lack of advancement vacillates between two points of interrogation: blame the women or blame the institutions. Researchers explore the reasons women give up and leave, or the structural constraints placed on women as a marginalized group in the male dominated medical academy. As mentioned above, currently graduating medical school classes are roughly 50% women. Some have argued that diversity in fully promoted medical professors is no longer a problem given this equity. And, if one looks at assistant professors of medicine across multiple sub specialties, the numbers more often than not are close to equal. Yet, the problem lies specifically in the dwindling percent of female professors of medicine as one looks at the rates of promotion to associate professor. They are even starker still at the full, senior professor level.

Here I explore the common explanations for women's failure to advance in academic medicine. These are typically empirically explored in previous literature on women's experiences in medicine with emphasis placed on gender bias and sexual harassment experienced by women in medical school and as faculty, the lack of representation in higher leadership positions, and a dearth of mentoring that effectively promotes women into leadership. Women also acknowledge a lack of

equity in salary compensation as problematic for their inclusion in the medical academy. Additionally, women who hold professorship in academic medicine cite the challenges of balancing work and family responsibilities among the challenges to their promotion and persistence in the medical academy. These studies have overwhelmingly put blame on individual actors for choices made and less often interrogated the institutional context in which these women make their choices. I outline here the most recent empirical studies dealing with these topics.

Lack of Representation

In academic medicine, the road to promotion to full professor is paved with service in leadership positions. The leadership level of the medical academy continues to be male dominated. It is not the case that female physicians are blatantly ousted from the leadership roles, but instead are kept out when they are not affiliated with powerful men. This is colloquially termed the "old boy's network." There is evidence that academic medicine specialist scouts look for recruits to their departments by assessing their own male dominated networks (Lee and Won 2014; Van de Brink 2011) thus alienating women by default. Put succinctly, women in academic medicine acknowledge that there is still an "old boys club" or network of men in leadership positions that keeps women in the lower ranks (Lee and Won 2014; Pingleton et al. 2016; Van de Brink 2011). In Carr et al.'s (2015) study, a woman physician stated that while the old boys club is benign in intention, it is not benign in impact. Yet, Risberg, Johansson and Hamburg (2011) assessed male medical education leader's views on women in medicine and found a complete disregard for addressing the issue. The men in their study stated that the lack of gender parity is of low status in the hierarchy of concerns of the medical academy. They claimed that addressing gender concerns might take away time from

implementing important medical curricula to their students. Quite telling, that the male dominated perspective finds the lack on gender parity not concerning and a waste of time and effort. It is no wonder, then, that women who had left academic medicine in Levine et al.'s (2011) study stated that they found the institutional environment to be uncooperative and biased in favor of men.

Further, women who work in male dominated specialties receive less social support from their colleagues than women who work in female dominated specialties (Wallace 2014). Women are underrepresented in grand rounds speakers at a rate of 28.3 % which is lower than the rate of female medical students, residents, fellowship trainees and medical faculty (Boiko et al. 2017). Westring and colleagues (2012) attempted to understand how the culture of a woman academic physician's department is more or less conducive to the assistant professor's success. Results show that four facets are needed: the department provides equal access to opportunities and resources, the department encourages work-life balance, the department facilitates the discussion and elimination of gender biases, and that the chair or chief is supportive. But even when women are in positions of power in academic medicine, they may hold women to a higher standard than they do men, in what is commonly called the "Queen Bee Syndrome" (Bickel, J. 2014). Bickel asserts that the origin of this cultural phenomenon originates in the socialization of young girls. At an early age, girls are expected to play in co-operation, and receive less experience with competition and aggression type of play. Couple this with a gap in the representation of varied female leadership and women in leadership may have only male models to emulate. Woman have historically struggled to persist in the male dominated space and have been promoted less often than men (Blumenthal et al. 2018; Carr et al. 2018; Halley et al 2018; Jena et. Al 2015; Tesch et al. 1995; Thiebault 2016). In 2014, women were 7% of the fully

promoted faculty in surgery in the United States (Blumenthal et al. 2018). And a study on invited speakers for specialty medical conferences found that women were underrepresented for plenary, keynote, and lectureship speakers based on AAMC workforce data (Larson et al 2020).

Lack of Mentoring

The lack of representation caused by systemic discrimination is the cause of other problems for women in academic medicine. There is a cascading effect on gendered outcomes of promotion that originates in representation of women in fully promoted positions but is borne from the processes of years of professional mentoring. The problem starts in medical school and carries over into professorship. Samuriwo et al. **(**2020) present findings on gender differences in clinical learning opportunities in medical students. Medical students in their study reported that their experiences of mentoring and support for learning in clinical practice varied by gender, with women finding more roadblocks in their experiences.

Female medical faculty have stated that adequate mentoring has been a key factor in mitigating career rejection and uncertainty (Ayyala et al. 2019; DeCastro et al. 2013; Pingleton et al. 2016). Andriole and Jeffe (2012) found that the trend starts even before medical school. They found that men enter medical school with more research experience which significantly impacts the trajectory of research in their careers. Medical school students in Levine et.al (2013) stated that gender concordance didn't matter as much as shared values, but that finding a gender matched mentor was difficult. In Kass, Souba, and Thorndikes' (2006) study of female surgical leaders, 90% of the women reported having a mentor but 50% of those women reported that their mentor was not very effective.

These finding is telling for two reasons. First, surgery is the most male dominated of all medical sub-specialties. That women are underrepresented in upper levels of seniority leaves junior women ill matched and forgotten. Not because men cannot mentor women. They certainly can and they certainly do. But given that the trend shows that men do not *seem* to worry themselves with the lack of diversity in fully promoted faculty demands an investigation into the matter. A mentoring relationship usually begins on the good graces of the mentor, as one who is willing to provide time, effort, and resources to develop those under them. What can seem as innocuous and good natured, fair and measured in a meritocratic sense (those who work hard are seen by senior professors as worthy of mentorship) may obfuscate the hidden gendered processes women have claimed in the empirical literature.

Secondly, there is a difference between just simply having a mentor and having an *effective* mentor. Good and effective mentoring has a sort of quadratic effect on one's professional success. A well-developed mentee often enjoys professional success, psychosocial support, job satisfaction, and a feeling of belonging (Cross et. Al 2019). Women are reporting they are missing these puzzle pieces.

Given this information on the lack of representation of women in leadership ranks in medical academia, understanding how current fully promoted faculty perceive of the field of academic medicine as meritocratic and not specifically gendered is imperative. By assessing who is troubled by the lack of representation at senior level ranks as well as the justification given for the disparity can illuminate how the professors of medicine perceive both the problem and the possible solutions to reproduction of the male dominated institutional climate

It is imperative, then, to understand in what ways academic medicine is touted as a meritocracy and upheld by a mentoring process that is billed on the hard work of the constituents of

the institution, yet may in actuality have gendered differences in who gets mentored, by whom, and the effectiveness of that mentorship. Also, asking both men and women can show the full scale of the mentoring experience.

Lack of Equal Compensation

A major theme of the empirical literature on the experiences of women in academic medicine is about the trend of unequal compensation. Research on negotiation in academic medicine shows that a lack of good mentorship affects the confidence of a junior medical faculty member in negotiations (Sambuco et al. 2013). In research conducted about junior faculty in academic medicine, the perception of junior faculty is that masculine traits are better for negotiation of awards and salary (Sambuco et al. 2013). Women academic faculty are hired at lower salaries than male counterparts (Cropsey et al. 2008; Halley et al. 2018). Female physician researchers had a lower mean salary by roughly $13,000 than men after controlling for subspecialty choice, rank, leadership, publications and research time (Jagsi et al. 2012). Jena and colleagues (2016) found that absolute difference in unadjusted salary between men and women physicians was $51,315. Male gender was a significant predictor of a bump of over $10,000 even after adjusting for specialty, academic rank, work hours, research time, and other factors (Jagsi et al. 2013). Not surprisingly, Lee and Won (2014) cite lack of equity in pay to be a driving force for lowered job satisfaction among female medical faculty. Surprisingly, Lee and Won (2014) found that junior women faculty who work at institutions with a woman president have worse pay equity than women who work at institutions with a male president. However, that same study found that at institutions with more women in the full professorship rank bodes well for the pay equity of junior women.

Gender Bias and Subspecialty Choice

Historically, women were denied entry based on sex, but contemporarily, women are put under the microscope for either conforming to or rebelling from their gender role. The assumed sex traits of women that are based on an essentialist categorization still permeates the medical academy today. Current research shows how female senior promoted faculty support the idea of medicine as a meritocracy, yet acknowledge how over the course of their careers that they had to outperform men in order to be seen as legitimate academic physicians (Pingleton et al. 2016). And women do speak of an intense focus and intention of becoming leaders (Guptill, Reibling, and Clem. 2018). Female leaders who follow an agentic style (a style the promotes the leader) that is more likely representative of male leadership are not as successful as women who follow a "communal" (collectively orientated) or more female-typed leadership style, which shows that women are still penalized when they act too much "like men" (Pingleton et al. 2016; Scott and Brown 2006). In Bhatt's (2013) research successful women physicians were seen as "hostile" and "less nurturing." Women also reported that they adapted their appearances as much as possible in order to appear androgynous or less womanly to navigate the setting of the medical academy (Babaria et. al. 2012, Pingleton et al. 2016).

Women are also policed for behaving "like women." (van Den Brink and Benschop 2012). Bhatt (2013) found that Indian women physicians experiences more overt, blatant discrimination and had a harder time getting promoted. The women in this study were told to steer clear of labor-intensive specialties because of the assumption that they would need time for a family. When Sambuco et al. (2013) asked faculty researchers about their mentoring

relationships, participants responded that they believed women were disadvantaged in negotiating because effective negotiation requires traditionally masculine traits.

The take away is that women repeatedly find themselves negotiating a male dominated work place in which they have to learn how to succeed as doctors despite being sex and gender type casted (Babaria et al. 2009; Pingleton et al. 2016). Part of this negotiation comes down to a very influential choice all medical students must make: which subspecialty they will focus on and become proficient in. This trend is arguably still seen today in sexist experiences of women medical and graduate students. Women are characterized as tender, empathetic, temperamental, and lenient and thus a funneling effect occurs into subspecialties that seem to utilize these types of traits (Kass, Souba, and Thorndyke 2006; Shrier et al. 2007). However, a woman may not exhibit feminine personality traits, but a women's *embodied* difference creates a need for a female to dress or present a certain way in order to downplay her difference *as woman* (Babaria et al. 2012; Pingleton et al. 2016). Women and men both hold women to a higher standard of "likeability" (Bickel 2014). Women must strike a balance between competency and warmth. This troubling aspect of gendering implications ensures that it is not simply a matter of equal access to erase difference. This "difference" in women directly leads to underrepresentation of women in particular fields and subspecialties.

Thus, gendered pathways still exist in medicine and science such that women are encouraged to choose subspecialties by the positive reinforcement of "feminized" subspecialties and encounter hostility in male dominated subspecialties. Women that enter medical school quickly learn by looking around that certain sub-specialties are more amenable to women than others (Ecklund, Lincoln, and Tansey 2012). Interestingly, being female and having lower-middle class status contributed to having an interest in patient care (Hardemann 2014). Jagsi and

colleagues (2014) found that while exposure to female role models or chairs of medicine didn't show significance for subspecialty choice, what did appear to affect choice was the number of female residents in the subspecialty the year prior. This in effect supplies a pipeline of women into traditionally female friendly subspecialties.

Sexual Harassment

To be denied and ignored based on sex and gender is one thing. But women also deal with outright discrimination in the form of sexual harassment. Overwhelmingly, women in academic medicine deal with an undercurrent of bias and harassment (Camargo, Liu, and Yousem 2017; Martinez, OBrian and Hebl 2017; Witte, Stratton, and Nora 2006). While women unfortunately deal with sexual harassment in all lines of work, academic medical faculty deal with it both from superiors, peers, but also patients (Kass, Souba and Thorndike 2006; NASE 2018; Shrier et al. 2007). Kass, Souba, and Thorndike (2006) found that 80% of their sample of female surgical leaders reported sexual harassment. In Babaria's (2012) study of third year female medical students, women reported that they dealt with sexual harassment in various ways. Patients who were inappropriate with them was a common occurrence, and these students were told by superiors to just "deal with it." Results such as these illuminates how the organizational leaders' response affects morale and persistence of female medical students and what they learn to expect from those around them.

How, really, can one be expected to navigate such a tightrope walk? Given that the climate of the medical academy needs to be navigated carefully by women, it is important to ask full professors of medical academia about their experiences related to gender bias, and how they view bias and sexism for women today. Most research on the experiences of gender bias in

academic medicine focuses on the perspective of those experiencing bias, particularly those who have left the academy as a result. What is needed is an understanding of how senior promoted faculty (and especially men) view the problem of gender bias in this setting, how that relates to notions of medicine as a meritocracy, how seriously they take the issue to be, and if they have different levels of awareness of the issue and ideas to address it based on their own experiences.

The Second Shift effect on Women's Attrition

Regardless of the myriad other factors given for why women leave the medical academy, more evidence shows the push and pull effect of family and marital obligations on a medical faculty's career. In a study about female medical faculty who leave academic medicine they stated that role models for combining work and family were nonexistent (Levine et al. 2011). Researchers hypothesize that more women than men who are married in medical school tested high for worry because of the problems that are anticipated in how to balance work and family in medicine (Miller, Kemmelmeier and Dupey 2013). Family-life obstacles in navigating the work-life *are* reasons for lower satisfaction for women faculty (Shollen et al. 2009), but when extensions of probationary periods in tenure track periods are extended, female doctor attrition decreases (Lowenstein, Fernandez and Crane 2007; Speck et al. 2012).

In the school of medicine, one can be clinical track or research track. Brod, Lemeshow, and Binkley (2017) found that women in the clinical track were more likely to leave academic medicine than their male peers. Beckett et al (2015) argue they show a link specifically between a clinical appointment and having small children on job satisfaction. They report that this link is shown with *no* gender difference in the findings. The relationship, they argue, is much more complex than simply being male or female or simply the addition of children in the household.

Medical professors with a research appointment and no children reported less job satisfaction than those with a research appointment and children.

These empirical findings in the sociological literature on how female medical academicians are dealing with the assumptions of their sex and gender roles with family and work life balance demands an interrogation into the comparative experience of their male colleagues. Most of the research of medical faculty regarding pressures about work and family come from those who lack persistence in the field. What is needed is a look into the ways in which senior faculty, male and female alike, persisted amongst the pressures of the two demands on their time, energy, and resources.

VI. Conclusion

The struggles of medical academic female faculty to persist in an environment that has been historically as well as contemporarily dominated by men are well documented. Blaming the individual and institutional factors has not given satisfactory answers for the lack of gender diversity at the leadership level in academic medicine. Research on the lack of gender parity in academic medicine usually focuses on women. We know less about men in academic medicine than we do women. A comparison of their experiences regarding opportunities and challenges with promotion is necessary to see if men and women experience the same trajectory toward success.

Additionally, an even murkier development in the sociological literature is the application of the ideology of meritocracy in academic medicine that may drive the social reproduction of difference. In doing so, I hope to reveal whether there is a gender difference in meritocracy belief, meritocracy practices, and if this might explain the lack of gender diversity at the leadership level. Analyzing the perspectives and experiences of all social actors of the setting can give a more complete assessment of how those who succeeded have done so. Thus, this project's goal is to

examine the perspectives and experiences of senior level faculty to investigate if these perspectives and experiences are consistent with medicine as a meritocracy. Understanding how a professor *conceives* of the meritorious academy but also *experiences* the academy as a meritocracy is a new area for exploration. More so, a gender comparison of these factors is a fertile ground for a sociological endeavor.

Chapter Three: Research Methods

I. Study Design

This study uses a qualitative approach and the intensive interview method (Charmaz 2006; Lofland et al 2006) in order to develop an interpretive inquiry into the experiences and perspectives of Full Professors of medicine. The research questions of this study require the participants themselves to describe in their own words the reasons for their success or the challenges they faced during their academic careers. Their own self elucidation of key experiences is the evidence by which I investigate the physician's meritocracy beliefs as well as whether their experiences demonstrate meritorious processes**.** The intensive interview allows for the researcher to understand a participant's "subjective world" (Charmaz 2006).

Therefore, I drew upon face-to-face intensive interviews, all which I personally conducted as part of a broader oral history project. This project involved 26 of the 30 women full professors on the medical school faculty of a midwestern university. For this dissertation, interviews from each of the physicians in this group (N=15) have been included. Previously, partial data from both basic science (PhD) and physician (MD) full professors from the project were used in an analysis conducted by another investigator of leadership development strategies (Pingleton et. al). The current dissertation consists of an independent analysis of only the interviews conducted with the women physicians. In addition, the original oral history project was extended to include a sample of men physician full professors from the same institution (N=16). I collected interview data from these individuals; however, these data were left unanalyzed until being incorporated in the present dissertation.

Overall, the qualitative intensive interview approach aligns with the research questions for this dissertation by allowing for in-depth exploration into an informant's own explanations for their

experiences and the motivations for their behavior. The "constructed conversation" that emerges using the semi structured interview guide allows the researcher to respond to both what is said but not said and what perhaps has been hidden previously by the need for social propriety (Charmaz 2006; Glaser 2001; Lofland et al 2006; Seidman 1998). The flexibility of this research approach offers a way for the researcher to prompt the subject to go beneath the surface of the described experience while remaining an expert on their own experiences. Allowing space for the subject to share significant experiences as they perceived them to be significant yields data that would not be possible in a study using a priori categories and preconceived notions of what the researcher might find.

II. Definition of Terms

To investigate the experiences and perceptions of physicians I have centered my interrogation around how they speak of meritocracy, mentorship, promotion, and their challenges and obstacles during the course of their careers. *Meritocracy* is signaled by these physicians by their use of the term "good doctor." They speak of hard work, dedication, commitment, passion, and a global sense of the justification that those who succeed worked tirelessly. *Mentorship* is considered both formal and informal assistance, advice, and instruction for success in the demanding and difficult field of academic medicine. Professors shared their experiences with *promotion* by speaking mostly about leadership, as this is how success is measured in academic medicine. Those who lead and give service to others through leadership are the bastions of the ideological and material institution of the academic medical field. Leadership positions are signaled by serving as a chair of a department, a chair of a committee, a lab director, a dean, or as any other position which entails overseeing another's work. In terms of obstacles and challenges, those terms were used verbatim in the questioning and the responses were analyzed accordingly.

See Appendix D for more detail concerning the medical school promotion criteria and process.

III. Data Collection

As explained above, subjects were identified and data collected in two similar yet gender-specific cohorts. I interviewed 15 female faculty of medicine in July and August of 2012 and 16 male faculty of medicine between the months of Sept 2016-July 2017. While there was a gap of four years between the two cohorts, there were no major structural, institutional, or cultural upheavals at this school of medicine during these years. All eligible women full professors were invited to participate in the study and 87% agreed. As stated previously, only the women physicians were selected for this study. Fifteen men physician full professors in similar medical specialties (see Table 1) were interviewed for the extended study, selected from the same institution on a first-come-first-served basis. The response rate from the men was 89%. Emeritus professors were included in the invitation. Three women MD professors emerita were included among the women interviewed; none of the male emeritus professors responded to the call for participation. It should be noted that this medical school, like many others, organizes academic faculty into several types of positions and promotion tracks. This study is concerned only with professors on the traditional tenure track. A description of the criteria for tenure and promotion on this track is included in Appendix D.

The sample recruitment was highly successful with the result that the data collected stands to be highly representative of the senior medical faculty of this institution. In part, this success occurred because I was able to utilize established faculty networks and had key leaders in the School of Medicine who endorsed the project. Recruitment of senior medical faculty can be daunting, as the methodological literature reports that "studying up"—i.e. collecting data from

higher status individuals and elites-- presents challenges pertaining to legitimacy, access and entre in the setting (Desmond 2004; Lofland et al 2006). For both cohorts of interviewees, one of the Medical School's deans—a colleague of many being recruited—emailed the full professor medical faculty to introduce me and my work as well as talking to some colleagues personally. I have detailed my experience and "lessons learned" studying up in the Conclusions of this dissertation. A sample of the recruitment email is included in Appendix B. Additionally, some faculty interviewees had seen me on the medical campus attending talks, panels, banquet functions, and in a working capacity as a research assistant on various projects. This is a note-worthy factor for sample recruitment because of the challenges in studying inaccessible groups.

Interviews were conducted with the female faculty in a boardroom at the medical center, and with the male faculty in their offices. Both locations facilitated a comfortable and relaxed atmosphere for the interviews and, therefore, enhanced data quality. Participants were informed of the study's purpose of the attempt to gain knowledge about their experiences as a medical professor over their life course. I stated that I was seeking to understand how their status as a full professor has shaped their perspective on how the medical academy has changed over the years in which they've been working. I sought to compare both men and women in order to understand how gender sensitized their experiences and perceptions of life as an academic physician.

I conducted my interviews using a semi-structured interview guide (See Appendices A and C). I asked participants about their perceptions of and experiences with gender disparities in academic medicine, whether they consider the lack of gender diversity to be problematic, if they consider working towards a parity of gender in the medical academy a goal, and whether they have adopted or support strategies that either challenge or reproduce the status quo in fully promoted demographics. I asked about their particular journey toward promotion and how they were supported

or challenged as medical faculty. In short, I sought to understand if the experiences and perspectives of senior physicians confirm or contradict medicine as a meritocracy, and in doing so gain new insight into the range of factors that act as barriers or facilitators of gender diversity of leadership in the medical academy. Probe questions were used if a respondent did not bring up a particular experience that others mentioned. Interviews were tape-recorded and transcribed fully. I wrote a memo after each interview and also coded these for emergent themes. Mean duration of interviews was 49 minutes.

IV. Validity in the Constructivist Paradigm of Social Research

The relativist ontology that informs the constructivist approach in qualitative studies like this dissertation posits that individuals of varying experiences and viewpoints are the experts of their own reconstruction of their lives during the interview process. However, it is then necessary for the researcher to establish the credibility of the data collected (Guba and Lincoln 1994). I did this by following the hermeneutic process of uncovering the meaning of participant's statements and then by the dialectic process of comparing, confronting, and contrasting their statements when appropriate (Guba and Lincoln 2001). Probes were used to elucidate muddy statements or unfinished thoughts. I would ask the participant to explain their meaning more fully, rather than assume I knew what they were meaning to convey. Often, I used an overly innocent inquiry as follow up so that they would have to explain to me in more detail. Establishing credibility in this research consisted also of utilizing "progressive subjectivity" (Guba and Lincoln 2001) which is the continuous checking of the data's developing constructs against the expected constructs that were developed before data collection.

Initial interview transcripts were read by the dissertation advisor to assure procedural competence and accuracy. All interview data were kept secure and confidential. Audio recordings were destroyed as soon as I transcribed an interview, and all interview transcriptions were kept on a secure USB locked in my office. No one else had access to the master interview list with identifying information, and in all write-ups of the data, pseudonyms are used and any identifying information has been removed or changed.

V. Symbolic Interactionist Perspective in Qualitative Research

The symbolic interactionist paradigm (Blumer 1969) served as a starting point for this research, and informed my reading and analysis of the data. This grounded approach (Charmaz 2006) allows for the emergent discovery of all themes and meanings that may present during the analysis. Symbolic interactionism posits that human interaction plays a material role in the construction of the social reality. Social agents will give and respond to particular cues and symbols in order to convey a meaning that makes sense for their particular reality. This also means that "multiple realities" exist in any particular setting (Guba and Lincoln 1994) even if participants have overlapping experiences. The men and women in my study shared the status of promotion and advancement, but I wanted to know if their experiences with these phenomena were comparable. I also wanted to know if they equally professed meritocracy beliefs as explanations for their experiences. Therefore, I was particularly sensitized (Blumer 1969) to comments by participants that indicated beliefs and experiences related to the meritocracy concept. See table two for detailed examples of the participants' "meritocracy talk."

VI. Data Analysis

Ideas for analysis emerged from the memos that I took after each interview. However, for

systematic analysis I used qualitative data analysis software (Envivo) to manage the data and memos from the interviews. I used an inductive, multi-stage approach to data analysis. Coding was completed "heuristically" (without auto coding features). Open coding began as soon as the first interview was transcribed. This allowed me to pursue emergent themes in more depth with future informants. I used open coding of the data by analyzing line by line the interview transcripts for emergent themes not previously conceptualized by the literature. I also coded for the themes outlined in my interview guide of the interpersonal and career experiences in academic medicine, the development of their leadership, their experiences with mentoring, and how the organizational climate has changed in their tenure. Coding was checked through each process with the study advisor to maximize code consensus. I then grouped the codes under "family" or themed codes and analyze them for patterns or relationships, both expected (the themes investigated) and unexpected (themes that emerged) (Warren and Karner 2010). I continued analysis until I reached saturation of the data, or when there were no new emergent codes found in the data.

VII. IRB Approval

Human subject's approval was acquired before the beginning of the original oral history study of the woman professors and an approved extension was granted for the male professor sample. Human subject's approval was acquired for this comparative study of both cohorts (STUDY00143014). Consent forms notifying the participants of confidentiality and anonymity were signed by each participant. Pseudonyms are used to assure the respondent's confidentiality.

Table 1. Selected Characteristics of the Interview Population*

Characteristic	No.

Specialty of Clinical Medicine	F/M
Anesthesiology	0/2
Family Medicine	1/0
Geriatrics	1/1
Internal Medicine	4/4
Neurology	1/0
OB/GYN	0/1
Oncology	1/2
Orthopedic Surgery	1/1
Pathology	1/1
Pediatrics	4/0
Psychiatry	1/0
Radiology	0/3
Urology	0/1
Total	31

** https://www.aamc.org/system/files/2020-01/2019Table13.pdf

Table 2. Meritocracy Talk by Gender	
How physicians stated meritocratic ideals	Frequency by Gender
"Just do the work"	94% Male / 87 % Female
There's a type of "fit" involved	81% Male / 19 % Female
Opportunity is there if one wants it	67% Male / 13 % Female
Negative experience wasn't personal	93% Male / 14 % Female
Unbothered by lack of diversity "Diversity is not what matters"	81% Male / 21 % Female
"Time at work"	96% Male / 77 % Female
"I worked hard"	87% Male / 91 % Female

Chapter Four: Gendered Meritocracy Beliefs

I. Introduction

I have established in chapter one that the culturally prominent ideal type of meritocracy in the United States is that individual success is achieved through hard work, possessing innate talent, playing by the rules, and performing with a proper "can do" attitude (Mcnamee and Miller 2014). Additionally, American culture holds that individuals who succeed do so by their intentions and their own efforts, not by being handed success or a "leg up." It is one's effort that reaps success, and not one's ascribed statuses, including gender, race, and/or social class. In a meritocracy, professional institutions do not systemically discriminate; status is not ascribed, it is achieved. At times individuals may attempt otherwise, but ultimately these institutions offer fair and equal chances and opportunities to all who participate in them.

This chapter examines research question one by presenting the gender-specific perceptions and accounts of meritocracy belief in academic physicians. This chapter specifically deals with meritocracy belief, but chapter five is where I examine the comparative gendered experiences in the institution of academic medicine. Many times, the nuanced difference between beliefs and experiences are woven tightly throughout my participant's statements. I have carefully constructed the body of evidence of belief first so that I can secondarily show the relation to their experiences. I assert that the comparison of academic medicine as a meritocracy by gender can explain the inefficacy of the passage of time alone to correct the inequity of full professorship for women. Because belief in meritocracy has been shown to have a protective effect for women who experience gender discrimination (Foster and Tsarfati 2005), it warrants examination in successful women

who persist in a male dominated medical academy. Focusing on meritocratic belief by gender in successful, fully promoted men and women may uncover unconscious and unrecognized gendered cultural processes that have historically bolstered men's success and dampened women's ability to persist to full professorship. We know that women are meritorious enough to graduate medical school in equal numbers to men. What we don't know is why they are not considered meritorious enough to achieve full professorship in equal numbers. The assumption has typically followed pipeline theory; that is, eventually as time passes there will be enough women to reach the summit of equity in full professorship just as they did in medical school graduation. But evidence clearly shows they are not clearing that hurdle. Richter et al. (2020) recently found no cohort difference in women's lack of advancement to full professorship. In fact, Richter and colleagues (2020) found the sex differences in advancement to be *larger* in recent cohorts instead of the assumed dwindling of the gap over time. My work to assess meritocracy belief in successful academic physicians sets out to offer an explanation by showing how cultural ideals have not changed even if diversity of gender participation has increased. I will show here that it is the ideology of meritocracy in academic medicine that explains the stubborn gap of fully promoted women.

Overall, as I will show with the data I have gathered, both male and female physicians made statements that *imply* meritocratic ideals. It was rare for a physician to state outright that the institution of medicine is a meritocracy, though some explicitly did. Interestingly, however, the same male physicians who implied that the institution is meritocratic were quite frank with me about their unmeritocratic experiences. Women described for me how their experiences were based on their dedication to hard work and a tenacious attitude toward success though at the same time recounting

experiences with various forms of gender bias. Overall, the most salient terms of meritocracy talk that I discovered were examples of (1) the institution itself is not discriminatory (2) therefore, attention to gender diversity and equity is unnecessary and, (3) any discrimination that happens is because of a pathological individual, not a cultural or structural process.

Even though both men and women physicians described academic medicine as a meritocracy, they also ultimately described successful medical academic work that was actually an ideal type and norm for a culturally male model worker (Acker 1990; Kanter 1977). They described the work norms of academic medicine to be ultimately suited for physicians who devote themselves both in body and mind, to be physically and mentally present and to choose their obligation to academic medicine seriously and without any other distraction (such as children). Both men and women detailed how this standard is ultimately difficult for women to achieve as they are culturally bound to norms and values about women as mothers. They described women as innately possessing or displaying more and different kinds of emotions than men. Interestingly, both men and women described empathy, typically a feminized trait, as a vital aspect of being a good doctor.

In sections two through four of this chapter, I give evidence and discuss comparatively each of the three salient meritocracy beliefs that emerged from my interview data. First, section two considers meritocracy beliefs regarding medicine being an institution that is free from discrimination. I will discuss and compare how the physicians described their beliefs about the role of networking and mentorship on promotion and advancement. Their gendered descriptions of their experiences of and suggestions about networking and mentorship belie a nondiscriminatory institution. In this section I will also discuss the 'boys club' phenomena that some female and male physicians alluded to. I will show the statements made by these physicians that implied a culturally male model worker. In section three I will give comparative evidence and discuss thoroughly the statements physicians

made about special attention to gender diversity and equity. In section four, I will compare the ways in which academic physicians excused discriminatory behavior as an individual trait.

Additionally, both men and women agreed on key concepts about how one succeeds in the institution of academic medicine. These were time at work, loyalty to the hierarchy of the institution, and the "type of fit" to be a good doctor as in who has "it". I have interpreted their statements as a form of informal internal social control (Bosk 1979) and a mechanism for dealing with uncertainty (Fox 1957) in an institution that has historically resisted formal outside control (Friedson 1988). As discussed in section four of this chapter, I develop an understanding of their statements by utilizing Bosk's and Fox's theorization about how one is socialized into the institution of academic medicine and what is considered deviant from that socialization. I claim that these statements of work devotion deviance are directly linked to physicians' socialization into an uncertain profession, with informal internal controls, and related to the culture of medicine being a male model.

Belief 1. The Institution of Academic Medicine is Meritocratic and Non-Discriminatory

In academic medicine, as with any other major institution in the United States, the assumption of meritocracy is first and most importantly that one can succeed no matter their ascribed background (Lippert-Rasmussen, Kasper 2009). However, gendered organizations theory propounds that professional organizations have abstract ideal workers that correlate culturally with men in society (Balmer et al 2020). My research shows that statements made by male and female participants reveal perceptions of medicine as a meritocracy as well as medicine as a profession dominated by a "boys club" culture with male characteristics defining the ideal worker. This contradiction sets in place the mechanism by which men and women academic

physicians have different experiences (discussed in chapter five) in academic medicine and different trajectories of academic career progress.

Both male and female doctors were adamant that they didn't "see" gender because gender ultimately is not a factor in the goal of becoming a successful physician. Yet, some men and women spoke candidly on the existence of a different playing field for men than women. This is significant because, as will be shown in this chapter, it indicates an internal contradiction in the perceptual landscape of these physicians. When the physicians didn't acknowledge gender difference, responses existed on a spectrum. For men, this ranged from outright hostility to questions on how gender can impact experience to a more benevolent disregard for gender as a factor in a physician's experience. For women, when I asked about gender inequality in their specialties, their responses were often a perfunctory account of the statistics of equal graduating medical school classes by sex. This initial response would sometimes give way to a more nuanced conversation on gender where women would describe for me multiple ways in which their gender had worked to their disadvantage while men had been given a "golden ticket." A few women however buckled down on their insistence that gender had never, will never, and should never be a factor in anyone's failure or success, including their own.

First, in what follows, I will give evidence for these physicians' beliefs about academic medicine as a meritocracy where the only factor in success would be an individual's efforts. Next, I will show their comparative perceptions about the (non) belief of a male dominated "boys club" of medicine followed by evidence indicating their perceptions of academic medicine as a male cultural model of professional engagement. I have emphasized the hegemonic male cultural model here because, while mostly unrecognized, especially by men, it directly contradicts the belief that academic medicine as a meritocracy is non-discriminatory.

In a Meritocracy Hard Work Equals Success

Both male and female physicians stated that there are two valuable assets needed for success besides hard work: a good mentor and access to networks. But even these efforts were seen as meritocratic because it is through one's hard work that one is able to get recognized by mentors and then build networking relationships. The unstated assumption here is that those who get mentors and access to networks do so because they are deserving and it is not from any sort of sex or gender alliance. Both men and women talked extensively about the need for access to networks in academic medicine. This is partly because achieving promotion hinges on proving oneself to have national and international academic community engagement. This engagement is shown in chairing important committees for national organizations, service as a president, vice president, or holding a key office for a national organization, or letters of recommendation from high-status medical academicians. While both men and women talked about the importance of access to mentors and networks, only women described access as more difficult for *women*.

The key message presented in both male and female physician's statements about gaining access to a mentor or a network was that one simply needs to do it. This appeared to imply that these relationships and networks were open access and without any gendered roadblocks. A further implication was that one has an intention to succeed and then one creates the conditions for one's success. This is exemplified by one male physician:

> **Interviewer**: What advice would you give to someone if they said they had leadership ambitions?
> **M1:** One I would tell them to seek out different forms and courses that will expand their knowledge relative to the types of activities and skillsets they're going to be expected to have as a leader. And so, there are you know all kinds of ways to do that you just have to make sure you're doing them. And then the other

> would be to establish relationships with individuals who are in leadership positions. Once that they think that they can go to, that they can service a mentor, you know, it would be those two things. To be in these leadership positions you have to have people who are supportive of you. And so it's important that you establish these formal relationships so that they can support you, but also so that you are able to enhance your skill set by learning from their knowledge. And that it is, you know doing the things, making sure you're attending opportunities and forums that will enhance your knowledge base and skill set relative to the different things you'll be expected as a leader.

Here a female physician describes the importance of tenacity in establishing a mentoring relationship, recognizing that the process of finding and establishing networks requires effort:

> So, then the question is what are the steps to achieve that. And certainly, mentoring in their own field of medicine... So, I think women…should seek out, if it's not provided to them then they should seek out. People that could help them in the professional side of their career. And shouldn't wait around. But that does suggest that they kind of have some idea of where they are going. Which, if they don't, then a mentor can help them with that. I would encourage young women to be aggressive. In a good sense, with their career. And seek out people, if they don't know what they want, seek out people to talk to, if they do know what they want, target that…But at the end of the day, their career is their career. And they need to take hold of that and do what they need to do to get mentored. - **F1**

But the contradiction of establishing oneself as a serious academic on one's own merit was underscored when another male professor admitted that his access was through his lineage when he stated how he was slated to be an invited speaker for a distinguished speaker series. Coupled with his experience is his declaration that access to networks is and never will be solely meritocratic:

> **M2**: I came to (state university). And that (the invited talk) was sort of the culmination of a career but I got with (important physician) because of my father. Sorry, it was not merited. You know merit—"
>
> **Interviewer:** So, it is kind of who you knew.

M2: Sure, sure. You know that is never going to go away in life.

Interviewer: You had access to that network because of your father being a physician.

M2: Yes.

As we will see in chapter five, a gendered comparison of experiences with mentors and access to networks shows that, despite the overriding idea of medicine as system based on merit, women had more difficulty obtaining access than men, who tended to be given easy access to both mentors and networks. In an interesting example of the commitment to an ideology of meritocracy a male physician resigned from a committee when he believed that a non-meritorious decision had occurred. He was steadfast in his loyalty to the institution as meritocratic even when the real processes showed otherwise. The institution of academic medicine's "do as I say, not as I do" culture of meritocracy means some must find their success by proving themselves, while some get a helping hand. Men often described the institution of academic medicine as meritocratic and then recounted experiences (shown in chapter five) that were based on gender affiliation. Women, however, would also state academic medicine as meritocratic and then recount experiences where they worked very hard to receive the same opportunities men were given.

Discrimination free, or Boys Club: Comparing Perceptions

Most of the men in my sample did not overtly reference discrimination against women and some stated explicitly that they believed the institution was non-discriminatory. Similarly, most of the men in my sample did not explicitly reference the "old boys club", though some did. Even though the women interviewed at first would defend academic medicine as non-

discriminatory, through prompting and exploring the topic further, most women would open up and reveal their own experiences with gender discrimination. And even if women stated that they were not discriminated against directly, some would describe to me the "boys club" that they perceived in medicine and how they negotiated it. A female physician who described for me how academic medicine was meritocratic also told me about a former chair in her department that had the habit of "dismissing me with the wave of his hand" socially and professionally. She said that he did not take women seriously. Her tactic was to produce a grant proposal that was top notch. Here she describes the experience:

> (He) was very clear that he was a male chauvinist, that's the way he was, that's the way he'd always been, he was very obvious about and would describe himself as a male chauvinist... And he was perfectly willing to interact with people who said, "you're a male chauvinist." He said, "yeah. I'm that. So, what do you have to show me?" So, you know, there was nothing covert about that. The honesty of it, made it a viable relationship. So, I got research funds from him when guys didn't, because I had a proposal that was clear, unequivocal, had a good design to it, and it wouldn't make that much difference whether he knew it was a female who was proposing that versus a male. -**F2**

Many examples of the physicians' experiences with discrimination are detailed in chapter five of this dissertation, where I compare men and women's experiences with challenges and opportunities with advancement. In this chapter I use some examples to illuminate how the construction of the institution is not meritocratic and thus informs the beliefs of my participants. The usual forms of discrimination stated by men and women *for women* included: being ignored in department meetings or conferences, having their ideas stolen in a meeting or in projects, and overt or subtle sexism. But the perception of a "boys club" culture in academic medicine was illustrated for me by statements about men's allegiance with other men, agreement among men regarding perceived "truths" about women, male dominance in representation in training and as professors, and beliefs about women as outsiders. Here I will demonstrate the statements made

that show evidence of a belief in discrimination – or the opposite- in academic medicine as well as a boy's club in academic medicine.

An interesting way in which male and female physicians signaled the institution of medicine as nondiscriminatory was to call on the hierarchical nature of academic medicine. Both men and women assured me that some of their adverse experiences were based on hierarchy (and they implied hierarchy is not gendered). But even this belief would then get contradicted by statements about academic medicine as a lateral institution where everyone works together to solve problems. The weaving in and out of describing the institution as a hierarchy or lateral demonstrates how my participants sometimes had to shift their understanding of the institutional culture and reconcile their beliefs vis a vis experience. This was most salient when they described for me moments when someone had stolen their idea (usually in a meeting). The phrasing both men and women would use was, "As long as the idea gets to the table." When I heard women describe this, I assumed it was because of their need to play nice and downplay aggression. However, when I heard men use this phrasing as well, it seemed this was a cultural phenomenon that involved a system of governance over and above gender. Chairs would describe for me how they "serve at the pleasure of the Dean" and both men and women described the high status of serving as a Dean or a Chair. Yet when asked about how he dealt with someone taking his idea, a male physician put it like this regarding the slight:

> But I never thought too much about that because I was in this culture for three decades where collectivism was everything and it was a right-wing democracy. I mean, it was a totally horizontal structure. It is like a corporation with a thousand executive vice presidents and so it was universally recognized that if we are going to progress. If we are going to move forward, we are going to do it together and it is going to be the team. And we are not going to have this vertical thing where somebody is anointed to be the boss. -**M2**

And some women responded in kind. Some women told me that they 'didn't let things bother them,' including having their idea taken at a meeting. Some women however would actively work to negotiate the interaction after this had happened to them. Experiences with getting ignored are shown in chapter five of this dissertation. In academic medicine, promotion is based on showing that one is a valuable member of the institution by one's work contribution. This is demonstrated by documented achievements and also by perceptions of contributions. When someone else takes credit for one's idea, the possibility is that one will miss the chance to prove one's worth. Here I show how a female physician states that it's not important that she get credit as a way to negotiate this slight. She told me that she didn't need credit because she could prove herself in other ways:

> …One hundred percent…. I can think of two instances specifically where you'll be in a committee meeting with you know, eight or ten other people and you'll say something and it'll fall flat. And then five minutes later the conversation will work its way around and some guy at the table will say the same thing and everyone's like, yeah that's a great idea. And you're like, I just said that! But you don't say that, but that's what you're thinking in your head it's like, you people I just said that. *But what I realize is that, at least the way I handled that which I don't know if it's the right way, as long as the idea is right, that's what's important. And if the idea takes some momentum and moves forward, it's all about the idea. I don't need the credit for the idea, you know, I've got other ways to show value like my presentations and grants*." **-F3, emphasis added**

Even though she claims that she wasn't upset, the key difference in women's responses from men was that most of the women told me they were upset that it had happened to them. One female physician even told me that she had seen women do it to other women. Comparing men's and women's responses even further I realized that men would claim the institution was a hierarchy in some instances, and lateral in others. But women would always describe it as a code for male dominance. But men neither acted nor revealed directly that they were bothered when they recounted this experience to me. To them, it didn't seem to be as adversarial and for them it

wasn't gendered. A female physician described for me how she understood this aspect of academic medicine (someone takes your idea), but that it was upsetting and it "ticked her off".

> Oh yeah, all the time. But that's academics, man, people are taking other people's ideas all the time, that's it, but then you think that, wait that's really my idea, but then you think, well you came up with it why wouldn't someone else simultaneously too, so I've tried to rationalize that. But that does tick you off, guarantee it. – **F4 Physician**

When my participants said that something like this happens because academic medicine has a hierarchy where the lower rung pays its dues, they meant that this is not a gendered occurrence. While both the male and female responses above show physicians rationalizing the experience in context of the hierarchy, or the culture of academia, only women described for me how this happened *more* for women and mostly *by* men. And only women detailed extensively the work they do to negotiate it when it happens. Men never told me about managing the occurrence in a way to regain their credibility in the interaction, nor did they rationalize it away like the female physician above who said she would make it up in grants.

Another way in which men and women differed on responses to engaging in the professional setting was when I asked participants if they had ever been ignored in a meeting. Most men said no and most women said yes. Two of the men said that they are usually quiet in meetings, which isn't the same as being ignored, and one man said that if he had something to say he would do it after the meeting in private. One woman told me she enacted the same strategy, to follow up in private if she had been ignored. But the difference in her answer is that she described it to me as working to understand if she had "done something wrong." She stated that she sought advice on how to "do better next time" with presenting her idea in a way that it could be heard. The potential for discrimination in being ignored is illustrated in stories women

told me about the propensity of men to discount women's contributions, for example, to scientific research.

Women would also describe how they had to be very careful about how they *managed* the discovery of gendered dynamics in their experiences of discrimination. At one point, a female physician explicitly related her experience relating to the need for women to walk a tight line between getting respect for their work or being ousted for bringing too much attention to the phenomena of gendered exclusion. She had advocated for over ten years for a certain scientific argument regarding compliance of patients, but had been repeatedly ignored by male colleagues. Then, after ten years of her arguing her stance, it was found by male researchers that her argument was valid. The incident this woman is describing did not happen in the past—it was not long before our interview. Much of the contemporary discussion about women in academics or women in professional realms is that gender hostility such as this is historical phenomena. The evidence I found, however, disputes this interpretation. Such arguments are also indicative of what was meant when women identified the "old boys club", or network of powerful men. But even if one experiences sex or gender discrimination, calling attention to the entrenched networks of female exclusion was viewed as being extremely detrimental to one's career.

> Now do I crow and say I told you so? Do I quietly... but the question becomes, you know, how do you manage in situations where somebody has discounted what you said, possibly because you're female…But then how do you go about saying, yeah, I did know what I was talking about and you didn't. I think women have to be very careful with that. It is difficult in any kind of setting, but for a woman to have had a major criticism against a hierarchy or a structure that is predominately male and then turn out to be correct, I think you have to be really careful about how you proceed from there. Otherwise there's a possibility of being shunned. -**F2**

More women than men had examples that recognized a male-defined culture or "boys club" in academic medicine. The few instances where men did acknowledge the boys club consisted of describing how they had gained access to higher levels of networking because of their gender affiliation. These responses are shown in their experiences with opportunities to advancement in chapter five. Women discussed the boys club by calling out men only socializing with other men (where work discussions continue) and by men's allegiance to men over women. Women also designated how male dominance in leadership creates in the institution more power and representation for men over women.

Not all of the female physicians felt left out of a group when colleagues socialized at conferences, but some did. Only one male physician supposed that he had been left out of socializing. The key difference in their responses was the gendered assumption of the rejection. While the male physician didn't appear to think too much of my question, the female physicians who had felt left out contributed it to their gender. A female physician who often described feeling lonely in a male dominated field stated:

> I don't think I've been treated anything other than respectful. But that's different than being in the in group. When you're a woman going to a professional meeting….and this still happens…and all the guys say, oh let's go have a drink and dinner-they don't include the women. And oftentimes as a woman you eat alone. And nobody's trying to be mean to you, it's just the dynamics of the group. -**F1**

And it wasn't simply hurt feelings about being excluded. Most of the women stated that being left out was professionally stifling, as even after work during leisure activities, men were still discussing important work matters.

> Well one thing I think is that a lot of mentoring for men goes on over a beer or when you're at a meeting and the guys go out, at least when I was at that stage,

> the men kind of went out for their own evening and you seldom got included. Unless…there was someone in the group who was really a good friend and invited you along. But not often. A lot of things, changes that led to an article being accepted or a new research project went on in that small group after the meeting. **F4**

I asked many women if this was still a phenomenon they saw in younger cohorts, since women now made up half of incoming junior faculty. One female physician told me that it absolutely still happens. The stereotype that women don't play golf (a quintessential male physician bonding activity) is not true anymore, yet women are still left out.

> **F5:** The golf course thing still is there, and the interesting thing is I've talked to some young faculty here, and they said, you know, I play golf. And they don't invite me. So, they even know how to play golf, and they're not getting invited onto the field. So, it's still an exclusive club, it doesn't matter; it used to be oh you don't like golf you don't play golf. I had a poor woman here she was so unhappy, she said I love sports, I can talk sports until I'm blue in the face, I am an excellent golfer, and I'm the loneliest I've ever been in my life. She was in a department that was largely male.
> **Interviewer:** What advice did you give her?
> **F5:** Well what do you do? I mean that unfortunately was a hire we couldn't save.

Male allegiance to other men was most evident when physician's spoke about their experiences with colleagues or authority. A female physician described for me how male allegiance was necessary for women to advance when I asked her if her idea had ever been stolen in a meeting:

> **F6:** Oh yeah that's true. If the men talk about it and think it's a good idea, then you're more likely to get it done. And that's ok. You gotta work within the system. …Oh yeah, absolutely. Yeah you have to know where the power lies and figure out how to use that power to your advantage. And you can do that. So, if you have a really great idea and you don't have the support of your male colleagues, it will not go.
> **Interviewer:** What about the support of your female colleagues?
> **F6:** It still probably won't go.

Knowing that power and representation vis a vis the boys club matters for women, a female physician was so keen on her status as an exemplar (a fully promoted women in a heavily male dominated specialty) that she spoke of actively engaging in projects that would make her visible to women who came behind her in the specialty. The heightened awareness in her response shows how engaged she is in the understanding that academic medicine is most definitely not a nondiscriminatory, value free environment:

> As far as moments of growth I think a lot of things that I've done I've done not so much because I wanted them for me or for my career, *but I understand the kind of position that I'm in and that I'm in a position where there aren't a lot of women* and that there aren't a lot of us to break the glass ceiling, to eliminate the glass ceiling, and so if I'm in a position to do that I will. So a lot of things I do, I mean I'm glad they're on my C.V but the main reason (for) doing it is for the people coming up behind me. So, they can't get the same messages that I got, that no woman's ever done this, ergo no women ever will do this. And so, I'm now full professor with tenure, I'm only the xxth woman in (in my specialty) in the country ever to become a full professor with tenure. I mean it's nice to have the title but that was something that I was aiming for at the very beginning, because when I started, and really started pushing things for promotion I think at that point there were only four women. -**F7, emphasis added**

She goes on to describe how impactful her decisions are on future generations of women, or even herself in this male dominated space. Not one male physician described their decisions in terms about visibility and representation in the male dominated environment.

> In my community if you as a woman are asked to do something, it's challenging to say no because then you're only [a small] percent of the people in (division redacted). If you say no, statistically if they're going to ask someone else, the next person they ask is going to be a man because that's what everybody else is. And there's always, there's sort of this subtle backlash at times that if she said no, then that probably means that other women would say no. So, we're going to be a little reticent to ask another woman. When I get asked to do something, it's always stuff that I end up enjoying and I like the projects, but I never say no because I'm always afraid of what the implications are going to be for me down the road. – **F7**

Moreover, male dominance in being represented in positions of leadership and authority matters. The challenge for women to assume positions in leadership is not an issue from the past, but remains a gendered problem, according to what this woman physician said:

> Women need to be in leadership positions. There are women who are capable who are passed over for whatever reason, I don't know. So, more women need to be in leadership to help create more women leaders. You can't create women leaders if you don't have good role models. And for whatever reason, and I don't understand the ceiling that we have in academic medicine. So, I think we have to move this along somehow, it almost seems like affirmative action, but in some way it's…I mean if we're fifty percent of the medical school class, there should be fifty percent of women in the leadership roles." -**F6**

Because some of the women had developed mentoring relationships with men early in their careers, when academic medicine was less gender diverse, I asked these women if it was significant that their mentor was a man. This female physician states plainly that men still hold institutional power:

> …Because a sponsor has to have power. They have to be part of the power structure to really help you as much as you need to be helped. So, in that era I think it was really important, and probably still, it's important to have somewhat of a sponsorship or a mentor/mentee relationship with a man. They still have all the power. -**F8**

Perceptions of Successful Work: A Male Model

Overwhelmingly, the participants in this study described the supposed meritocratic setting of academic medicine in terms of a male-centric model of professional engagement at work. Perceptions were formed and decisions made within the influence of these cultural parameters. The statements of my participants that have led me to this analysis are supported by Acker (1990) and Kanter (1977). Their theorizations conceive occupations as male sex typed in reality even when they are touted, ideally, as spaces where the best fit worker succeeds. The

most salient ways in which both men and women signaled to me that academic medicine was male typed was by describing women as having more feelings and emotions than men and thus don't work like men, and that women bear and are responsible for children and thus can't work like men.

In the sections below I will first address comments made by both male and female physicians describing women as being "innately different" because of women's emotions. I will then showcase comments made by male and female physicians about the necessity for women to negotiate their emotional display more than men. Next, I will address comments made by both female and male physicians about how women are required to control their reproductive responsibilities more than men. Lastly, I will assess how both men and women stated that women are required to spend more time caring for children than men.

Women Feel More Than Men: "We are wired differently"

Both male and female physicians explained to me how women and men display emotions differently, and some of the physicians described how men and women are just *made* different, and nothing can be done to change that. Some men and women described how they and/or others around them perceived women to be *inherently* distinct. Some male and female physicians stated that these differences were driven by gender socialization differences for women and men. One of the most repeated statements said by both male and female physicians about the difference between men and women was that "women are relationship builders."

A female professor in a highly male dominated specialty described for me how stereotypes about women as latitudinally sharing power and control starts in childhood gender socialization. She stated that working with subordinates was sometimes tricky because female

subordinates would treat her as "another woman" instead of someone who was in charge of them. This harkens back to the statements that physicians made above about medicine as a hierarchy where someone is "in charge." While she was not stating that the differences are biological or inherent, she asserted that the outcome of the difference created challenges for women academic physicians that men never recounted in their experiences to me:

> Nurses especially…can be a little challenging…female nurses. And it's not just me, when I go to (specialty) meetings other women have the same issues. Women tend to grow up, playing at least to some degree playing noncompetitive games. Yes, we're playing sports but early on you're playing with your friends and you're playing dolls and there's nobody that's in charge, and you share stuff and it's a much more level playing field. To some degree, women don't get rid of that. And so, they think if they're with another woman it's still a level playing field. And so when I'm (working) with certain female nurses or (additional subordinates), they want to talk about what they're doing in the coming weekend, they want to find out what I'm doing and talk about what their kids are doing and if I need (something required for the task) it's like it's negotiable because it's like, well this is what I have, and it's like, but that's not what I want. And so, there are a lot of people here who I won't (work) with. Because we're not, we're not playing and we're not having tea and we're not playing dolls. We're actually in a very stressful situation, you have your area of expertise, I have mine, it's just like a football team. Everybody's good but you still have to have one person in charge, in the (work space) that's me…But you gotta understand who is in charge. And so that becomes a bit of a challenge, and I'm not going to negotiate what it is that I want and who's in charge, we're not socializing." **-F7**

Some male physicians would weave in and out of "women are biologically different" and "women are treated differently therefore have different outcomes." But even while describing women and men comparatively, it's that women have something about them that makes them better at social graces. Here a male physician described the perception of inherent difference versus different treatment starting in medical school:

> So, I remember there being a subtle bias about "isn't this so nice." I mean just to paraphrase. "Isn't it so nice that the fairer sex has joined us here in medical school. And they bring a different perspective!" It was kind of paternalistic.

> …and they'd say things like "we have about half women and the population is about half women and so isn't that grand." …We've reached some kind of a parity. But then the parity in their mind was, and I realized…I mean I probably had my own little bit of a bias because I always find the female students a little more serious, a little bit more but in a way that they…have a more *therapeutic personality*. **M3**, **emphasis added**

Another male professor echoed what he was describing as something that may or more not be inherent or learned. He argues that these differences cannot ultimately be changed:

> I believe in gender equity but I also would assert that we cannot abolish all differences between men and women. We are wired differently. We know this at birth that the brains of women and men are different…So, we are not going to abolish differences between men and women. And so when my wife changes her mind all the time or cannot seem to focus. I do not think we are going to change that entirely. I do not think we are going to abolish entirely the differences in the role of men and women as parents and caregivers. We can strive for equality and I just think it is terrific that you can get paternal leave today. This is great for children but I think it is an illusion to think you can abolish all differences. - **M2 Physician**

And a female physician described for me how what keeps women from being leaders in academic medicine is essentially because logical thinking (a stereotypical male trait) is valued but emotions (stereotypically female) aren't valued in leaders. The assumption here is that only women have (or display) their emotions. Nevertheless, this female physician argues for a culture that values both contributions:

> So, there may need to be a different way of looking at that, the world may need to get a little more kind to everyone and perhaps more accepting of the value of looking at things from an emotional as well as a logical perspective. Which I think is by the way, sometimes valuable. I think our emotions are good and strong and useful, you know, I think we ought to flaunt the fact that we're women. I flaunt it every day, and I don't think that we should be, you know, limiting ourselves by trying to become men, that's way the wrong approach. I think we ought to be obviously female and strong. **-F9**

A male physician described for me his view on how women are doubly punished by their own emotions when they spend time at work and not with their children. And he wasn't mistaken that some women feel this way. Some women also described their tug of war feelings over not being with their kids when they were at work, and not being at work when they were with their kids. Eight out of fourteen women in my study had children. All of the eight women with children described difficulty managing professional work and child responsibilities. More detail and their statements on their experiences is presented in chapter five. But the perception that it is *women's* fault that they feel this and not the institutional culture was plain when I asked a female physician, a mother of two, if her chair supporting her work life balance was key to her success she stated, "100 percent. I think a lot of the pressure women feel about this, they put on themselves."

> **Male 4**: This is the sexist thing, I think the same amount of time, if I miss 40% of time with my kids, the same amount of time for a woman is greater. So, if she misses 20% of the time emotionally it's like 40%. I don't know how to say that without being offensive.
>
> **Interviewer:** That's how you think women feel or that's how women have told you that they feel?
>
> **M4 Physician:** uh well the way I think that is because of what they've said. I just think it's a bigger cost. No one ever said, you know, "(his name) you're going to have to make your job decisions based on how you're going to manage the child care." No one ever said that. And I would have never thought that way in my head, I would just assume that it would all work. You know where every woman that comes to medical school from day one is already mentally calculating about how they're going to make all this come together, and that's why I think it is important to have good female role models. Because if you see somebody that's done it the way you feel most comfortable with you think I can do that. And I didn't have any of that.

Whether my participants saw the differences between women and men to be essentially biological or the result of gender socialization, the bottom line is that most of the women and men in my study made statements that they are distinctly different from each other. These assumptions carry with them ideas of fit for academic medicine. If the cultural consensus is that women are constantly negotiating a "tug of war" between their dedication to their work and their emotional bonds to children, and men are not, the set up creates division for working mothers. This ascription of gendered traits harms women before they even enter the setting of academic medicine. Their contribution is seen as devalued by a scattered attention before they even walk in the door.

Women must control their emotional display: "If you're in a tough negotiation, it's best not to smile"

The second way that both male and female physicians spoke of women as different than men was about how they must manage their emotions at work. This emotional management is needed because women are held to a different "code" in their interactions with colleagues. Additionally, I saw how women were aware of their need to carefully construct their femininity as women in order not to be seen as too aggressive or too weak. A female physician explained to me how women have a delicate tightrope to walk. What she is describing is that women's emotional range at work is limited in such a way to police their presentation of self. This restrictive emotional allowance is taxing to women because constantly monitoring one's behavior like this is added emotional labor that men do not have to perform:

> Women can say exactly the same thing and in exactly the same tone, exactly the same cadence as a man and a woman will be considered a bitch. Or that she grumpy, or not nice. A man can, that's just kind of part of being a man. So, I think that there's a different dance that you have to do in order to be seen as a

> leader. Um, it's a very hard dance to teach. And I don't know if you teach it, what happens is a woman may react in a certain way and then you go to that woman and you say, "you know, I think that wasn't the best way to handle that, you know, you're being perceived as, you know", but the last time something like that happened it did no good whatsoever! And so, I don't know whether you can teach (a woman to handle a situation without being labeled a bitch), I don't know. I think they have to watch it; I think they have to feel comfortable in themselves and I think they have to just be themselves. I don't think you can compete with being manly, anyway. But I think you have to be…you have to know kinda who you are and what you believe in. **-F10**

Other women in my study echoed her statements about being cautious about how their emotional behavior is perceived:

> **F1:** I think my generation…I think we walked a delicate line between being feminine and oh the opposite of feminine is unfeminine. And maybe a little bit more held back because the opposite of kind of holding yourself back is being aggressive! So, it was a very delicate dance.
> **Interviewer:** So, you're saying aggression was not equated with femininity.
> **F1:** That's exactly right.
> **Interviewer:** So, you ran the risk…
> **F1:** yes, of being seen as aggressive. Bitchy.
> **Interviewer:** What were the implications if you were seen that way, what happened?
> **F1:** Oh, it was negative, it was pejorative. It didn't help in your career, if that was your persona. So, it was a very delicate dance. My observation is that it is not quite so much (now), but I think it's still there.

In fact, a female physician told me that no one ever calls her by her first name because she has a personality that is more intimidating than most women. She recounted a story for me where she conducted her rounds earlier than usual, and thus encountered a day nurse instead of the usual night staff. The day nurse exclaimed that she always assumed this particular doctor was a "big tall man" because of the reputation that had preceded her. I should note that this professor was very proud of the fact that someone had mistaken her for a "big tall man" by her reputation. This physician offered advice for women who want to advance in academic medicine: Keep emotions out of it.

> I guess maybe the one thing is…particularly in a man's world, you have to make sure that you try to leave a lot of your emotions behind and to try to back off from any kind of you know real emotional liability, and to try to take things more calmly than many women do. Because many women are a little more emotional than men and are more willing to share their emotions. They're less adversarial, and so you have to figure out how to not be afraid to be a little more adversarial perhaps and a little more reign in the emotional stuff and just, you know, level the playing field. **F9**

While women above describe their experiences with negotiating a setting in which their emotions are policed more heavily than men, no men in my sample described the same phenomena *for men*. It is important to note that men never reported needing to work at how they were perceived so that another person in their professional experiences wouldn't see them as too aggressive. Men also did not describe mentoring junior colleagues, residents, or medical students about managing their emotions. Yet a few female physicians would tell me that men *do* sometimes act badly, but they are not policed as women are. It seems to be that what is considered by men and women in academic medicine as "emotional" is not the aggression or yelling that men do but rather the tears that women display. This gender specific behavior creates an inequal standard for performing one's emotion in the workplace.

> I do think that in leadership positions you have to earn your position in a different way than the male gender, for the most part. Because I see, and this is one thing that I think is legit, I think that dysfunction in leaders is more tolerated in, seems to be more tolerated gender wise for males. I think especially the anger issues, acting out, these sorts of things, then I've seen just groups of leaders talking amongst themselves and you see what happens to folks. The removal of certain chairs and that sort of thing, and it would appear to me that it's more acceptable for the male than the woman chairs, though it hard to say, it just seems that there's quite a bit of shenanigan activity in some of the male chairs but with women it's considered instability and there's more judgment passed. - **F11**

Women described being seen as too aggressive if they speak out of turn, but confounding to others if they don't act feminine in expected ways. In an interesting example of enacting a

behavior to control emotional display, a female physician described to me how she attempted to manage the interaction in a surprising way: by not smiling. In this example, she negotiated her presentation of self in a non-feminine way and negotiated terms of a deal with all male colleagues. This type of awareness is underestimated, but most of the women in this study all show how being aware of their gender status as women created a need for them to interact with others in careful and calculated ways. Not one male physician ever made a statement about himself negotiating the interaction in order to manage the impressions of others. Here she explains how it went:

> …society expects women to smile all the time. And they think that if we smile then it means that we're in agreement. And not understanding that women's body language, that if we smile it just means that we're listening, it doesn't mean we agree or not. If you're in a tough negotiation the best is not to smile. Because then people can't, they have no idea what you're thinking. So yes, I was involved in a negotiation that I, I sat through the entire negotiation, the two-there was a gentleman that was with me and a few men that were on the other side negotiating and I didn't smile the entire two hours of the discussion. -**F7**

But a male physician described for me how he noticed the cultural tightrope that women walked in how they had to work to be perceived as serious academics.

> **Interviewer:** Have you seen a difference between men and women in mentoring styles?
> **M5:** I would say yes. I think it sort of depends on what specialty you're in. Some of the (highly male dominated) specialties, I've seen some women handle that very well. *If you're in a man's world, some (women) can become overbearing just to try to prove to you, they almost become abrasive.* And difficult to deal with. And another group are just a little too subservient. If you can find people, and we've had several in our program, very good female residents who have become great (specialty doctors) and academic (specialty doctors), they know how to walk that line very easily, they're just very professional, they're good with their hands, they're very bright, good teachers, people respect them, you have to gain people's respect.
> **Interviewer:** Are you saying because it has been a man's world women have to be careful about how they approach this, they can't be too aggressive and they can't be too meek?
> **M5:** Trying to walk a thin line, it's been harder for them I believe

Interviewer: Do you see that lessening?
M5: yes
Interviewer: what has changed it?
M5: People's perception. The old guard are starting to move on, you've got a whole different generation. …. I worry sometimes that what we do is, we try to create too much of this… how do I be a woman in a male dominated field. I think it's more important to say, how do I become a good (specialist)? I mean a very empathetic person who really can speak to the patients, treat them with kindness…
Interviewer: So, are you seeing the environment becoming less of a factor for women?
M5: Yep. I am. But what I think it takes a cultural change.

A female physician told me that women's emotionality hinders them in communication and negotiation. When I asked her for advice for young professionals regarding leadership ambitions, she answered:

> You know and it's tricky you know how I mentioned the part where I thought women of a different generation over compensated and were taking on more male characteristics and to an intense degree. …being able to communicate clearly, I think communication is very important. I tell people to focus a lot on learning excellent communication skills because when all else fails, if you can talk yourself out of anything. I can't, I go completely silent, I think that is a skill to be had. …I have seen people do that. I have seen people; men go into a room about to get fired and come back with a raise! And a woman, she goes in, she gets tongue tied, she cries, and she's got a box in her hand. - **F5**

But a male physician described for me how a female physician in his specialty had been treated as irrational when in fact she had not been:

> **Interviewer:** Do you see more men or women in positions of leadership?
> **M6:** well it's still men, we're seeing more women that are becoming leaders…I can tell you that I know that women have a harder time. They just aren't given a pass the way men are. I can tell you that a lot of people have grave misperceptions about Dr. (female physician). They think she can be difficult and rigid at times. But when you sit down and talk to her… And people would criticize me about things that I would, they would perceive as concessions I'd made for her. And they would always perceive that she'd yell and scream and stomp her feet together. And that's not how she did it. We sat down and we

talked and she would outline her rationale and very reasonably. And we would reach an agreement and that's how things would be. She never ever ever ever did anything like that.
Interviewer: That's such a big thing you're telling me, that you would sit down and talk but the perception is that she would throw a hissy fit.
M6: Right and she never threw a hissy fit with me. Ever. Not one time.
Interviewer: Why was that….
M6: I have no idea. I really have no idea. You know and if you think back on her career she has now been appointed as the (high level role). She has never been asked to be a leader in anything here before, that she hasn't created herself. And I can tell you that she's doing 100 times more than the previous person. She's taking it very seriously, she's spending a lot of time getting to know the people that she has to work with, and trying to figure out what she needs to do, and she is doing a very good job. And I guess because I'm a man, you hear people's comments. And you know you hear people talk and say "well women are never going to make as much as men in medicine because they're taking all this time off." (Senior female physician) and (senior female physician), I can tell you, never took six weeks off to have a baby.

The perception of women as emotional that both male and female physicians described for me was linked to their cultural roles as mothers by the male physicians. Statements about women's emotionality were interwoven with statements about their reproduction *by men*. Thus, these statements further the elucidation of academic medicine as a male cultural model.

Women Have to Work to Control Their Reproduction: "You gotta be present to play"

There was no difference in how men and women described the ways in which women but not men are expected to control their reproduction. Many of the physicians, both men and women, equated my questions about part time work as a proxy for women taking time off to have a baby or raise children. Both men and women would describe animosity towards women who took time off in residency because of call loads, but then would continue the discussion into how women are forced to negotiate their time even as assistant and associate professors. Their

statements illustrated that women still incur the motherhood penalty (Budig and Hodges 2010) at all stages in their professional trajectories.

A female physician who had her first baby in residency described the way in which the subtle messages build tension for women that they have to work doubly hard to overcome. She even worked during her whole six weeks of time off because her baby was later, and didn't end up getting her time off with her child.

> I felt, and it wasn't anybody who said it, but there were subtle messages that if you want to get ahead as a woman you have to prove yourself. And to do that you had to work longer and harder than the males. Because women don't work as hard. And because they get pregnant and they want time off and all of those kinds of things. So…I had a baby, my second year of residency. So, I had to make up all the calls that I was going to have during that six weeks that I was gonna be off while I was pregnant. So, I was taking anywhere from seven to eight calls a month and the males in the residency were taking six. Because I had to make up for being pregnant and being gone. So…the message to me was, you have to work harder, you have to work longer, I don't care if you're having a baby. It was very clear. If you're going to be gone, you have to make that up because while you're gone everybody else is gonna have to work harder. So that really wasn't the truth it was six weeks for god sakes, you know, and they had maybe one extra call. Well I was taking one to two extra calls every month during my pregnancy. But it was hard! So, my maternity leave was six weeks, was not long enough, first of all, and second of all I was trying to just get rest with a new baby, it was incredibly hard. Back to work. -**F4**

Women don't get this idea of constant availability and pressure to work through their reproductive years out of thin air. It is first present in medical school, as a male physician described for me how women who take time off in medical school, residency, or during their professorship are policed even by other senior women physicians:

> Well they'd say, you know, it's a good thing you can have your eight weeks…It was both male and female (saying that). There was also a culture early on, with the female faculty, would lead them to say, you can do it like I did. You know. So, what's up with this "take a break"? Push through. Don't let these guys show

> you up. And it wasn't even that, some of it was but some of it was "I did it, I got kids and school and a husband." It wasn't until the 90s that some started saying "my husband stays home. -**M5**

And he wasn't the only male physician who described women policed reproductively to me:

> **M4:** It was out there. "You can't get pregnant what are we going to do with the call schedule?" I'm talking about (specialty)…but in my experience going through I think I was a third year, on a service and…six women announced they were pregnant in a period of three or four months and that had everyone kind of undone. How are we going to manage that? And then…one of these women, you know I thought she was just amazing and still is, and she started having blood pressure issues and had to be off of work. And in those years, there was NO flexibility with that stuff at all. Now of course it's an expectation and when it happens you just deal. But in that era, they had to restructure everything and at least in our department that had never been done before. Also I'm in a different era right so as a male in that era I had no trouble if they wanted to pull me from one service to go cover another one because we had a woman that's off on leave, that didn't bother me at all, but I gotta tell you there were a lot of people that didn't want to be pulled, did not want to be inconvenienced, some of them women who had already had their children and didn't inconvenience others and so "you're not gonna have me pull extra call away from my children now because I worked it in a way that didn't hurt the rest of you" and there were some pretty vocal comments at the time.
> **Interviewer:** Did it make it really contentious?
> **M4:** It wasn't as ugly as it sounds, because I'm condensing it into three minutes, but even at the time I remember thinking you know you should be sticking together just because you're all women, but at the same time I understood. …But I was single and I didn't have children so it wasn't the inconvenience for me that it might have been for others.

This difficult negotiation of their loyalty to the profession and their reproductive choices follow women into their junior level professorship. A male physician who was a former leader in his department, when I asked him what was needed to bring gender equity to his field described it to me like this:

> I do think they truly make an effort in (his department) to recognize women and there are enough women there that the men can't fulfill all the positions anyway, nor do they all have interest in doing that. I do think the challenge for all women is both having the babies and rearing the children, much of it still falls to them. And so, where they're taking you know a chunk out of the time that they're, let's

> say they're a faculty member, the men don't do that (take time off) for the most part. There's some (women), maybe they'll take two weeks off. Maybe they'll take three weeks off. But I don't see, it's unusual for them to take six weeks, eight weeks, that sort of thing. So there, I think, it sets them back. It doesn't take away their opportunity, but I think it makes it more challenging for them. -**M7**

Men and women alike recounted to me tales of caution about anyone that might "take too much time off." This included the idea of part time work. Both men and women described for me how taking time off or going part time was the sound of the death knell for anyone's career. A female physician assured me that one could "make a comeback" after going part time, but it would take many years to get one's momentum back. Most physicians simply stated "Part timers don't get promoted." Almost all of the physicians described women taking part time, but a couple of physicians stated men sometimes needed to reduce their professional duties as well. But only one female physician stated that she had seen a male physician go part time and that he "never made it back." It was overwhelmingly stated that women take part time to the detriment of their careers. Here a male physician states how "being present" was imperative. In fact, employing this idea was a key way the doctors signaled to me the meritocratic idea of effort. Being there was imperative and part time would by design create gaps for someone's career:

> Yeah, I think there is a certain threshold for a clinician. I think there is a certain threshold that if you drop below you very quickly lose your connections and your credibility with your peers. *And for me that has been if you're talking about going to less than 50% involvement in clinical people aren't going to know who you are, aren't going to know whether they can trust you, uh trust your judgement um you're not going to be able to establish those connections*, particularly in an environment where like any academic medical center where you've got turnover all the time, you've got new residents you've got new partners you've got new referring physicians. *You gotta be present to play*. **M8**, emphasis added

Two separate male professors described to me with incredulous awe how a female physician dealt with her doctor's orders to bedrest during a difficulty pregnancy. They recounted with reverence how she put a hospital bed in her office and continued to work.

> And (female professor) had been put on bedrest during her pregnancy, so she brought the bed into her office. She'd read, write, whatever she needed to do in her office, and lay down when she needed to, *she's amazing.* And *you didn't know about it*, it's not like she said "oh I gotta do this or do that because I'm pregnant" *she just did her job*. **-M4,** emphasis added

Given the difficult terrain women face in academic medicine in their child bearing years, I was not surprised to see that both male and female physicians also signaled a male cultural model of work regarding women and continuing childcare after the birth of their children.

Women are Burdened by Childcare: "Now it should be such a given and it's not"

Nearly all of my participants (both male and female) brought up children when asked what held women back from promotion in academic medicine (even the childfree female professors stated this). Women's cultural role in caretaking and household obligations in their personal lives is well established (Hochschild 1989) but my evidence shows that the expectation for professional women is still a blurred line between the personal and the professional. None of my participants brought up childcare or household duties for male physicians. My participants talked about the relationship between women and children in emotional and material ways. Both male and female physicians stated that institutional child care was imperative to support women's promotion. And both men and women described how women shy away from leadership workshops because of the time away. But women described this negotiation as a struggle, while men described their absence as "women want to be home with their kids."

The statements made by both men and women about the effect of children on a woman's career and how to manage it elucidates Kanter's (1977) framing of the "two-person career" in

which professional managers were bolstered by their wives doing all of the work at home. A career such as academic medicine is similar, in that to be the *best* academic physician, one needs a helper to prop up their lifestyle so that one might be fully charged and focused at work. As women are culturally wives and this helper is almost always a wife, women themselves are at a catch 22 while managing both cultural roles.

Regarding institutional childcare, both men and women stated their support because of the boost to women in leadership positions. But even the way they talked about how this helps women was distinctly different. Women talked about struggling to get all of their needs met while men talked about childcare lessening women's burden because of stereotypical devotions of women desire to be home with their children and must actively work against that pull. A female physician stated for me how managing the struggle is what keeps women from advancing:

> **F6:** Well the power structure, and I mean women physicians are still paid less than men. And women are not, still are not, there aren't as many women deans in medical schools for example. Vice chancellors and the power structure is still male orientated, I think. Nothing's changed. And some of that, I'm sure is that women tend to turn down administrative jobs because of family responsibilities and they're trying to keep their professional life going, it's hard, it's not until later when the children are a little bit more independent that they can take on some of those extra loads…
>
> **Interviewer:** so, what still needs to change to bring real gender equality to your field?
>
> **F6:** Um, it's difficult. One of the things that I think does have to change is that somehow, we have to well, childcare for example. We have to make it easier for women in the training years especially, the younger years to obtain affordable child care. I think that's a huge issue.

A male physician also suggested that institutional childcare would be a possible draw for committed professionals, stating that the time management boost afforded by onsite childcare would be a rising tide that lifts all boats:

> It seems much more fluid and easier that way. I think people do plan carefully about starting families and all that but whatever their plan is there's a way to work through the system and make it happen. I still think we suck at childcare in this country. Until that gets fixed, none of this is going to work right…And we absolutely have to have that on site. Maybe it's over in (building on campus) and you can walk over there when you need to, it is not that hard. It would be a plus for our training programs, it would be a plus for our school. It would be a plus for our hospital…because people will flock to work here, you're gonna get the best and the brightest, and I'm telling you, I would have picked a residency program based on great childcare if it even existed in that era. And it didn't. Now it should be *such* a given and it's not. - **M4, emphasis original**

Specifically, when talking about women in leadership, men and women both responded that it is more nuanced professionally for women in leadership roles because of the time constraints. Leadership roles add time to a physician's work day, and women who are beholden to young children are already squeezed for time. A male physician, when asked why there were less women in leadership positions in the medical school described it this way:

> So there just aren't as many women in those positions. I also think that some woman, administration takes up so much of your time, so once you actually take those roles, if you want to maintain your other clinical and research roles it takes extra time. And I think (that) a number of woman and even some of our own faculty have explicitly expressed to me the idea of the interest in doing this when their kids are older. And I think that the men that I've run into…I've never heard that from a man and I've heard that from a (woman)… Now I think most of them would be willing to take on those administrative roles once they're (kid is) 13 or something like that. -**M7**

This same professor posed the question: Do women really want leadership positions?

> So, the question is, and I think this would be a very good question, is do we have a lot more woman who want to be in administrative positions that aren't getting them, as opposed to men? You know, I would love to see more women in leadership positions, but I don't know that it's fair to ask people to want to be necessarily assume those things. I would want them to be ready for those positions when they want them. If that makes any sense. I'm not assuming that; I'm just saying I have some who don't want them. -**M7**

This perception of women struggling to manage their devotion to work and their children was pervasive in men's responses about why women weren't in leadership. A male physician alluded that women receiving attention about their difficulty in managing the delicate work life balance could be about how one presents themselves. And he wasn't alone. Another male physician responded to the same question, "No, but I think it all depends on how you comport yourself" This subtle victim blaming of women who struggle with being perceived as professionals when they are mothers is a burden that men don't have. When I asked him if anyone had ever mentioned to him how to balance work and family he responded:

> Nothing of that sort, just sort of social conversations you know, but nobody asked about what would I do in this situation, no. And some of that is on me, because I never really offered. You know, again, *it's how you present yourself, you know, and a lot of times I, particularly in those days would present in ways as very business-like, we're here to do this, not that*. – **M2**, emphasis added

No male or female physician ever described for me men's stigma as fathers. For women, the best way to "present professionally" is to erase any indication of having children from their professional lives. One way that professional women do this is by hiring nannies. A female physician told me that she had been told in medical school by a woman with five children to always hire help to get it done. And another female physician described for me how she encountered an understanding of this presentation work of a professional self (for women) at a leadership training:

> I went to the AAMC midcareer training and sat around in my small group with the women and we talked about just this issue, and there were probably 20 women in that room who were associate professors, mostly physicians, some PhDs, and 18 of them had live in nannies. And that's how they were doing it! You know, their husbands worked and they worked and they had live-in nannies -**F3**

The stigma of women and child care is still present because of current stereotypes about biological imperatives. Both male and female physicians described contemporary attitudes about working mothers that were negative. A male physician describes how women are still patronized when they are working mothers:

> **M3:** I still think there's an awful lot of discussion still, rightfully so I think, "oh isn't it wonderful we're getting a female dean. Isn't it wonderful she was able to work her way up through the ranks" so it's more subtle, but I think it's still this thing of "we have these two candidates, and we…?" …and "well we don't want to consider this candidate you know she's female." And they still say "Oh isn't it wonderful despite having two children and being married she was able to achieve this."
> **Interviewer:** Do they ever say this about a man?
> **M3:** They don't say this about a man. They don't say, "oh isn't it wonderful that he's able to be married and have two children?" And usually it's because they have a supportive wife. And sometimes even if she's also a physician or a professional attorney, it's not thought to be well, she still has, probably self-imposed given cultural norms, the second shift.

Again, drawing on the biological imperative that women are just different, a female physician stated she felt that child rearing is inherent to women, and will not likely change:

> **F9:** You have to make the choice at some point as to how much time you're going to put into something. Um and I don't know how to change that because I don't think I necessarily want people to work less hard to obtain goals. I think that we need to give people the right to do what they want to do and not worry so much about the gender equality thing. If we need to have men working less hours and a few more women working more hours, you know, let the men do a little bit more of the child care and child rearing
>
> **Interviewer:** What would enable that to happen? What would enable that change?

F9: Well let's ask another question, are we sure that would be good? There are certainly men in this world, and some very nice ones, who are naturally the role, take the role of parent very seriously and who really want to change diapers and take care of their children in a very one on one very good way. But there are more women who want to do that. And I think that's biological.

Interviewer: So, you don't see that change happening?

F9: Not really.

Conversely, some male physicians would claim an optimistic view of the possible changes in this gendered dilemma. When discussing how women didn't take on extra tasks in their child bearing and rearing years, a male physician predicted, invoking pipeline theory, that it was merely time that would be needed to change the distribution of women in leadership:

I think a little time and patience would be helpful, because I think we have a cohort that's arising that may be more interested (in leadership roles), and so we would probably have to give them opportunities to get exposure without extraordinary time commitment. – **M7**

The argument of "in just a little more time we will see equality" is one that has been bandied about for quite some time, so it is not surprising to see it declared here. But we already know that time has not been enough to right the path for fully promoted women in academic medicine. A solution besides childcare that was offered by both male and female physicians was to negotiate more carefully one's partner in child rearing. A male physician described a way for women to find the time necessary to devote to leadership roles—get a wife!

M1: Yeah, I think it's hard to get people to take on those roles, it's just more work. So, when you get a leadership position, it doesn't necessarily mean that you get paid for it. So, again when we get back to what you said about how do you balance family, well, yeah? How do you balance family? So, first of all, I think it's difficult to be a woman in medicine and have a family. I think it's harder for a woman then it is for a man.
Interviewer: But, why?

> **M1:** Because my wife stayed home and took care of everything. I mean, my wife takes care of everything!"
> **Interviewer:** So, women need a wife at home.
> **M1**: Well, I've said that to a lot of women. I've said, what you need is a wife at home.

Men were not the only ones to state that having a wife makes an academic physician's life easier. Women echoed this statement as well. Additionally, women, and a few men, would state emphatically that one of the keys to success was "finding the right relationship." What they meant by this was that by picking the right partner one could eliminate the tension and strife that can crop up when professionals devote themselves to their careers and have less time to spend at home with housework or child care.

> You've really got to prioritize…you've got to find out with your significant other, if you have one…you've got to find out what their expectations are. I feel fortunate that I …married somebody, she grew up in a house where her dad worked all the time, and that's the way it was. That was what she saw, and you know, we both worked when we got married, but her plan was, well once she started having kids, she wanted to stay home. Great! It worked out great for us. Yeah, that was, that was her hope, and that was my upbringing and that's what I'd grown up with, with my mom stayed home, and it worked great… That you kind of see what worked and I had felt like my childhood was wonderful. And so, when she said, *that's what she wanted to do, well then there wasn't anything more to discuss, we were both in agreement, that makes it easy.* -**M9**, emphasis added

Women also described it to me as finding a partner who would "pull his weight." Men did not speak about finding a female partner to pull her weight. All but two of the men in my sample had stay at home wives. The two wives that were employed worked in the medical field. But women did not describe their husbands who contributed at home as acting like a wife. There is a key cultural difference between "being a wife" and "pulling one's weight". "Pulling one's weight" is about a partnership where both members share in responsibilities. "Having a wife" implies that one partner will assume all child and household duties while the

other partner will be completely unfettered by all child and home responsibilities in order to devote oneself with undivided attention at work. These deep gendered cultural ideal types are actively present in these physician's accounts of their and their colleague's experiences. An institution is not completely meritocratic while these cultural models are present.

Some of my sample may not personally subscribe to the ideal that women and men are inherently complete opposites, yet as we've seen in the previous section, many have adhered to their gender role socialization that women are nurturers, collaborators, relationship builders, and part of a team (with men as the opposite). Studies on perceptions of women doctors have shown that they are perceived in these same ways (Babaria et al. 2012). Acker (1990) states, as I have described here, that gender inequalities are built into and somewhat formed by organizational processes, which would explain how the unequal distribution of women and men in higher medical academe persists. Acker states that the "image of the worker" is masculine and male: men's bodies are worker's bodies, because under patriarchy, their bodies do not have the "imperatives of existence" (pg 149) of procreation to contend with. These disembodied (read: male) workers do not have household and childcare duties that will interfere with work. The ideal worker, able to devote full time and effort to the job, is code for "male." Thus, women are disadvantaged in occupational structures because of the gender inequality built into them in structural, cultural, and interactional ways Conversely, men are doubly advantaged by the exclusion of women first, as competitors in the professional realm and secondly by the material support they receive from the women in their lives who do the work at home to leave their professional lives free and unencumbered.

Adding to women's disadvantage in a male cultured environment is what Williams (2014) terms the descriptive and prescriptive bias women endure because of their cultural roles

as mothers. Stigma for working moms (descriptive) and assumptions that all women who are mothers are not competitive enough nor "all in" at work (prescriptive) directly links to Blair-Loy's (2003) findings that women describe their work life balance as nearly impossible to surmount. When my participants said that "women do it to themselves" (the feeling of being persecuted as mothers, and feeling like they couldn't achieve work life balance) they were assuming that being a professional and a mother comes with no cultural baggage at all. But it certainly does.

Belief II. Attention to Gender Diversity and Equity is Unnecessary

The second tenet of meritocracy is that meritocracy is assumed to operate solely on the basis of individual effort alone. Thus, attention to gender diversity and equity is unnecessary and unwarranted. To design interventions to affect outcomes of special groups would erase the first tenet of meritocracy as a setting in which individual merit prevails and discrimination cannot obscure the outcomes of individual efforts. Because the setting is defined as value free and non-discriminatory, any special attention to ascribed traits of an individual (such as sex and gender) is antithetical to meritocracy. In reality, however, this tenet obfuscates the dual gendered processes at work in the institution.

Both men and women would state that gender shouldn't and doesn't matter in academic medicine. Even when men acknowledged that they received their positions without proving themselves (at least, not vigorously), they would still argue for a system that does not give attention to gender difference or discrimination. And even after recounting sometimes harrowing experiences with gender discrimination, women would also sometimes emphasize that gender shouldn't be an institutional focus of academic medicine. Below I give evidence for the

second meritocracy belief in this study which deems special attention unnecessary in academic medicine.

Some physicians in this study displayed hostile reactions to discussing gender. Particularly when I asked about challenges and obstacles in their early professional life versus their later professional life, some women would state that they had experiences in the past but that it shouldn't continue to matter for their current professional experience. Female physicians as well as male physicians expressed dismay at a conversation of gender when discussing the various social mechanisms at work in their experiences in academic medicine. A female physician who described for me past occurrences of gender bias responded when I asked about any current bias:

> **Interviewer:** Do you see any persistent gender biases?
> **F9:** I really don't see much. *I mean I guess that's what I'm not sure the purpose of the interview is,* um, I don't feel that there were a lot of biases that I could detect. I'm sure there were implicit biases and implicit messages, and I'm not questioning that they were there, but I received from my view very fair treatment as a medical student, I graduated at the top of my class, I didn't run into anybody who stopped me from doing anything that I was willing to work hard enough to do. And I don't feel like there were gendered themes almost anywhere, with the exception of maybe the oldest male physicians, and I was the youngest student, who seemed puzzled by it. Um but as far as direct lost opportunities go, and I'm sure that's because a lot of the people went before and did a lot of that hard work. But I have some trepidation about making gender a theme in an era where in a field where, half the medical students are women, half the internists are women, half the, our residency class is half women, and *I think we can twist it into something it shouldn't be if we get too focused on gender (*my emphasis added).

She's not alone in her befuddlement regarding gender as a topic to be discussed in this day and age. Men also expressed a disdain for approaching the topic, treating it as a conversation for a bygone era:

> Honestly, I don't recall anything being said about the number of women, or the prevalence of women, or the increasing, you know, presence of women in medical

> school. And *I still don't pay a lot of attention to those things*. You know it's like, I really honestly try to deal with people as who they are, not what sex they are, I mean if they are good and honest with me, I owe them the same". -**M9, emphasis added**

This same doctor, when asked if he ever saw a climate that was hostile to women, sighed and answered,

> You know the only thing, I think…. I think a lot of the pain that we feel is inflicted upon us is actually inflicted upon ourselves. Depending on our situations. And, you know in my case I know that's true; I know I'm much harder on myself than the system has ever have been. -**M9**

Another physician, when asked if he saw more men or women in positions of leadership at his institution stated that a previous dean had "promoted women" and that he was ready to move on from talking about gender. What is interesting about his statement in particular is that the dean he is referring to had the opposite effect on the women. Most of the women in my study did not view this dean as friendly to women and in a handful of cases as detrimental to their careers. He explains his frustration with the continued conversation of gender:

> I actually see it pretty open. I felt like, and now, you wanna be politically incorrect, I felt like (the dean) in particular really promoted women. I mean everybody around, whenever (the dean) had a position…tried to put a woman in it. And I really felt like (the dean) had a strong sense that (the dean) has to play this role to get this, to kind of bring everything forward. And sometimes I'd find that irritating as a male. Particularly as a male with my mindset in the way I grew up, because again like when does it stop, when do we just look at the person for the job and quit thinking that they're all white middle class males. When do we quit looking at gender, when do we quit looking at race? **-M4**

While the respondents quoted directly above expressed the strongest reaction against considering gender in the experiences of academic physicians, they were not the only ones to couch this kind of sentiment. Some women *and* men expressed their concern or disagreement

with "looking for" gender, and some of my respondents would adamantly say that they do not look at things "in this way." Both women and men would tell me when I asked about gender diversity in their departments, "The opportunities are there if one wants them." One male physician when I asked about gender diversity in his department stated, "Oh I just knew this was about women." The second type of gender-blind statements were less hostile about a conversation of gender, specifically gender diversity, but showcased how some physicians saw gender diversity as being simply unimportant. While the men in this study did not appear motivated to exclude women, they consistently argued for the "best fit for the job", which in academic medicine, is someone who fits with the male cultural model. A male physician told me about a job search for a new chair for the department, where a man was appointed when a woman had also been in the running, and described it like this to me:

> (Regarding the appointment of) the chair of (department), that's not an anti-woman thing, he's just an incredible fit for the job. You know but I think the women probably have to still feel this way, I mean I'm not saying it doesn't exist, I just don't see it the same way. -**M4**

And another male physician describing gender diversity in leadership:

> "In my current institution, I do not know why I see a preponderance of one or the other (in leadership). *I have not thought about it.* I am aware of some women in key positions both past and present. But no, I do not, *it is not something I have really given thought to*." **M7, emphasis added**

Both of these attitudes create a double bind for women. One implies that women who do experience gender discrimination do so only because they are not as smart, savvy, or successful as their peers. At best, perhaps they are just too sensitive or too attuned to looking for gender trouble. These statements could be perceived as a way to ignore gender and the effects of gender on advancement in medical academia. Sociologists argue there are structural elements

that explains why women do not succeed, but these statements erase them and place the blame on the individual.

Another way in which the women enacted the meritocracy code was to remind themselves and others that women are not here to make excuses (about gender) and that hard work creates the conditions for women's success. Many women described variations of this when I asked them what advice they had for women coming up in their specialties or fields. The question I asked was specifically tied to how to mentor young women in the field, but the women respondents would often say: work hard and you shall reap the benefits. This meritocracy belief had served these successful women well, as they were all fully promoted and successful physicians. This also ties into how women would also couch obstacles to success or an inability to progress in rank as something because of personal choices, personality, lack of inherent ability, and drive (but never because of gender). Success, one woman told me, was in "how you put things together." Many women, when I explicitly asked if they've seen gendered patterns in mentoring or differences in their students or colleagues would respond with something along the lines of "maybe, I don't know, I'm not looking for it, I try to ignore that stuff." These statements reveal that women work hard to protect their meritocracy beliefs, at the detriment of uncovering the unequal experiences that women have in academic medicine. Men on the other hand, when I asked them about gendered patterns or differences in mentoring would respond that women are more inclined to listen better and to treat individuals as a "whole person" which is a doubling back to the code for women as an "other" in the male dominated culture of academic medicine.

Regarding mentorship, a male physician offered his opinion on targeted approaches even though I hadn't asked. He argues adamantly for a merit-based system, but as I've already shown with previous statements, we know that the merit-based system is a male cultural model. His

disdain for a "quota-based system" showcases how belief in a meritocracy discourages attention to diversity because once diversity is acknowledged, it becomes a slippery slope away from meritocracy. He stated:

> …I mean as you might guess, I am not a quota guy. I hate quotas. You know, in my opinion it should be illegal to label somebody as black, or white, or male, or female, or I don't think there should be any data kept, because when you keep data, then you're driving towards a quota. It should be based on merit. Solely on merit. -**M8**

Another male physician dismissed the idea that one's ascribed status should be considered. Though I did not explicitly ask for an example of such an instance when he was faced with a peer or student who "demanded sensitivity to culture and identity," he ends his statement with something seemingly good willed: "tell me about your difference and I'll tell you about mine." But he specifically said at the beginning of the statement that he was "offended" by an assumption that cultural identity could affect the outcome of a relationship. As someone of the dominant culture in medicine (a man), it is not difficult to understand why he would say this. A lack of adversity in one's own experience will likely cause one to directly ignore, or even dismiss, a conversation of someone else's "cultural identity" (which here is a code for different experiences in an institution). Harding's (1986) standpoint theory is applicable when analyzing his statements. This physician is using the phrase "cultural identity" to signal not-white and not-male. It's curious to see how he doesn't consider himself to have a "cultural identity." Those who already possess dominant status in an institution will likely misunderstand how "cultural identity" experiences of a marginalized individual directly shape their perceptions and further experiences:

> Yeah, you've touched on something that I have found frustrating in my work with students and things like that, and even peers. Is sort of this whole sensitivity to

> culture and identity and if you don't share my culture or my identity whether it's racial sexual what have you, then there's a barrier to a relationship. I've never approached it that way, and I'm offended by (it). But I find this whole discussion that seems to be percolating in the broader culture right now about cultural identity as offensive…So my approach has always been…so tell me about the difference. You tell me about your experiences, I'll tell you about mine, and we'll come to some understanding. -**M8**

An interesting finding of male physician responses were that they would talk about their mentorship experiences in medical school, residency, and as early career faculty as a kind of perfect fit, as in, they and their mentor were just drawn to each other. Women did not speak about their mentors in this way. I began to ask them how they felt about more targeted approaches to mentoring, such as formal mentoring programs where junior level people are matched with a mentor to guide them. For example, some men stated when asked about formal mentoring: "There is definitely value in it, but I think even in this day, a lot of the strongest relationships tend to happen spontaneously," and another male physician echoed "some people just don't have it." A male physician stated, "you know, I don't, I'm not a big believer that you can make a leader. I think people are either leaders or they're not." And a female physician stated,

> If someone doesn't want to be mentored, you can make this relationship and they can to lunch once a month or once every six months but I don't think, it's not going to have the same impact as if someone is going from stage to stage in their career and is really seeking out mentorship. But anyway, I kind of digress there but I do get frustrated with mentoring programs where people try to, it's almost like match.com, they try to match people up. -**F3**

To be fair, some physicians stated that formal mentoring wasn't always going to work because some senior physicians aren't good at mentoring. They noted that some senior physicians are not warm or kind or attentive enough to mentor someone. But some responses

showed how men were hostile to the idea of giving special attention to certain groups, echoing my finding of gender hostility above. We must pay close attention to what he is signaling in his response. Like the physician before him, he is unwilling to pay attention to "political correctness." He used this term throughout the interview, and it was always when I asked about gender diversity in academic medicine. His use of the phrase whenever talking about gender diversity was not surprising, as I've already established that a meritocracy would not need "political correctness" (attention to diversity). But if you look at how he codes for difference, he says "Some personalities are immutable." He meant that some people are not adaptable to mentoring because of how they are hard wired. And he stressed for me how forcing people into mentoring relationships was akin to "political correctness" (attention to diversity, which is unneeded in a meritocracy). I should note here that this is the same professor who above told me that his career boost was absolutely not merit-based. A second male physician responded similarly, that mentoring may not work because of "personality clashes". Describing the problem as personality fit is a more amorphous signal than the previous "cultural identities." This is benevolent sexism masked as meritocracy. What they are implying is that it is nothing personal, it's just that some people don't have the right personality for mentorship. Even while claiming to disavow attention to diversity, they have learned that there are savvy ways to signal a justification for excluding groups:

> Well, to some extent, I can see how there might be value. I think that at the core of mentoring is a personality that pretty well-established. It is not mutable. It is not-- it is what it is and let us see. Maybe you could say, "Well, let us take that personality and see if we can nurture it, and get it to express itself in a way that would be positive." You know I am old school and I am old. *I am suspicious of change and I am distressed by rules and regulations, and I am just absolutely apoplectic about political correctness.* -**M2, emphasis added**

Lastly, there were more men than women who used tokenism examples or individual solutions instead of institutional, structural solutions to the problem of a lack of gender diversity in fully promoted medical faculty. However, *some* men did give structural arguments for what would be needed to solve the issue of gender diversity. One male physician explicitly stated, "We need to be more inclusive in hiring and promotion of women." A professor who was previously in a leadership position of a department spoke about his dedication to hiring more women and professors from outside of the institution. He stated many times that diversity made an institution stronger. He was the only former leader who spoke about his overt dedication at the institutional level to promote gender equity of the department. Yet, despite his efforts, a look at this department showed that his department follows national trends in gender equality. Women are 17% of the full professors in his department, despite being 49% of the associate and 42% of the assistant professors. Recent research on the trend over the last 35 years shows that fewer women than expected are achieving senior rank in the expected predictions based on statistical models that adjusted for graduation year and department type (Richter et al 2020). And what's even more interesting, a female physician explained to me that she hadn't exactly noticed anything was unequal *until she reached a senior level*. It would make sense that she wouldn't notice until moving in senior level spaces because data shows that gender diversity is not an issue at the assistant and associate levels. It is specifically the senior full promoted level in which the trend will not budge:

> I've been a little unique from that perspective in that I haven't, I haven't really felt that male dominated nature of medicine until lately, when you work your way up and you're in these leadership positions and then you suddenly realize you look around the room and you realize wow, I'm the only woman in this room. So that's not something that has happened to me a lot, up until the last I would say two or three years. -**F3**

Those who dissented in their statements about the lack of gender diversity did so by calling on the representation of women in medicine and the male dominated culture of academic medicine. But all of the participants who described this problem to me also adamantly supported the belief that academic medicine is a meritocracy. Surprisingly, a male professor in a highly male dominated specialty explicitly called for targeted attention a need for change:

> I hear it a lot more today, being on the American Board of (specialty), one of the biggest things that we talked about frequently was, we don't have enough female input. We need it. We've got so many female residents coming through, so many applicants. In my mind you have to appear that you have enough diversification on your board like that to not appear to be conflicted. Same thing with our board of (specialty) directors. Ok so for the American (Specialty) Association I'm on the board of directors. Never had a woman on there until this year (Summer 16). And that's kind of crazy when you think about it. I think that's changing because people recognize it. But I think if you're going to have some face validity with the people out there that you're governing, especially when about a third of (specialty) are now female. You better have some females on those governing boards. (Specialty) in general have been very male dominated until it started to change. But I think there has to be a conscious effort to change it to some extent, especially when you talk about governing boards, some of the highest levels of governance, there has to be a conscious effort. -**M5**

However, another male professor described how the ideology of meritocracy could derail conversations about increasing gender diversity in fully promoted professors:

> There are more women (in leadership) but it's not so much that is has been precipitous as it's been very gradual. So just thinking back, I mean I'd have to count up. And it's usually a specialty. I think that it is, I have seen a bigger change for clinical departments than basic science departments. They're still keeping the females down. I will tell you that I serve on the post tenure review committee, and the female (professors) are given less opportunities for flexible schedules in basic sciences, and less flexibility to time to tenure. The leadership still has lagged and there's still more male (professors). And you see it changing, and there's been explicit discussion, which I think it's extremely helpful to discuss it, but there's also a little bit of a backlash too, the more you discuss it, the more like, why can't we just leave this alone, all I care about is good doctoring. And that's how we discuss now affirmative action, well we don't need to do this stuff because we're just going to reward people for hard work. **-M3**

And a female physician stressed the importance of finding a mentor who wouldn't pigeon hole women because of gendered stereotypes. Her ambivalence about the belief of meritocracy and the understanding that gender affects women's experience in medicine can be seen as she weaves comments about both into her statement:

> Find someone with a very open mind and I say that and I don't mean an open mind as far as social open mind. *Because there are, in academia, there are individuals who still can't get past gender…believe me, academics like smart people who work hard who, you know, it's not like the gender gets in the way of that.* But they do worry about, er, are you going to go part time and need time off or whatever, so I think you just have to make sure you have someone who's not going to be preoccupied with anything but the skills you have and what you need.
> **-F11, emphasis added**

Given the above evidence for physician's statements on the tenet of meritocracy as a setting in which special attention to diversity is unneeded, it is clear that one's perspective of a problem is shaped by one's own experiences with adversity in an institution. It was more so men who argued that there was no need for special attention to be paid to the lack of gender diversity in fully promoted medical faculty. Additionally, men who have been sensitized to the issue (a training in social sciences or a relationship with someone who has experienced a marginalized status) possessing a perspective of the need for institutional change falls in line with Harding's (1986) standpoint theory. Privilege is invisible to the person who has it. Most of the men, because they don't experience a marginalized status in academic medicine, are unattuned to how disadvantaged women are in the male dominated environment. So then, if the women in my study do experience gender discrimination and the men don't, the third tenet of meritocracy and diversity, that is, a belief that the system will always reward even if there are discriminatory actors warrants examination.

Earlier, I showcased evidence in my participant's statements about the ideology of meritocracy meaning effort equals success. While it is not surprising that the physicians in my study would talk about hard work, the way in which they perceived and talked about what hard work means to them was notable. Most of the physicians would adhere to the standard of effort being time at work. This was the expectation and anyone not conforming was perceived to be deviant and devalued accordingly. A common complaint, for example, was about physicians who didn't want to put time in *at work*. I found these statements about effort and hard work to be an extension of Fox's (1968) findings about the socialization of medical students regarding uncertainty and Bosk's (1977) findings about efficiency and the mechanisms that physicians use for informal internal social control. When male physicians signal to me physician deviance they are alluding to the informal internal social control that facilitates trust and sameness in an uncertain profession.

Belief III. Systems are Meritocratic, but Individuals may be Discriminatory

Given the belief that meritocracies are non-discriminatory institutions, how does one account for discriminatory acts when they inevitably happen? Here I found most of the men in my sample perceiving acts of discrimination as emanating from pathological individuals instead of groups or systems. Conversely, a handful of women also explicitly described discrimination as one-off events and not systemic. Most of the men saw discrimination against women *as a group* as a thing of the past (usually in recounting tales from medical school or residency). If the men recounted stories of themselves as experiencing adversity, it was never on the basis of their sex *as men*. Every single time a man described dealing with an adverse event in their career (and

there weren't many), when I asked how they had handled it or how they felt about it, they would account for the individual's behavior as "oh so and so is just like that, he does that to everyone…." Below I give evidence for belief that discrimination is an individual trait and not systemic.

Downplaying discrimination: "Adversity makes one stronger"

Most male and only a few female physicians in my sample denied that discrimination was systemic and attributed unfair experiences to pathological individuals. One of the differences between men and women's responses, however, were in how they managed adversarial events in their professional careers. Women overwhelmingly described for me the emotional and presentational work they had to do to deal with the discrimination they experienced. No male physician described this kind of professional presentation of self to me (and it should be noted men hardly described *any* discrimination or challenging events, which I detail in chapter five of this dissertation). Additionally, a male professor insinuated that if individuals are discriminatory to you, one might consider it fodder for a well-developed character, as "adversity" is a whetting mechanism to develop strength as an individual. The implication is that one should be thankful for adversity!

> You know, this is life. This is the adversity of life that we should expect and cherish. Going back to the business about the bubble. The political correctness. I mean, it is just tough. I was really abused in junior high and I do not like it. But I do not think it crippled me. I think it probably made me stronger. So, there is a scripture that says which does not kill you makes you stronger. Makes you stronger. **M2**

Women also spoke of ignoring discriminatory behavior in colleagues, but they explained their reactions as being "easy-going." When I asked them about gender bias or

discrimination that they had encountered or seen, they told me that this was not the type of thing that they noticed, or that if they did, it didn't matter much to them because they just don't let things like that bother them. Even though many women presented to me the undercurrent of meritocracy as the reason for their success, they would then also acknowledge that they had been or were aware of the gender hierarchy of male dominance, backlash against women, or unequal distribution of resources. But they often explained away these contradictions with responses like "I'm easy-going" or "I don't really notice that stuff." A physician explained her tokenism in the group in this way:

> But even now I mean it's not unusual that I am one of the only women in a group of men, so among the module's directors for example in the medical school there are only two of us who are women the rest are all men. Um and I you know, after a while you just, you know, *that's just the way it is and you just don't worry too much about it.* -**F2** emphasis added

One of the questions in the interview was about experiences the respondent had with those who were to address the doctor as an authority such as students or residents. Most of the women I interviewed stated that students were more likely to call a woman doctor by her first name and a male doctor by his title. Most men stated that they did not mind being called by their first names but that even when they told their students, interns, and residents to call them by their first names, they would still be addressed by their title and last name. When the women described the pattern of how they were addressed differently than their male colleagues, almost all of the women would explain that this meant very little to them and that they did not mind being called by their first names.

> I've not found that, you know I'm so easy going that I think they just kind of, they come up and they want to know about that, and they all refer to me as (first

name), except for the newer ones, and they all refer to me as Dr. xxx. And I don't care how they refer to me that really doesn't bother me. -**F9**

This strategy of being easy-going extended to all kinds of experiences, including sexual harassment. This medical doctor had told me how she had experienced sexual harassment in medical school, residency, and even in her clinic:

> *You know it didn't bother me you know a lot because I was so used to it.* When you look back and you see some of the stuff and think, man that was, you know, I would not want other women to have to be in that position. *But it didn't bother me that much. And a lot of times I would just kind of blow it off.* – **F2** emphasis added

Conversely, a couple of men did acknowledge that women experienced discrimination in academic medicine. These men were more likely to state that a way to make academic medicine more gender equitable would be to increase the representation of women in leadership positions. A male physician hypothesized that having more women in leadership would garner more women in leadership. Here he describes why:

> **Interviewer:** And why do you think there's more men than women in leadership?
> **M10:** I think it's historically there's been barriers for women and the process of breaking those down has been slow
> **Interviewer:** What would need to change to have more leadership among women in the profession? And specifically, in this institution
> **M10:** Well I think that mentoring programs are a good thing and that having women as mentors makes a difference for women coming up in their careers. That's one. I think you know just anti-discrimination things for what we think are still the vestiges of the old boy networks they still exist in ways that we can fight that would be helpful.

And he wasn't alone. Another male physician described the same remedy:

> **M11**: Well I think, in a sense, it's still at proportion gender, and that is I think it would, the more woman we can get into positions of responsibility, it will aid

those that are coming thru training, because they will have more role models for their development
Interviewer: What would those ways be? What is needed?
M11: Well, I guess, ultimately this is where structured mentoring would help as well as identifying people who might be good candidates to assume those kinds of role's and try to get them engaged early on, instead of waiting for it to happen spontaneously. I mean, that's what comes to my mind.

There's a dimension of nuance happening in the culture of medicine at the institution of my participants. Both women and men are describing their views of the setting as a meritocracy where gender is unimportant and not worthy of investigation. Some male physicians describe a potential adversarial gender experience as inevitable "life is tough" or a rare occurrence. And some women described responding to gender discrimination by enacting a strategy where they just "didn't let it bother them." It is important to note that one's marginalized status could affect how adversarial interactions are interpreted. Whether the dominant status person intends to disparage someone because of gender or some other reason (perhaps the dominant status person *is* just adversarial to everyone equally), it will be more difficult for a marginalized status person (in this case, women) to "brush it off" unless, specifically, they believe it is a one off occurrence and not a system that is rigged against them. I've already described how Foster and Tsarfati (2005) found that a meritocracy belief is effective when dealing with a gender discrimination event. Because men occupy the dominant status in academic medicine, they rarely, if at all, attribute discrimination based on sex. The women in my sample were mixed regarding their perceptions and experiences. Knowing what Foster and Tsarfati (2005) found, it makes sense for the senior level women I interviewed to express that same meritocracy belief as the men. Specifically, choosing to see adversarial interactions with others in their professional careers as inconsequential to their long-term goals of promotion, or even describing their reactions to these interactions as cool, calm and collected might be related to how women are not allowed a full

range of emotional reaction in these professional spaces. The evidence for how women must conform to the male cultural model that exists in academic medicine supports this claim.

Conclusion

In the above statements, I've given evidence for my claim that the meritocracy talk of senior physicians shows a gender difference in perceptions and belief in meritocracy in academic medicine. I reiterate that meritocracy in academic medicine has not yet been investigated in the sociological literature even though it is a cornerstone of the profession of academic medicine. The evidence above suggests that academic medicine is built on perceptions that encourage gendered patterns of reproduction policing in the workplace, cultural ideas of fit and devotion, and gendered representation and power. These perceptions impact women differently than men because men enter an institution that is built for them culturally and professionally, while women are constant outsiders to the male cultured organization. Women consistently encounter ways in which their presence does not fit with the assumed tenets of meritocracy. Despite their own meritocracy beliefs, they encounter subtle and blatant messages about their lack of fit for academic medicine.

I am specifically making an argument about the cultural constraints female academic physicians face when entering the male dominated (both structurally and culturally) space of academic medicine. Structural impediments are well established, and predictions have varied as to how and when exactly the structure of academic medicine would reach a tipping point of representation, power, and economic agency on behalf of women in order to create real systemic change. Time alone has not changed the gradients of inequality toward full professorship and top leadership. The cultural ideology of meritocracy persists. Therefore, I put forth the

argument that meritocracy, as an informal internal cultural and social control mechanism, is the sticky floor keeping women from the same rates of promotion as men.

Specifically, the evidence shows a nuanced gendered difference in perceptions and beliefs in the institution of academic medicine as meritocratic, the attention to gender equity and diversity as unimportant, and discrimination as the work of a pesky individual and not an institutional failing. Comparing the male and female perspectives reveals that while both women and men profess academic medicine to be meritocratic, women are more likely to state a nuanced understanding of how academic medicine is still male dominated structurally, culturally, and interactionally. The ambivalence and internal contradictions in women's perspectives of the meritocracy of academic medicine is shown in how they protect their meritocracy belief even while discussing their own disadvantaged gendered experiences. They consistently discount the evidence of their and other women's disenfranchisement as a defense mechanism for persistence toward full advancement. The male perspective of academic medicine and perceptions they use to justify it reinforce their position. I have found little evidence that men conspire to keep women relegated to the lower rungs of institutional power and representation. Motives are not under investigation here. What is missing from sociological conversations about the persistent trend of gender inequity in promotion in academic medicine is how differences in perceptions of the institution of academic medicine as a meritocracy can be used to uncover mechanisms that link ascriptive characteristics to outcomes (Reskin 2002).

By displaying the gendered comparison of perceptions and accounts of academic medicine as a meritocracy I show how important beliefs about meritocracy are in reproducing gender inequality in fully promoted academic physicians. Reskin (2002) argued for evidence of mechanisms over motives to explain the persistence of ascriptive inequality. Gender dominance

in academic medicine requires both men and women physicians to subscribe to a meritocracy belief so that organizational processes of opportunities and award allocations seem to be fair and equitable. Comparing the difference in gendered perceptions and experiences with meritocracy belief in academic medicine in aggregate form instead of by a case by case basis is the evidence needed to show how both the male and the female meritocracy belief is a *mechanism* by which gender discrimination persists. The mechanism of meritocracy beliefs of men and women physicians work together to establish and reproduce the ascriptive inequality women experience in academic medicine.

The statements made by women and men in academic medicine show two distinct perspectives that work together to promote men more readily and hold women back. Men believe that academic medicine is a meritocracy but that there are also ways that one gets special treatment. But they assume that this is normal for everyone and doesn't fully take away the integrity of the meritocracy system. They do not give much thought to why women aren't getting the same boosts they are getting on path to advancement. As they described the male cultural model of academic medicine, most of the men failed to link the culture they were describing and how women may consistently be at a disadvantage in that culture. Many times, men account for women's inequity as an unfortunate side effect of the rigors of academic medicine. Their sympathy for women's position obscures how their (subliminal) cultural beliefs for women's lack of fit reinforce powerful institutional, cultural and interactional drivers for women's difficulty to advance. Men enter a space that has been cultivated from the beginning as a place where they just fit. And what they define as hard work (necessary for promotion in a meritocracy) is really only the kind of hard work that men can do as they are free from the cultural confines of being a woman.

Conversely, women do their best to stay in the game by carefully playing by the institutional, cultural and interactional rules of engagement. Women also subscribe to the meritocracy, and they are willing to play by the rules of such a system. The trouble comes when they start to acknowledge the evidence of their own or other women's discrimination. Their assumptions are the opposite of the men. Where men assume that everyone gets a boost here and there, women assume that everyone deals with disadvantages that must be navigated on the path to promotion. They do their best to ignore seeing women treated as less than men because their strong meritocracy belief assists their efforts for promotion. When women downplay their struggle, it keeps them in the game, but the treatment they receive is not equitable. These two similar yet distinct perspectives function as the mechanism that prevents women from succeeding in the same manner as men.

These cultural reproduction patterns have not and will not change based on individual efforts to mitigate the male cultural dominance of academic medicine. Especially because the culture of medicine is based on a strict set of cultural beliefs about efficiency, uncertainty, and internal informal social control (Bosk 1979; Fox 1957) that are masquerading as meritocracy. My argument extends Bosk's (1979) legacy findings of the way in which physicians enact informal social control by investigating how meritocracy is used as a proxy for internal informal social control. Additionally, I follow the theoretical line from Fox's (1957) contribution to Bosk's (1979) work to understand why exactly physicians need this type of internal informal social control in the first place. Medicine is a place of great risks. Mistakes cannot be normative and physicians must find mechanisms to decrease uncertainty in the face of such high stakes. The profession of medicine has long resisted outside, formal social control (Friedson 1988) and thus developed internal informal means of social control (Bosk 1979) by evaluating each other

on efficiency and error of judgement or morality. Errors of judgement must be placed against a backdrop of uncertainty, as in, a physician may not fault a peer for a call that could have gone either way for the patient regardless of the physician's intervention. The internal, informal social control then is like a curling broom socializing a trainee (student, intern, or resident) into the norms of a physician. Bosk (1979) found that events that shaped the trainees were mostly interactional conversations between an attending and a subordinate, or peer to peer conversations that reinforced the norms of evaluation. I found meritocracy in these interactional spaces, living as a cultural norm even though it wasn't necessarily a pure cultural practice.

As Bosk (1979) already developed a theorization of internal informal social control, I utilize his findings to investigate how meritocracy is used as an "informal discrimination" (Lorber 1984) which is by definition more difficult to challenge by marginalized groups, in this case, the women. The idea that systems are meritocratic but individuals may be discriminatory will overshadow the effect of microaggressions (by nature, performed by individuals and not systems) on a female physicians' internalized voice that affects her self-esteem and her dedication to the trajectory towards full promotion. Additionally, Acker's (1990) theorization that "competence" as a judgement against a worker is made by people who are already in power in the organization. As it is established that academic medicine is male dominated by numbers *and* culture, the unspoken process of male to male allegiance that gets reproduced will be an incorrigibly rutted pathway. *Saying* that academic medicine is a meritocracy but acting in partisanship ways is cultural inconsistency at best and discriminatory at worst. Yet we know from prior research that belief in the system as meritocratic could be advantageous (Foster and Tsarfati 2005). A meritocracy belief may be what supports persistence for women when they experience more barriers to their promotion than their male peers. Believing that their hard work

will pay off serves the long-term goal of promotion more so than tallying the institutional, cultural, and interactional wrongs. That the women in my study persisted is evidence that a belief in a meritocratic system that rewards is necessary to overcome gendered discrimination.

A second side to this phenomenon is that the men in this setting, also believing that systems are meritocratic but individuals may be discriminatory, come to find themselves as pillars of the meritocracy. What I mean by this is, if they have also persisted in this meritocratic institution, they themselves believe that they may personify the culture of the meritocratic institution. Therefore, they themselves are also not discriminating individuals. This explains their hostility at worst and indifference at best for attention to gender discrimination. They likely see no need at all to reflect on their own gender biases. They likely assume they possess no gender bias at all. When the men do see themselves as gender allies, and make efforts to turn the tides (as the former chair told me he worked to increase gender diversity hiring) we see that it had no real effect at all. His department still follows the national trend of senior level women stagnation.

Women face stricter social control mechanisms precisely because cultural roles on women in modern society still rely on outdated norms that see women as mothers first, professionals second. The same is not true for men. Men are always seen as professionals first, and fathers second, and their secondary status bolsters their first, for a compounded positive effect. The opposite is true for women. Women's primary expected cultural role and status as mothers has a compounded *negative* effect on their professional careers, outlined above as the motherhood penalty (Budig and Hodges 2010). Women encounter professional challenges when they have to navigate their identities as mothers that men do not have to face as fathers (Varpio et al. 2020).

Besides the cultural role of mothering, women are seen as innate cultural vessels of feeling, emotions, and dedication to relationships more than professional systems (Kanter 1977). My respondents would acknowledge that other women (or themselves) have a problem with self-promotion, confidence, presentation, and feelings of extreme inadequacy. Other studies have shown the same results of women dealing with self-promotion and feelings of confidence (Blanch et. al 2008; Carr et al. 2003; Ceci, Williams, and Barnett 2009). I ascertain that constantly battling cultural bias about one's sex and gender is exhausting and expends energy that can influence a female physician opting out of academic medicine. It's possible that the women in my study were successful because they did not have these problems. The women in my study that enacted meritocracy beliefs showed me that this thinking paradigm had worked for them: if one is invested in long term rewards, one can't expend too much energy battling the system the whole time. There is something to be said for hard work and dedication, when it looks like keeping low and working hard is what is needed to succeed.

Based on this evidence, the core gender difference for women and men in academic medicine is that women have to work harder at "meritocracy" because of a cultural negative while men are given the "benefit of the doubt[1]" because of cultural positives. This directly affects the reproduction of gender inequality in fully promoted academic medicine professors because the insidious nature of a dual gendered process like this is gaslighting women for their own failures in a "meritocratic institution." If you fail, women, it's something you did wrong. Some misstep brought you to attrition. And the men, also believing that the institution is value free and non-discriminatory believe that nothing structural needs changing. This directly ties in to Castillo and Bernard's (2010) study of meritocracy belief among male managers. When the

[1] Zimmerman Forthcoming

male managers expressed explicit beliefs in the organization as meritocratic, they were *more* likely to pass up women for promotions when the women had the exact same credentials as men. Just speaking of the system as meritocratic absolves any reflection on interactional and cultural bias. The profession itself is noble, and any bad actors will surely be weeded out. That they achieved full promotion means the profession vetted them and they are not complicit in the reproduction, culturally or structurally, of gender inequality in their prospective departments.

An extension of Acker's theory of the gendered organization is seen in Williams, Muller, and Kilanski (2012) when they focus specifically on Acker's theorization of organizational logic, stating how hierarchies in an organization are rationalized and legitimated. Both men and women in my study were less likely to problematize the structure of the hierarchy, and more likely to consider individual actions and efforts as the cause for success or failure. Acker was the first to argue for these hierarchies to be seen as gender discriminatory, instead of the gender-neutral bureaucracies they are touted as in mainstream culture. This has been shown in other male dominated professional sciences. In Williams, Muller, and Kilanski's (2012) study of women geoscientists in the oil and gas industries, they found that women were beholden to "gender consequences" by way of the organizational logic of teams, career maps, and networking. Because advancement is based on personal performance, but the geoscientists must work on teams, the supervisors of the teams (usually men) have a heavy hand in each worker's "career map" (or team placements). This goes hand in hand with networking, in that whomever a woman knows because of her team placement will affect which team she can go to next. Thus, women are still being shut out of the most powerful leadership positions based on the lack of opportunity to become supervisors, affect their own career mapping, and network with the right powerful people (Williams, Muller, and Kilanski 2012). The women in my study did in fact

mirror the trends seen in this study, in almost identical ways. Without access to the powerful network (men), women acknowledged that it was difficult to succeed. This is a significant piece of gender organization theorization in that it shows that women are still being tied to gender norms and expectancies in contemporary times. The interesting aspect of a gendered comparison shows that men are already "in the club" before they arrive, and thus their "special attention" is built into the system. It's easy to deny that special attention to any particular group is needed for success in a merit-based system if one's ascribed status is status quo.

The concept of meritocracy alleviates uncertainty in the profession of academic medicine because one can *say* "just be good and do well" while pretending that these directions are simple. They are simple directions for an allegedly simple task. Work hard to succeed. But the evidence above shows that Kanter's (1977) finding of same sex allegiance *because* of uncertainty holds steadfast. She found that managers in high risk company positions were more likely to gender discriminate because "the stakes are high." The underlying gendered processes of women and men's meritocracy in academic medicine is also based on sameness and trust in the face of uncertainty. If you are "like me" I can trust you in uncertain situations. Women are tokens in this system. Because they are not men, the women who do succeed are the ones who have been able to do their best to *act like* men. Trust being a male standard, women must meet the male standard to fit in. They meet seemingly impossible male standards of reproduction and emotion work in their interactions that men are not required to clear. They negotiate gendered informal internal social control of "meritocracy" that is considered a fair and non-gendered standard. And when time spent at work is used as a measure of *quality* of work, as shown in the male physician's disdain for deviant or part time work ethics, women can experience a push pull factor between their competing devotions (Blair Loy 2003) of work and home obligations. I argue this

is directly linked to what the male physician stated about trust: if you're not here, we don't trust you. Given the nature of how uncertainty must be managed in the medical profession (Fox 1957) and how evaluation in medicine is based on evidence of one's efficiency of time (Bosk 1979), we can see why the female physician who placed a hospital bed in her office did as she did. While it is admirable that the female professor in question was able to create a work around to a difficult situation, it seems that women must be superhuman to accomplish the visibility needed to prove they are working. Could she not have read and written in bed at home? And why must a woman work to erase a challenging situation she is going through in order to persist in her profession? She knew the meritocracy code was different for her.

Chapter Five: A Gender Comparison of Advancement Challenges and Opportunities

Section I. Introduction

This chapter builds on the doctors' beliefs about the medical academy, established in the previous chapter, by examining their reports of their actual experiences within a (non)meritocratic institution. While the challenges for women that exist in academic medicine are heavily documented in previous sociological literature, a sociological gender comparison of men and women's experiences of promotion in academic medicine has not been previously available. The contemporary issue is not women's inability to graduate from medical school, but rather that as female academic physicians get closer to full promotion, gender equity drops off (Bonsall, Bertram, and Cofrancesco 2020; Jeffee, Yan Yan and Andriole 2019; AAMC 2020). Existing inquiries regarding women's opportunities in academic medicine usually focus on their experiences with leadership development such workshops and camps, mentorship and sponsorship, research opportunities, and access to networks (Lee and Won 2014; Van de Brink 2011). The previous chapter focused on beliefs and perceptions of academic medicine as a meritocracy. In this chapter, I develop a gender comparison of opportunities and experiences related to advancement. Previous sociological literature has also established how the challenges that the women in academic medicine face are a contributing factor to their struggle for success. Here I construct a gender comparison of challenges, describing their experiences with male dominance, lack of representation, the 'boys club, lack of inclusion, being ignored, a heightened pressure to perform, sexism, struggles with a work/life balance, and the second shift.

A comparative investigation of the experiences of men and women medical academics tells a story of two different paths to success. The path for men is paved with greater opportunities which often come early in their careers, and fewer barriers. For women, evidence points to a rockier terrain. Women in my study recounted an experience of fewer advantages and many more challenges to promotion. In the next section, I will compare and contrast women and men regarding their experiences with *opportunities* for advancement and promotion. Then in section three, I will compare and contrast experiences with *challenges* to advancement and promotion.

Section II. Opportunities for Advancement and Promotion

All the physicians in this study experienced opportunities for advancement and promotion. This is to be expected of fully promoted senior faculty. These physicians garnered opportunities at various points of their careers, but the most impactful opportunities came in the form of strong support at the beginning of their careers in the form of mentorship and access to networks, or as support in mid-career in the form of leadership experience and research opportunities. Both men and women had mentors (only three women did not) although they described their mentors and positive mentor qualities differently. Women who had female mentors described how women's representation matters. They were also more likely to emphasize mentors as someone who would listen and someone entrenched in networks. Men also described mentors as role models, but they did not describe the role model using gendered language. Only women described difficulty accessing the networks necessary to establish themselves in the medical academy. Significantly, their point of entry into important channels of academic physician organizations was less that they were sought out and invited and more likely

as a result of being persistent in seeking their place at the table. Men received invitations to these groups. Men also reported more instances of being simply put into a position of leadership (as opposed to applying) than women. There was a striking difference in the ease and timeliness with which male professors acquired their opportunities. Women did not describe their experiences with promotion in the same uncomplicated way.

Support in Early Career: Mentorship and Access to Networks

The role of a mentor was discussed heavily in the interviews with my participants, as mentorship is commonly agreed as a necessary factor for one's success as an academic physician. My participants described multiple ways a mentor will support, guide, and bolster a junior academic's career. The most notable way both male and female participants described their mentor relationship was how a mentor can facilitate a professional relationship with other academic physicians, national specialty organizations, or directors of labs (therefore boosting research opportunities). Yet there is an important distinction in the literature between *mentors* and *sponsors* (Ayyala et al. 2019). Men used the term mentor to describe someone who in fact was providing sponsorship—someone who brings professional resources to their mentees and provides access to positions resources that would otherwise be unavailable. Sponsorship carries the promise of professional advancement and does more than just give advice.

All but three female participants in this study had a mentor for their academic and professional development. Two women described a mentor who was a sponsor—but the sponsorship happened in residency and internship, not as junior faculty. All men reported receiving mentorship though all of the men's descriptions of their mentor's help painted a picture

of sponsorship. One male physician named four explicit mentors. The majority of mentors for both female and male physicians were men, although two men and two women reported female mentors.

Sponsorship: "The first real research I did with him"

The two women who reported a mentoring relationship that actually resembled sponsorship received their sponsor's help in their residency and internship years. One described her sponsor's help in getting into a research lab and thus getting publications. The second female physician described how knowing someone in the higher ranks can get one access, in this case a committee position:

> He nominated me for committee positions when I was a young faculty. And the interesting thing about this, and this is still true today. There's any number of excellent people that could be on these spots. And just because somebody nominated you, doesn't mean you're better, it just means somebody knows you. So that's an important thing to keep in mind as far as why, it's not that you're trying to prove you're better than anybody else, you're just trying to get equal access. -**F1**

When asked how his mentor facilitated his success, a male physician described how he was given entre to research opportunities and access to international networks of specialty physicians, which is a good example of sponsorship:

> Well, certainly, academically… I started the first…real research I did with him, I was able to get several publications because of the work that I did with Dr. (name), that jumpstarted my academic career. He introduced me to people across the country, across the world really, who are (specialty doctors)…you know early in my career…you know access to international contacts that, I was able to…almost expand this mentor role to these other people in the field who were…a generation ahead of me…that was a huge advantage for me. -**M12**

A male physician that listed four mentors described how his mentors' guidance created a positive environment for him in academic medicine. He was not the only one to describe the richness of his experiences with opportunities as "good fortune." Other men described this to me as luck, blessings, and "being in the right place at the right time." This particular male physician described how he has enjoyed "professional latitude" due to his mentors' ability to "see something in him." He had described for me how at various points in his career someone shepherded him to each higher position he held in academic medicine. What he described was sponsorship:

> **Interviewer:** So, you've had quite a few different mentors at different stages. Do you think that your experience is typical? Because I've never heard of so many mentors along the way.
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> **M8**: Right. No, I had the good fortune to have a lot of people who saw something in me at various points in time and allowed me to be very opportunistic in my career path…and this is something that I feel very strongly about. I think a lot of people get lost in the fact that there's so much negative it seems in medicine right now, everything is changing, it's not as well paid as it used to be, but I you know, I can't think of anything I'd rather do. I can't think of anything that would have allowed me the latitude that I've enjoyed in my professional life.

Mentorship: "Having the right kinds of conversations"

When asked what qualities were most important in a mentor, women responded someone in networks, someone you can talk to, and someone who is a role model. When men were asked which qualities were most important, they responded with someone who is a role model, someone who gives the necessary time, and someone who challenges you. One key difference about mentoring styles was that women stated that men don't listen very well and don't

understand the outside responsibilities of being a woman. In fact, one male physician said to me about the difference between himself and the women in his department: "I don't listen as well."

A female physician stated that this difference may be due to men's reluctance to "cross a barrier" in professional distance. She seems to be referring to how women want interpersonal understanding and advice, which men do not seem to want or need:

> First of all, even though men can be your mentors they don't always listen very well. Women listen very well…to subtleties and I think they listen to your face, your cues, your body language; you don't have to say something for them to pick up on it. The interesting thing about men…sometimes, the unspoken things that they might pick up they don't want to ask you about. So, with a male mentor there's always probably a little bit of a barrier there because you know, they're trying to protect a boundary. There's gonna be a little bit of a barrier, and that's probably appropriate because you know there's a boundary that should be there between the two of you. And for women, there may not be, it's a little fuzzier and warm. -**F5**

A couple of female physicians drew on the problem of missing key mentorship about how to advance their career like the women below is describing. What they actually needed from mentors; men were getting from their sponsors. A female physician told me, "Nobody talked to me about what I had to do to get promoted. Never." While men didn't explicitly state that a mentor told them how to get promoted, they received various resource and asset support that translated into success and promotion. A female physician distinctly describes advantageous mentor qualities of listening *and* connections related to navigating promotion in academic medicine. The problem seemingly lies in the conundrum that men don't listen but they have the connections, therefore putting women in a bind when it comes to mentorship:

> I think one who's willing to really listen…not tell you what to do, but to help you figure out what you want to do. It seems to me that that's the most important

> quality. And they need to try to choose somebody who has quite a few connections…you have to have somebody to open doors for you…particularly in academic medicine, if women want to have a career in academic medicine, you need to be able to have someone who will help you get on the right committees, and help you get connected to the right research groups, and can really open some doors for you, as well as help you deal with the substance of your work."-**F8**

A female physician described for me how the specialist she admired did not mentor her *or* give her access to networks. Her phrasing of how he didn't "open doors for me" is significant because men described the opposite in their experiences, that their mentors *did* open doors for them:

> You know I find it real interesting all this mentor kind of thing. Because the closest thing that I had to a mentor was that (specialist), who was the only (specialist) I ever really knew and…he made me interested in what he did. But I can't say that he ever, he never took my hand and helped me. He didn't open doors for me. He didn't…and when I hear about mentoring now, and what's expected of mentors now, that didn't happen to me. I don't have someone like that. -**F4**

A key theme in women's responses about their own mentorship and what they have seen in their colleagues is that without the proper guidance, many women lack the laser focus necessary to get promoted, or they don't "get" how academic medicine works. It can be hard to "get" how it works if the places where it happens, i.e. networks, are difficult to access. A female physician stated, "There are… a lot of young women that I see that I think … have a lot of potential, and maybe don't know how the whole system works because it's very difficult in academic medicine." (No men stated that it's difficult in academic medicine). And another female physician stated, "For a female, I think you need to find someone who understands what the politics of the field are and is willing to tell you." Women need someone to tell them the

informal rules of the game and how to have the "street smarts" needed to negotiate their way into the ranks of senior academic physicians.

Access to Networks: "It was kind of an old boys club"

The access to networks via trusted mentors was a key component of my participant's recounting of their experiences with professional development. The majority of women physician's descriptions of their mentor facilitating access to networks were experiences in residency and fellowship, and less so in their early career at junior faculty. Only women described these networks as difficult to access, though not all of the women in my sample described their entrenchment in networks as difficult. Some by-invitation-only elite specialty organizations did not admit women at all, including some until very recently. And some men were frank about how their access to particular networks was not merit based. A male professor illuminated for me his experience with this type of organization. His discussion of how even his wife was evaluated when attending the organization's events is an example of Kanter's (1977) "two-person career" where the status of a male physician is signaled by his "helper wife" at his side. Because academic medicine is a profession that demands complete devotion, a wife is necessary for a successful medical academician:

> **M9:** …then I was invited to be in the academy of (specialty), there's the American society which is for everyone, and then there's a small academy that's limited to 70 members nationally. Invited only… I was invited to be in that, and many of those individuals were chairs, and so I established some relationships there, so like I'm having this issue I could pick up advice from them.
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> **Interviewer:** The society that you were invited to, that happened before your full professorship?
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> **M9:** Yes. I had established relationships with individuals with national prominence who could then support me when I wanted to go up for professor. So

that was an important part of getting my professorship. And the national association I was active in that. And so, I was chair of (xx) committee, so I was establishing relationships there as well… if I wasn't in that, I probably still would have been fine, because through other means I was establishing relationships. But I think that was one of the more, it was equally as valuable for me.

Interviewer: I've heard from other doctors that the kind of invited society that you're talking about is very prestigious, what is your perception on the gender breakdown in that society?

M9: I think originally it was years before they invited a woman into the society. In fact, when I was there, I don't know, it could have been right around that time that they first invited a woman. And that would have been probably the late eighties. And this organization had been around for…. you know, it was kind of a good old boy's club. And you came in and even the wives were evaluated. You know if the group, when they were coming in, and this is kind of more before I got there, but if someone didn't like the wife, you know, when they came, you would first get invited to attend a meeting. And you gave a presentation. Your spouse needed to go…as to whether you wanted to join, this prestigious group, you know they wanted you to…fit the mold kind of thing.

Comparatively, only men described access to "old boys" networks that benefitted them, whereas women described these networks as a gatekeeping measure. Two of the male physicians in the sample were elevated in their specialties because of relatives who had occupied key positions they themselves inherited. A male physician describes for me how he was shepherded into the medical school program, and then later, how that mentor facilitated his research activity in his early years as an academic physician:

M12: …the chair at the time, back then you could be a little bit manipulative as far as getting into programs, can't do that anymore with the current match systems…you can't play games. But he played a game, and I got into the program.

Interviewer: Did he know your (relative)?

> **M12**: Yes…he replaced my (relative) as chair. So, as a fourth year, Dr.(mentor), at that point I had really gotten into teaching as a resident and I was recognized for that by the students, so I thought that I should plan to stay in academics, so he started looking for a niche for me, something to kind of give me, a class, so to speak, and I took over what was then called (xxx) clinic, which is evaluating (medical test). I did that as a fourth-year resident.

And another male physician stated how a mentor facilitated his "fifteen-year track" to developing a professional identity by inviting him to be a vice chair in the state chapter of a national specialty organization:

> **M9:** I've worked their group in (city) as a resident, and so they kind of got to know me and so, he calls me up and says, how would you like to become the vice chair of the (state) section…it'd be kind of fun, kind of interesting to get involved, and so this is kind of the entry level for the national organization, and so I did that, and it's three years as vice chair, three years as chair, and then a year after that, I was recruited by then the district chair to become…what they call the program chair where I would set up the…district meeting, and the district program chair would then develop the whole meeting, including the talks and speakers, and since I was kind of an academic tie...so he asked me to do this, which then put me on this 15-year track, in the national organization.
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> **Interviewer:** So, you're building this leadership, getting a national reputation.
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> **M9:** Correct. And, so I did three years as program chair, three years as treasurer, 3 years as vice-chair, three years as chair, and then three years as a past district chair…The three years you're a chair you sit on the executive board of the college, a national organization… just being involved in a national organization, you know, you develop the network connections.

Only a few women would also describe for me how their mentors facilitated their success by "opening doors" for them (what a sponsor would do), but they talked about this happening more in their residency and fellowship years, and didn't describe this as much in their early and middle career experiences. This female physician describes how her mentor in her fellowship years helped her career "get started." Women didn't describe experiences like this when discussing their middle career where the role of these opportunities in academic advancement

becomes more relevant. This mentorship (what women receive) versus sponsorship (what men usually receive) distinction is important to note for the effect on advancement. But what this female physician described happened in her residency years:

> They opened doors for me. He was on a lot of national committees and things and I ended up getting a grant with him, and study sections, and able to present at meetings, I travelled places. So, he got me started. -**F8**

Most of the female physicians did not describe the same *quality* of access to networks during early and mid-career as the men. Men's descriptions of their access illuminated an institutional culture of belonging and an expected ease of access. When most of the women described their mentors creating connections for them, they stated how their particular mentor was an upstanding person because they "didn't see gender." As in, their mentor an exception to the rule because they treated the women physicians as worthy of mentoring, access, and professional development. Men did not talk about their mentors as special because the mentor took a chance on them.

Mid-Career Experiences: Leadership Development and Research Opportunities

Occupying a leadership role is imperative if one is to be promoted in academic medicine to full professorship. However, many administrative positions require skills that physicians, by nature of their education in the physical sciences, do not acquire in their education. Both men and women told me that they attended leadership training workshops in order to learn how to complete administrative tasks. The key difference in men and women talking about their experiences with leadership development training was that men acquired their leadership

positions and then went to leadership training, and women were sent to leadership training to prepare them for leadership positions.

Everyone who went to these workshops stated that it was the dean who suggested the training as well as found the funds to pay for it. Because of the top down structure of medical schools, oftentimes it is the dean who makes decisions about resources for faculty without faculty input on those allocations. There is less faculty governance in medical centers than nonmedical academic departments. This can obscure favoritism or bias in a dean's decisions. When male physicians described their workshop experiences, they did not use gendered language to describe their experiences. A male physician describes the "Dean's Camp" he went to in order to learn the administrative skills he would need in his new leadership position he was placed in by the dean. He went to this workshop *after* he was placed in his leadership position:

> So, at that point, when they said we'll take him, the dean…put me in for one-year interim position…and I heard about…this thing called the deans camp which is a five-day session to train people who are new chairs in academic medical centers how to do that job. And they just put you in a hotel room for five days and go through you know eight hours a day of here's what things chairs do. How to read spreadsheets, how to do HR, you know what happens when there's controversy among your faculty, you know every session, you know leadership styles and we had to do Meyers Briggs for the 8000th time you know and think about our leadership style and all those silly things. It was very helpful. - **M11**

However, some women went to workshops that were specifically designed for women instead of the gender-neutral workshops.[2] Some of the women told me that the leadership courses, which were anywhere from a week to six weeks long, were difficult to negotiate with

[2] The initial study of senior tenured women included Ph.D.'s in basic science, who are not included in this dissertation of comparative men and women M.D.'s. In that study, the Ph.D.'s made similar statements about going to gender specific trainings for their leadership development.

their responsibilities as mothers. No male physicians told me that they considered the time away to be a problem. Here a woman tells me that the time away was difficult to reconcile, but that she really benefited from the course as a woman in a male dominated field. She went to this workshop specifically for women in order to learn "how to be a leader":

> (Regarding developing leadership skills as a woman) I think it's still not easy. I do think that I did do a course, ELAM, and it was like twelve weeks, and I thought, oh I can't do this (time) away... It's two six-week periods. And that was a chunk of time... And it was extremely helpful, I didn't realize how helpful until I got back…It didn't work for, you know, meeting new colleagues, well you met nice new people, but it really wasn't a networking thing. It was billed as something like that but that wasn't it…I did see a lot of different types of leadership strategies in different people, and they had some great speakers, I mean the kind of mentoring types that would really show you how best to, or what they thought was the best way to approach things. It was very helpful. -**F6**

The greatest difference I found when comparing what women and men told me about their experiences was that almost all of the men stated that someone had "put" them in leadership or authority positions (only two women stated it the same way). When I asked a male doctor how he had developed his leadership abilities he answered, "well I think I was kind of put in those positions." Among the men this was the most shocking revelation to me. One by one they told me how the chair, or the dean, or a director of a lab thought that they too would make a good chair or director of whichever facilitation of their career made the most sense. Like I stated above, they saw their appointments as something based in luck, not the meritocracy they espoused in their statements I included in chapter four of this dissertation. They didn't acknowledge that their experiences were exceptions to the rules of meritocracy.

Some of the male faculty described for me how they had been resistant to leadership roles. Only two of the female faculty stated a resistance to administrative roles. A male physician stated to me like this:

M10: I joined the faculty here and within two years, I was director of the (xxx specialty for xxx department)

Interviewer: That's pretty quick right?

M10: It was, and it wasn't something I think I was…I definitely wasn't asking to do that.

Interviewer: Who put you in that position?

M10: The chair of the department. So, you know they, again, thought I had, relative to all the faculty, we weren't a huge group. Then the chair retired, and they did a national search, and again, it wasn't something that I ever had aspirations to do, and yet I could see along the way that they were kind of looking at me to at least be the interim. The chair was definitely saying, it needs to be you. So, I was always kind of reluctant with that.

Interviewer: Why reluctant?

M10: I just, it had never been one of my goals, you know, I loved being a physician, loved being (specialty doctor), in terms of being a leader, it wasn't something that I wanted. It wasn't…I want to be a chair, someday I want to be a dean…it just wasn't something that I wanted. So, the chair was retiring, I didn't apply initially, and yet I was getting immense pressure from the fellow members of the department and other individuals outside, you know, you do need to apply for this. So I did apply, and I was appointed chair.

Another male physician told me he had not asked to be an interim leader which turned into a five-year tenure in that position:

Interviewer: Did you ask to be interim or were you...?

M8: No, I was asked by the current dean at that time, so when the dean left, the current dean at that time, asked me to be permanent. I served in that role for a little over 5 years.

And a male physician who stated that his department was gender equal in physicians but not in leadership roles told me his placement in a leadership was because it was the dean's choice:

> I think I was chosen because I was the easiest choice for the dean at the time without doing a formal search and process. - **M7**

Another male physician described for me how a position was created for him:

> Neither of those positions were open and actually I was getting ready to go back and start working on my master's in business and masters in health services research part time. And so, the dean said, you know, those positions aren't open right now but I tell you what, I'll make you vice dean, you get to be the fireman when there are problems. And so, the dean did that and then the senior associate dean for (position) left and so instead of just demoting me to senior associate, the dean said (she would make me) vice dean and senior associate dean for (position), which is the one that put me in charge of all of the (program)."-**M8**

Only a couple of the female physicians told me that they had been "put" in leadership positions:

> **"**You know, looking back I think my biggest sponsor was actually (a dean). And I didn't really realize it at the time but (the dean) was the one who appointed me as chair when I was the chair last, and I was totally not expecting that and…I'm not sure how good I was but (the dean) really forced me to do something that was totally outside my comfort zone. - **F12**

Additionally, research opportunities are imperative for establishing a national and international presence through publishing, invited talks, chairing and serving on important committees in the medical center and for specialty organizations. Only a few of the physicians explicitly talked about their research trajectory experiences, but those who did talked about them in gendered ways. A male physician described for me at length that early in his career he took over a clinic with which he was able to get substantive institutional support and which created for him the ability to publish extensively from the research he did there. He said he still travels all over the world presenting on this research, but when he left the clinic, another (female)

physician took over the clinic. He stated that she either "didn't have the drive or the support" and the clinic withered on the vine. And a female physician told me that it took until she went on sabbatical in her later career to establish an in with the "good ole boy" network of grants and research opportunities:

> Probably the most difficult area for competition was in the research realm. Because that's really a good ole boy system, still. With all the granting processes. And actually, my research career was really opened widely when I was about (later age) when I went on sabbatical to the University of (xxx) to work with a very prestigious person in xxx, which is my major area of research. And that opened all kinds of doors for me. You know, I got things accepted more readily. - **F8**

Section III. Challenges with Advancement and Promotion

Women described many more and varied challenges than the men described in their depictions of their experiences with advancement and promotion. Women described experiences with male dominance, a lack of representation for women, more difficulty with feeling and being included or ignored by colleagues, a heightened performance pressure, sex and gender bias and difficulty negotiating work and family. Men did not report experiencing these issues.

Male dominance and Representation: "That was the first time I thought women can do this too."

Both men and women described medicine to be male dominated. The only difference between their accounts was that mostly men described a male dominated setting in training, residency, and internship, while women described the male dominance both historically and

contemporarily. A couple of men described academic medicine as contemporarily male dominated.

Some of the statements that women made about the male dominance of medicine early in their experiences were based on the sheer number of men proportionate to women. Some women spoke of instances that the male dominance in medical school, internship and residency required special solutions to deal with their entre into the male dominated field. For instance, more than one woman had to have a call room established for her gender, given that all call rooms had historically been men only. However, when the conversation shifted to their experiences with male dominance in their promotion experiences, the dominance of male culture and the good old boy's network comprised most of the female physician's answers. Many of these statements were shared in chapter four of this dissertation, where I outline the argument of a male dominated setting in academic medicine.

A female physician describes how the pressure to represent women in a male dominated setting means getting to meetings early enough to literally sit at the table instead of on the sidelines:

> You feel like you have to show up because you're one of the few women who has been, invited isn't the right word but who is officially anyway in the club. So, there's also this funny dynamic where there's this board table and it seats twenty people but there's more than twenty people who come. So, they have these chairs back around the edge of the room, extra chairs. And the first few times that I went, I always sat back in the chairs around the edge. And then I thought, well why am I doing that? Why am I sitting…I belong at the table! You know, you hear that in books, have a seat at the table. So, I try to go in time to get a seat at the table. -**F3**

A male physician described for me how the changing demographics in his specialty was directly related to the visibility of a female physician in my study, who was one of the earliest promoted women in her specialty:

> **M9**: If you looked at the last five years of the number of women we've interviewed (for the residency) versus the number of women we interviewed between 2000 and 2005, so if you went from 10-15 vs. 00-05, we interview a lot more woman.
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> **Interviewer:** So, more women are interested?
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> **M9**: Oh, I think so. Either that, or we totally just weren't interviewing women before, because we interview a whole lot more than we did 15 years ago. I think that there are more women interested in (specialty) then there were. And, you know, I think part of it is because of people like (fully promoted female physician) that are pushing it. And they're a mentor. I mean, you can imagine if you're a female medical student here, and you're interested in (specialty), who are going to go see, me or her? You're going to go talk to her.

As evidence for how representation matters, one female physician made the following statement about another fully promoted woman who gave grand rounds[3] during an era when women were not given such an honorific. The representation impacted her understanding of her ability to persist in a male dominated environment:

> …but her example, I'll never forget when I first started making grand rounds, I thought grand rounds? A woman is giving grand rounds? (when I was a) student, she gave ground rounds and she did an excellent job. But that was the first time that I really thought about oh women can do this too. **-F11**

When I asked a female physician how challenges have changed over the course of her career, she drew on the previous lack of representation and its effect on aspirations. She states that growing

[3] Grand Rounds is a formal meeting in medical education where physicians and scientists meet to discuss clinical cases or present current research findings.

representation has an impact on future academic physicians, but her experience as an academic physician was stifled from a lack of role models:

> …I think in the past that a lot of us simply didn't aspire to do some of these things because we didn't have role models, so even going to medical school, becoming a physician was a groundbreaking process. Becoming the chair, you know, becoming the dean, those sorts of things in academic medicine. Again, I know there were women out there who aspire to that but the majority of us really didn't think about that. -**F6**

Being Ignored or Being Left Out- "I've found it incredibly irritating"

When I asked participants if they had ever been left out of group socialization at meetings or conferences, all but one man said no. One male physician's answer encapsulates how untroubled men were at this question. When I asked if he had ever been left out, he said, "Yeah, probably." All of the women had been left out, and some of the women were unbothered by it. They were more likely to be the women who were proponents of the medical academy as a meritocracy. As I stated in chapter four, the ambivalence women displayed centered on their meritocratic belief but gendered experiences. Believing that academic medicine is a meritocracy yet having gender discriminatory experiences forced women to reconcile these conflicts in their accounts and some presented themselves nonchalantly. The women who *were* bothered by it stated that the reason it was problematic was because getting left out continued the chasm they felt as medical students and othered them as professionals. A female physician stated how it persists to this day:

> **F1:** That really, that bothered me…I could see it wasn't malicious but I think you asked me what would be a sad memory you would have, it would be that I wasn't included…as I have gotten more, you know, more networking, know more people, I don't feel that so much, but-
>
> **Interviewer:** But it took some prestige to get you noticed?

> **F1:** Yeah. Yeah…so I'm often by myself (at conferences) and still the people that I interact with, all their wives are there. And many of their wives still don't work, again, that generation…if you're a woman there without a man, socialization still isn't' the same and that's one thing that I wish it would be different and I hope it is different for young women…in the social situation you don't always need a man. I'm afraid that it's still the same, but I would hope that it would be different. Yeah, like you go to the conference and then you go out to dinner afterwards. If you're a female without a man it is just different.

As for being ignored, most of the men reported that they weren't ignored in department meetings. A couple of women also stated that they weren't ignored. Again, these women were more adamant that medicine was a meritocracy. But most women reported being ignored[4] and described for me that it takes skill and negotiation of the setting in order to manage it when it happens. A female physician was very animated when describing how this happens:

> I think that I let a lot of stuff…I don't pay attention to a lot of things, so that if I'm ignored I just sort of don't pay attention to it. But certainly I have, when I look back, there have been times (I was ignored) …I've found it incredibly irritating…you're the only woman…you say something, and no one acknowledges it and they just go on!...And it does happen, I mean if you had told me, at the beginning of my career that that would happen I'd say …no, that doesn't happen. But it does. And so, I think women need to be aware that it does, I mean, how do you handle it? I think that's tough! That's incredibly tough. **-F6**

Performance Pressure "We were supposed to work longer and harder"

When I asked participants if they had experienced performance pressure, most women said yes and most of the men said no. Men often thought I was asking about an internal drive that most professionals have in order to succeed. If men did describe a performance pressure,

[4] This was also stated by most of the Ph.D.'s in the sample of women not included in this dissertation.

they didn't describe it in gendered ways. A male physician, when I asked if felt performance pressure, took a minute to think and then responded, "very little." A male physician described for me how academic medicine is demanding, and wants more than he gives, but he didn't tie this into gendered norms:

> Yeah, I think so just not doing as much as I need to do. I think like in medicine like you should be taking more call how come you're only seeing eight patients instead of ten you know it's usually pretty polite but there are all those pressures in medicine. I think medicine wants me to do more, I don't do more for them. - **M11**

Women reported that they had to "work harder" at the same job in order to prove that they were serious academic physicians. And female physicians plainly stated that they experienced performance pressure from others. When I asked about work expectations, a female physician stated, "we were supposed to work harder and longer. And that's still true today." A male physician described this for women as well, but in the past, noting that he saw that there was some latent hostility for "average women":

> **Interviewer:** So, was it the old guard, the dinosaurs?
>
> **M4:** In that era, it would have been the old guard, the medium guard, the young guard. I mean it still was very much women coming into a male field….and I gotta say oh (female physician in my study), oh my god amazing… That is reverence. And the women, and this is the world according to me, they were so amazing that I think they found it frustrating when women came through in my era that were average. Because all of their peers, and I really mean this respectfully, if you were someone who went to medical school in (Dr. Jane Doe)'s era, you were amazing. You were completely top. So, when my era came through and (women) could be average like the rest of us, like many of us, I think it was harder for them to see that, there were times when I sensed that, and then boy they had no patience for anybody that wasn't pulling their weight. And…it seemed to me that the women even had higher standards.

Women who were more likely to describe medicine as a meritocracy were more likely to respond that they were "up to the challenge" when faced with a performance pressure from

peers, professors, or attendings. A few women stated for me that they were internally driven and would only accept the best from themselves. A female physician that told me that she was the top of her class when I asked about performance pressure. She acknowledged in her statement that women being held to a higher standard was wrong, but that women in her era just "did what we had to do: and referenced her competitive nature:

> But again, it was the same way in high school for me, it was like ok, it's on. I can prove all of you wrong. And I didn't care necessarily so much about the grade as far as proving that I was confident. And then in some ways I could do it better. So, it was just one of those situations that we kind of accepted even though it was wrong and did what we had to do. -**F9**

Sexism and Gender Bias- "A woman in a man's world will be in a man's world."

Both men and women described sexism for women, but no one described sexism against men. Male physicians mostly described the sexism and sexual harassment they saw in medical school. Women described past *and* contemporary experiences with sex and gender bias. No one gave contemporary examples of sexual harassment. When male physicians described the sexism, they saw happening to women, they detailed comments professors had made about women's bodies and intellect. A male physician that had been married to a classmate (another practicing physician) was the only male physician to detail explicitly how women's bodies were targeted:

> Oh yeah. There was anti female stuff that went on frequently in that era. A lot of it was male culture that was offensive but I didn't think it was offensive because I was male, but if you looked at it through female eyes it was. And it didn't have to be something that overt. Some of it was just like the yuk yuk old boys club thing. You know it wasn't necessarily like you'd come on service and they'd start singling out the women to be difficult with. You know I had the chair of OB-GYN comment on the size of every woman's pelvis one day in rounds. Oh, I'm not kidding you. "you've got a great pelvis you're not going to have any trouble delivering." And the thing was, he too was an icon of the era and nobody would

> shut him down. But I mean by today's standards that wouldn't happen. And he kind of fancied himself as a protector of women but it was one of the most, let's just put it this way he really wasn't. **-M4**

Women echoed this climate of rampant sexism and sexual harassment. A female physician was frank with me about how it was par for course in the early days:

> When I was at medical school there was a lot of sexual harassment…a resident during surgery rotation who told me that I had to sleep with him if I wanted to get a superior. And I told him a superior's not worth it. And I went to the chairman of the department to complain about this, and he said oh well he was just kidding, that's just the way it is…. It was just the time, you just took it as…and there were a lot of comments, you know about women overstepping their bounds and you know that kind of thing...it was very common. **-F6**

And another male physician describes how women were considered "less serious academics" and had to negotiate the sexual harassment to get by:

> There was an awful lot of power differential between the clinical sciences and the clerkships, it was kind of clear that the residents and some of the faculty really thought, well, all the guys are here to really get the work done, and join us in our specialties, and the gals…just like to have fun. And I remember the faculty seemed to just ignore it. And the residents would do stuff like "so nice having you here" …in surgery they'd pull the drawstrings on the girl's bottoms, and you know the girls would respond, I hate to call them girls but they were of course young women. They'd be like "Hey betty, so nice to have you here, did you get the right size?" and they'd pull the string, and this is in the mid-eighties. And they'd laugh and the girl would giggle. These were girls I knew from basic sciences that were as bright and as capable or more so than I was. And they were serious students. So, you can see that there were two sides. "I have to negotiate this interaction with this resident" …this sort of explicit you know, and the attendings were just right around, and they'd like chuckle. But the girls were to go on to some prestigious universities, *but they just didn't want any trouble*… the girls would say "well what are you doing? Don't do that" then there would be this kind of cold shoulder like, "well you're not very fun. **-M3, emphasis added**

Many of the female physician's statements about sexism that occurred in the past were about questions they had been asked during their medical school interviews.

> My interview was interesting, it was back in the day when there was a panel of interviewers, they were all male except for one female, who was a (specialty) here... And it was three males and myself that were interviewing that day. And one of the interviewers asked me, you know, what would happen (because I was engaged to be married to my husband) "What would happen if medical school interfered with your marriage?" And Dr. (xxx) spoke right up and said, "That's not a fair question, you didn't ask that to the males." And it really shed a light on how things were going to be, that there was pretty much a double standard about what was expected of females versus males at that period. **-F6**

Another female physician recounted the same type of question asked of her devotions:

> **F8:** One of the questions that I was asked for my interview for medical school was, "Well what would you do if you had a child who became very ill and you were called away to take care of someone else?" Well you know, there's no way to answer that really. I said, you know I can't really say what I would do. It would depend on how sick my child was, who else was available to help take care of my child, and if I was the only person available for the other person, I mean there are so many other variables that I couldn't just say, well this is what I would do.
>
> **Interviewer:** Well you passed obviously.
>
> **F8:** Yeah, I guess they liked that.
>
> **Interviewer:** That was a difficult question.
>
> **F8:** It really was. But they didn't ask that of the men. And it would be just as valid a question for a father.

And this female physician was asked about a hypothetical partner that didn't even exist yet:

> So, I was interviewing for medical school ... And one of the physicians on the panel said to me, well what are you going to do if, he said, are you engaged? And I said no. And he said, well if you were engaged, what would you do if your husband said he didn't want to be with you- he didn't want you to go to medical school. And I said well, he wouldn't be my fiancé anymore. (she chuckles) What a stupid question! But—can you imagine that question being asked today? -**F1**

Because of the sexism rampant in medical school interviews, a female physician told me how they still hold workshops for women on how to negotiate the sexism they may encounter. No male physicians described this to me about themselves or about their students. Here she states the way these workshops tutor women about how to negotiate the sexism in the setting of medical school for women today:

> …one of the things that I've done here previously for the female medical students…to talk about you know if you're in for residency…the people for the Equal Opportunity Employment office speak with them about what questions are permissible, what aren't, and how to respond. And that's always one of the woman's questions, how do you respond to something like that? And my answer to them is it depends on how badly you want to be in that residency. If this is a place that despite their question, you know they should have known better but you really want to stay ranked in this program, then be very careful and tread lightly when you answer the question. If you have no interest in going to this program and they're hostile, slam dunk them if you want to. There're no ramifications of doing that other than hopefully protecting the next female applicant from having to go through the same thing. -**F7**

Another contemporary example of persistent sexism that this female physician gave was about how a male medical student treated her differently than her male colleagues when she met him for his interview. The rules of engagement for medical school interviews is that physicians cannot ask about family or partnerships unless the applicant themselves bring it up. When the male applicant brings up his wife, and the female physician asks about it, his response highlights how he feels comfortable saying something sexist to a female physician:

> When interviewing residency candidates, I see medical students coming through, some of the medical students, the male medical students will let their guard down with me which is at least interesting. They're not quite as formal with me, they kind of kick back a little bit. We talk about it at the selection process. It's like, they gotta respect all of their faculty members, don't treat me differently because I'm a female. We had one gentleman who came in, in his cowboy hat and cowboy boots, and again, I didn't ask anything about lifestyle or anything, but he mentioned that his wife was an attorney. So, I said oh is she going to get a job if you decide to come to (City) and we select you, and he said, "Well, I haven't decided or not if I'm gonna let her work." And interestingly enough when I brought that up at the selection meeting, he hadn't said anything about his wife or her career to any of the guys. And the rest of the faculty just laughed and said,
>
> "well that was the wrong person for him to say something like that to!" I said, "That's right! That was not smart!" So, I'm guessing he thought that I really had no authority so he could just kick back and say what he wanted to. Like, that's not very smart. -**F7**

When male physicians described past sexism, some referenced the way female medical students and residents were "pimped" harder than males. "Pimping" is the term medical students and medical faculty use for the hostile and aggressive way that attending physicians treat medical students and residents by asking them increasingly harder questions, usually very quickly, in an effort to reach the end of that person's knowledge. It is seen as a "breaking" measure and part of the hazing that shapes medical students and residents into a hardened physician who will be ready to conquer the demands of a high stake's profession. It is used as a form of mistreatment and a way to reinforce superiority of the attending physician. A female physician echoed the climate of "pimping" women harder than men. She told me, "But there was that, "let's see if we can break the woman" attitude, especially if you were on surgery." This statement by a male physician shows how the pimping of female students was used to single them out:

> I hate to use this term, but it was apparent the pimping, and I hate this term because of the connotations but a lot of doctors use it, the pimping would be harder on the female students. So, I'd see attending ask a general question, and they'd get it right, then they drive a little deeper, until they can't answer it. The specialty that's most known for it is internal medicine. At its best you drive down and say "well why don't you read up on that and tell us tomorrow" At worst it's,
>
> (his voice is patronizing) "well you really should know more." …But I think in general females were kind of picked out to see what they really know. It was this back sided kind of thing... -**M3**

Women had many more contemporary stories of sexism they had encountered as academic physicians. They described for me how they had to carefully negotiate these occurrences. Often, I noticed that the women "laughed about it" as a way to downplay the devastation of being treated wrongly. A female physician described for me how a newly hired physician treated her:

> **F5:** Here's a story I could tell you about. Just in the doctor's lounge in this hospital, in this century, in this decade as a matter of fact, I was in the doctor's lounge. You can't get in there without a badge. And I was sitting down there, I think I was eating, and talking to another physician, and a relatively new hire physician…he came in and he said, "the coke machine is empty, can you fill it up?" … I have gotten over race, most people just get stuck at race and get all upset, so I just "did you say that to me because I was a woman or because I was black?"
>
> **Interviewer:** What did he say?
>
> **F5:** Oh, he never talked again! And then he found out I was chair! And he never talked again.

Another female physician stated that she was treated with benevolent sexism that fell away over time:

> Oh yeah, who you are is who you are, and a woman in a man's world will be in a man's world. I had one of the chairs in my department always treated me kind-kind of like his daughters. But as our relationship grew, I became respected more and given more stuff, but it was a process. It didn't start out that way. -**F1**

Previous research (Pingleton et al. 2016) found that women physicians wear their white coat to signal that they are doctors. The men in this study also described wearing a white coat for the same reasons. They described that presenting themselves as professional was necessary for the patients to see them as an authority. The few men who said that they did not wear a white coat said that they didn't wear one because the coats themselves get very dirty.

There was, however, difference in the honorific used to address men and women physicians by patients, medical students, residents, and junior faculty. Two men said they encourage others to call them by their first names but will still be called Doctor. However, both a male and a female physician stated they had seen women called by their first names more often.

> Well, I should say, people sometimes disappointingly are more apt to call the male doctor "doctor" and you by your first name. A woman by her first name. -**F5**

A male physician described women as still typecast as lower than doctors:

> I know women, it still happens, oh my gosh, one of the female fellows will go in and come out and I'll walk in and they'll go "the nurse that was just here **-M4**

A few women told me that nurses will treat them differently than male physicians. No male physicians described this for themselves or for women. One female physician attributed this to women's early socialization experiences of "horizontal play" instead of boy's socialization in competitive games. She theorized that a cultural change might happen as more women get involved with sports. But another female physician described for me how nurses treat her differently and less of an authority than male physicians:

> …let's say you're doing a procedure …and you've got three or four nurses doing stuff with a patient and they'll say "hey (her first name)! Can you get me that container over there and undo that lid for me?" You know, I'm not above helping, I'll help, but you called Tom Dr. blah…you don't do it with witnesses, I

> think if you call someone out with witnesses it's humiliating you get a wedge… you take them aside you go, you know, it may seem petty to you, we are all Dr. Somebody, it just sets the tone, and I'm not above being (first name), but we're gonna go with Dr here. It's just like the captain of the ship, you know how that goes, this isn't new to ya, you know better than that...-**F7**

Multiple female physicians told me that sexism wasn't over, and multiple men said that it was. A female physician stated how even currently junior female physicians, residents, and medical students think that "all of that is in the past." She described for me how these issues persist and women coming into academic medicine don't want to acknowledge that there are still issues of sex and gender bias:

> It makes me feel really old to say that, younger women coming through don't understand that things have changed. And so, when I was going through, once you're actually in the trenches you realize what the issues are and that they're real and you're gonna have to work really hard to get through them. Young women coming through now…assume that since those of us who came before had to work so hard that everything's fixed and everything's fine. They don't understand that there's still really big issues out there that need to be tackled and need to be addressed…. they don't realize it until they're hit in the face with one. Then they're trying to scramble and figure out how to fix it, well that's not the time to figure that out. The time to figure that out is early on so that you're cognizant of these things, you're not paranoid but you're at least on the lookout for some of these issues so you can hopefully prevent them or at least plan for them. This concept that everything is fine, that feminism is a dirty word and that nobody should be a feminist is not understanding that feminism isn't any sort of radical or political philosophy but is just asking for equal rights and opportunities for both genders…the first female resident that we had, there was a group here that would get female medical students together with female faculty and residents to talk about the issues and what was going on. I asked this woman to join this group as the only female (specialty) resident that was here at the time, and she said, "well why would I want to do that there aren't any problems, they just treat me like one of the guys." Well the fact that they're treating you like one of the guys is issue number one, and second, there are still issues. You need to be engaged in part of the solution. If you don't see the issues yet, that's great. But you will eventually. And she has. And it's like, let's talk about it. -**F4**

Motherhood Penalty and the Second Shift- "I didn't do a bad job, but I didn't do extraordinary"

Both men and women described a motherhood penalty and second shift challenges for women. No one described the same mechanisms for fathers. All but two of the men had stay at home wives. None of the women had stay at home husbands. Men overwhelmingly reported that they were able to do the amount of work that they did because of the fact that their wives did everything at home. Every woman in my study that had children described how they struggled to negotiate the balance of excelling at work and being mothers. Both men and women described the hostility for women who take time off to have children. Many of my participant's statements are shown in chapter four of this dissertation for evidence of the male cultural model of academic medicine. A few are selected here for illustration of the difficulties the female physicians in my study experienced.

Some of the women in my study had difficult pregnancies, sick children, or demands on their time as mothers that the male professors didn't profess. Two of the female professors told me that they downgraded to part time to manage this. Even working "part-time" (at part time pay) however didn't mean they *actually* worked less. A female physician discussed her work schedule when she had already worked through her "leave":

> …my baby came three and a half weeks late. I had been scheduled to have leave; they had put me down to be gone at a certain time. But I worked through that whole three and a half (weeks), and they didn't extend any of the (leave), that I would start my leave later… basically when my baby was about two weeks old…I went back to work. Because the expectation is that I'm going to be back at that six weeks, at that date. So it wasn't, you'll be gone six weeks, whenever that starts. I was expected back…. So, at that time one of the reasons was that all the faculty had left town to go to a meeting and had left me the only (specialist) in town to cover two hospitals. So, I had a baby two weeks old, and I covered two hospitals…my baby had been in the ICU for a little while and was awakened every hour and a half and so when he went home, he woke up every hour and a

> half. So, my baby kept me awake. I thought that being an intern was good training for it you know because you're used to waking up and going back to sleep, waking up and going back to sleep. And when my second child was born, a grant was supposed to be written, and nobody said, oh you are home on maternity leave. No…I was expected to write the grant during that period of time and work during that six weeks that I was supposed to be off with her…-**F4**

Looking back on her career, she acknowledges how her choices in her work life balance left her feeling 'what if' about her career. She didn't push herself to excel the same way she might have without the tension of her work life balance. The only corollary in male physician's statements is that two male physicians told me that they missed out on more of their home life and it was a point of regret for them. Here she describes how her choices affected her career:

> I think that sometimes because I did all that…extra mother stuff I mean I was the PTA; I did all those things. And I had a great time doing it. I think the energy I spent doing that and the energy that I spent at home…took away from time that other people put into building careers. Because grants are written at night, labs you go to at night…So sometimes I feel that my academic career is not as productive, I have not had as many grants, I have not had as many publications ,I don't have as big a name…I don't have a cure for some of the things I'm looking for…because I did spend the evenings with children activities or husband activities. And sometimes the guilt of being a mom you feel like you could have been a better mom if you hadn't done so much career and you could have had a better career if you hadn't been a mom. So I think all of, in my mind, that's something that I think about. If I had gone home, instead of going home and going to Girl Scout meetings…if I'd just gone home and just read journals. That I would have been more productive. I don't have a bad career, no, nobody could say that… Sometimes I think about that if I had done those, how would my life have been different, should I have been doing that, would it have been more…I don't know. And then there are times when I know I stayed late at night taking care of a sick patient or talking to a family of somebody who's dying and wasn't at home. And not with my kids. That you worry about what I missed. What did I miss there? I think by doing both things I didn't do one of them extraordinarily well. I didn't do a bad job, but I didn't do extraordinary. I wasn't a star in that field. -**F4**

The tug between work and home creates a tension that women reported difficulty negotiating. The physician below ponders the same process happening for men contemporarily, but ultimately the process is harder for women. Men also reported seeing this happen for their male students but that it hadn't previously happened for them in their careers. One woman describes for me the staying power of these problems:

> I think that's always been the case. When you talk to young women it's the same. Men have grown up seeing men in the workforce. I think men probably struggle more than they used to. I think a lot of them now feel like they want to be home more with their kids. But I think women still struggle more with that. And we talk about it sometimes, what is that? Is it because we feel more nurturing? Is it because since we were little children, we've been taught to take care of the kids? I don't know what it is exactly but I think women still feel guilty. You feel guilty is you're at work and you're not taking care of your kids at home, you feel guilty if you're home and you're not putting more into your career. And I don't know how to make that go away…how do we balance our kids and our families and our careers? -**F12**

Regarding the lasting impact of these mechanisms in female academic physician's lives, she goes on to say that there's "more discussion" about these things, but challenges persist:

> **…**there are still fewer women at the top, there's still fewer women in leadership. Being on the board and you're the only woman, that is still there. And being ignored sometimes that still happens. But I think it's better, overall, it's better. And we're more aware. And I think the women on top now, I think we're trying harder to help the younger people to get up the ladder and do it without feeling that they're not taking care of their responsibilities at home. -**F6**

Section IV. Conclusion

This gender comparison of men and women physicians' experiences in

academic medicine illustrates a qualitative difference of both opportunities and challenges for academic physicians. Men recounted more opportunities that happened more easily and earlier in their careers than women. Women described fewer opportunities than their male counterparts. They also experienced mentoring quite differently and with different consequences in terms of career advancement. Men were more likely to have sponsors who gave them access to scarce professional resources than women. Moreover, women described more challenges than men during their academic careers. Because of academic medicine's male dominance both in their training but also promotion years, female physician's experience leaves them two steps behind and weighted with a baggage that most men are unaware of not possessing. In fact, every one of the challenges women recounted for me was not echoed by men.

When men and women's experiences are compared, it shows a clearer picture of how the culture of meritocracy in academic medicine is disparate. Both men and women when discussing their experiences with opportunities seemed to assume that their experience was the norm. Yet when talking about their opportunities, women would talk about their need to be savvy and smart acquiring their opportunities. Men talked about their experiences with opportunities as being lucky or in the right place at the right time. Men didn't adamantly declare their right to persist in medicine as women did. Women perceived how they had to persevere and fight to fit into the mold of medicine. They described their understanding that they needed to work through the system of advancement without challenging the status quo of male dominance, lest they be booted from the game. In chapter four I showed how men uphold academic medicine as a meritocracy but this chapter's evidence of experience shows favoritism to men. Yet men did not reflect on how they were exceptions to the rule in their own experiences. Women also uphold academic medicine as a meritocracy but this chapter's

evidence of their experiences shows that they encounter many more difficulties and far fewer opportunities. Much like Bernard (1972) argued for a "His and Her Marriage" there are "His and Her" experiences in academic medicine.

All but three of my participants had mentors, but as mentioned above the male physician's mentors gave them more and better access to networking and facilitated leadership opportunities. Significantly for the issue of advancement disparity, this type of mentorship for the men continued into early faculty careers and beyond while for women it tended to dissipate. Women were more likely to describe for me that their mentors were "above and beyond" because their mentors treated them as someone worthy of mentorship. Most of the women and men had *male* mentors, which is to be expected in a male dominated environment. A couple of the men and women did have female mentors, and that they were women in this study is an interesting feedback loop on the insidious representation of fully promoted women. There are so few women, even today, that it's difficult to compare the effect of male and female mentorship on a mentee's trajectory in this qualitative study. LaPierre and Zimmerman (2012) found that in female healthcare managers' success, having a male mentor was a significant predictor of promotion to the highest levels of management, but having a female mentor was not. They proposed that the mechanism for this may be because of his establishment in important network relationships. The statements both female and male participants made about their mentoring relationships suggest that those with male mentors do fare better gaining access to important networks, which is a form of sponsorship. Sponsorship relationships confer advantages of resources, assets, and important professional connections. Yet even women with male mentors still did not receive the same access that the men received. The woman in my study spoke about how male mentors may "keep them at arm's length" or have trouble "listening" to them. Even

when having male mentors, women physicians are disadvantaged in a way that male physicians are not. The statements women made about their mentoring experiences differed in distinct ways from the mentoring experiences of men. Women did not speak about their mentoring in terms of sponsorship, which is what matters for academic physicians (Ayyala et al. 2019).

Academic medicine's gender representation trouble persists in the male dominance of men at the leadership level. Many of the men and women in this study told me that men are more likely to know how to be leaders, even while also telling me that everyone needs training on how to be a better leader. This draws on the male cultural model I espoused in the previous chapter of this dissertation, but looking at physicians' experiences shows how that cultural assumption plays out in lived experiences. Men were put in leadership positions and then given training on how to be better leaders. Women were sent to leadership workshops specifically for women in order to prepare them for leadership roles. Kanter (1977) hypothesized that if the number of women in a professional space went up, the cultural effect would be that women would be seen as just as competent as men. But my data here shows that there is back handed and subtle bias still happening to women even when the face value of the institution is that they are just as deserving for a spot at the table. Yet again, men are given the benefit of the doubt while women are asked to prove themselves as competent again and again.

When asked about challenges, men rarely reported anything significant. Women experienced many challenges. The most salient of the challenges that women negotiate that men do not is the second shift duties and motherhood penalty that comes with the territory of being a professional woman. If there were *no other challenges* besides this, women would still be advancing with one hand tied behind their backs. This challenge speaks to how women as a sex are still bound by reproductive responsibilities that men should share but don't. The motherhood

penalty (Budig and Hodges 2010), or missed opportunities for advancement because of the time women spend caring for their children, was evident in my participant's statements. No male physician stated an experience with missing opportunities because they chose to spend more time at home.

Some critics may ask "Are women doing this to themselves?" Is it possible that women themselves are stuck between choosing one devotion over another? Are they holding themselves to a higher standard or is it the medical academy that does this? My interviews suggest that women receive messages, starting in medical school and continuing throughout their entire career, that they do not "fit the mold" and must actively work to promote themselves as serious medical academicians. This evidence is not just from the past, either, even though most of the male physician's statements were about the differential treatment they saw in the past. Even some male physicians had contemporary examples of women being treated in sexist and antimeritocratic ways. The evidence in these interviews shows that women struggled to "get in the door" of opportunity while men had the door held open for them. And while men strolled through each new opened door, women labored over consistent hurdles placed in their path. The significance of the differential experiences of opportunities and challenges for men and women in academic medicine is that there is not one unified meritocratic institution. This is a tale of two academic medicine paths: the male experience and the female experience. Even when women argued that they were "like men" and could persist in the male dominated culture, they were consistently treated differently in sometimes subtle and sometimes blatant ways. Academic medicine is not an equitable institution as long as women experience more challenges and less opportunities than men.

Chapter Six: Conclusions and Implications

Introduction

In this study I attempted to answer the questions: Do the experiences and perspectives of senior faculty differ by gender and to what extent are these experiences and perspectives consistent with the idea that academic medicine is a meritocracy? Gender imbalances in the academic medicine workplace continue to create a rocky terrain for female faculty who strive to persist in a male dominated space. Recent empirical studies have shown exactly how impenetrable these male dominated enclaves can be. I argue that this study sheds light on what is missing from the previous literature by showing exactly how senior level medical faculty, as stakeholders of and perpetuators of department culture explain their environment and their experiences within it. Also set forth here is the understanding of exactly how notions of meritocracy and gender diversity operate in this setting as a mechanism of ascriptive inequality. Some have claimed academic medicine to be inclusive and a meritocracy yet the institution *still* lacks gender diversity in leadership fifty years past the achievement of gender equality in medical school graduation rates. With this research on the perspectives of senior level faculty, I shed light on the mechanisms of ascriptive inequality that persist in academic medicine because it is male cultured and believed to be a meritocratic institution. I also reveal the dual experiences toward full promotion of both male and female senior tenured faculty.

I began this study of senior level faculty for three reasons. The leading theories of gender in organizations, Acker's (1990; 2005) theory of the abstract worker as male and Kanter's (1977) theorization of the male manager as the most trustworthy peer inform my examination of who is more likely to persist in the organizational climate of academic medicine. Problems of sexism and subtle bias are reproduced when leaders do not address them as a problem and insist that the

medical academy is simply a meritocracy where all one needs to do is work hard to succeed. Lack of representation and mentoring inequalities will not change without targeted attention to the issue. Organizational climate is set by those at the top in a hierarchy such as academic medicine. Moreover, understanding what senior level academic physicians experience and perceive is key to assessing with empirical data whether there is an as yet uncovered mechanism contributing to the production of gender inequality at the top of the organization.

This study uses qualitative investigation into the gendered processes in academic medicine. The objective is to investigate and unpack how the issue of professional advancement as framed in academic medicine—that is, "Everyone just needs to be a good doctor" -- actually plays out. Meritocracy is an ideology that assumes equality of experience and starting points. Meritocracy ideology posits that the only difference in outcome between men and women should be an individual's efforts. This study works to unveil the myriad ways in which women and men in academic medicine do not have equality of experience or starting points. Yet, all professors interviewed were Full Professors, meaning that they did persist and achieve the ultimate goal of full promotion. What this comparative research hopefully yields as an important contribution to the sociological literature is how the institutional, cultural, and interactional processes of academic medicine, which claim to be abstract and value free under the guise of meritocracy (which is by definition not a gendered process), fosters gender inequality.

The research presented here showed that men and women described beliefs that academic medicine is a meritocracy where hard work is the key to success for physicians. At the same time, they described a work culture and environment that is best fit for a male worker. While they expressed belief that hard work was necessary, the hard work they described was predicated on time at work and male-centric signs of full devotion to academic medicine. They gave

evidence both in the past and contemporarily for how women do not fit their cultural model of expected behaviors, traits and perceived values. As a result, women were subject to devaluation or exclusion; however, most men did not seem to recognize that their cultural definitions of work and meritocracy contained gender bias. Instead, most men gave statements that showed a lackadaisical attitude toward attention to gender diversity. Most male professors insisted that gender parity was a reality in their field and that the lack of diversity at the highest ranks was mostly untroubling and soon to be passé. They perpetuated the pipeline argument that gender parity at the leadership level was simply a matter of time, as in, soon it would all be gender equal. Professors told me stories of the strong female leadership they had benefited from, or that they were raised up in the academy under female deans, chairs, or chancellors. One professor even argued that the mayor of the city he works in had been a woman, so female leadership "was everywhere." Most (but not all) male professors were seemingly untroubled by the current lack of female leadership in academic medicine. Yet, their own experiences with leadership development showed they were given more advantages and given these more easily in their careers. They experienced few if any challenges. My findings suggest that women who enter the medical academy still enter a male dominated space because men comprise the majority of senior physicians. Nonetheless, women also expressed beliefs in a meritocratic academic medicine. They also believed academic medicine is an institution that recognizes hard work. But women showed an ambivalence about their experiences of discrimination coupled with their belief in the meritocracy of academic medicine. They gave countless examples of academic medicine as a male cultural model and how they consistently sought to manage their place in the institution as women. Most but not all of the women experienced isolation and exclusion, sexual harassment, and/or pressures to perform the "second shift" at home that made their work in the academy a

balancing act (that men did not report). The women also worked to negotiate their professional identities as women by managing their femininity so as to be considered adherent to the unspoken code of the "non-gendered worker." The strategies women faculty utilized for this identity work was to appear easy-going (i.e. ignoring gender constraints in the work place) or to carefully construct their femininity in order to downplay gender differences in the professional realm. Some women explained their success as based on being exceptional and/or hardworking in a meritocracy of medicine that is not based on gender. These women were more likely to adamantly state that academic medicine is a meritocracy. But their opportunities were hard won instead of easily given. This contradiction highlights how some of the women persisted by temerity because they had to perform bold strides in a male dominated culture.

Women's meritocracy beliefs work in tandem with the male meritocracy beliefs, constraining their agency to speak up about the evidence that they are treated differently than male academic physicians. While both men and women believed in the meritocracy, men recounted that some advantages were given through affinity with those in power over them. They described experiences when they had been ushered through key moments in their career by someone "liking" them. What they failed to disclose in their statements was the reality that women get less of those affinity advantages. What is clear is that when comparing senior men and women, there was a striking contrast in experiences. Men received more advantages and less challenges. The women in my sample, it seems, persisted in spite of their challenges.

These two contradictory patterns constitute a duality largely unrecognized by either men or women. Together they signify parallel processes that work together to bolster men and constrain women. Advancement in academic medicine is impacted differently for men and women. The consequences for men are better positions and less red tape en route to promotion so

that they arrive at promotion fulfilling the legacy of the "hard working physician." Their belief in the meritocracy is never challenged, at least in a negative way, and they continue to occupy the status quo in fully promoted academic physicians. Women, on the other hand, battle their ill fit in a male dominated work culture at every step. They too have meritocracy beliefs, but these beliefs are consistently challenged. To persist, they disregard discriminatory experiences they and other women navigate so that they can forge ahead. Women arrive at full promotion after significant struggle. Their persistence shows tenacity. They overcame receiving fewer easy opportunities, often working harder to get around obstacles than men, ignoring blatant and subtle discrimination, and still arriving at a precipice where men are again the status quo. This dual gendered process replicates the consistent gender inequality for women in academic medicine.

A Mechanism of Reproducing Ascriptive Inequality

No one has yet in the sociological literature been able to grasp how the organizational and cultural processes operate to devalue women in academic medicine. My findings suggest there are two worlds in academic medicine: the male experience and the female experience. Previous sociological literature has not compared gendered experiences in academic medicine, and no previous work has studied meritocracy beliefs comparatively in men and women.

Reskin (2002) argued that specific processes that link ascriptive characteristics such as sex to workplace outcomes must be studied to uncover the mechanisms that allow sex and gender inequality to persist. Organizational mechanisms are found in the processes of opportunities and awards allocations by those in power in the organization. In academic medicine, opportunities and awards are doled out by deans, chairs, provosts, and even peers. Reskin argued that only when allocators are made to communicate and defend their decisions are

these processes uncovered. Obscuring these decisions, as often happens in academic medicine, allows the bias to continue. No one demands an explanation of a dean for their decision to put a man as interim chair. No one demands explanation from a dean overturning a vetoed promotion. In academic medicine, the informal internal social control mechanisms of peer to peer socialization is never checked by outside sources (Bosk 1979, Fox 1957) because physicians reject outside formal authority of their organization (Freidson 1988). Academic medicine's organizational decision makers are never formally questioned about or made to defend their decisions. Case by case comparison does not uncover these biases because "one man" against "one woman" can be explained away by an explanation of "fit." It is only by comparing aggregate groups, as I have done here, that one can show the repeated pattern of consistent bias against women.

Reskin argued that the previous sociological literature has focused too narrowly on explaining the motives for sex-based discrimination at work. Intrapsychic motives (stereotypes) such as "men just don't want to work with women" or "men prefer men" cannot be tested, as there is no empirical test for someone's innermost thoughts and feelings. Intrapsychic bias mechanisms can only be truly empirically tested by priming experiments. However, the intrapsychic bias mechanism is brought out in interactions, and evidence from the experiences stated by men and women is the closest proxy to understanding what happens because of intrapsychic bias. Interpersonal bias mechanisms can be studied for the affinity for like others (Kanter 1977). But it doesn't actually reveal what someone was thinking when they acted the way they did.

Reskin's (2002) lament was that sociological research on ascriptive inequality had focused too much on intrapsychic motivations but not organizational mechanisms. This study

fills the gap in sociological literature on a particular mechanism for inequality and discrimination in the workforce. Previous sociological literature on women in academic medicine has only described outcomes for women, both women who stay in academic medicine and women who leave it. This study enlightens that body of work with an explanation for women's consistent failure to advance at the same extent as men. We know from previous literature that women work very hard and they encounter many difficulties. But we have never yet learned why that hard work and negotiation of their challenges at work are not enough. This study gives evidence for the impenetrable male cultural model of academic medicine. I have shown how the culture of academic medicine consistently produces gate keeping measures that women cannot easily traverse. This informs both the sociological literature on physicians as well as women's labor force advancement. If we follow Kanter's (1977) and Acker's (1990) theories about organizations, we may likely see this same mechanism in any male dominated organization.

Methodology

I developed this work using the grounded theory (Charmaz 2006) method during my coding, memoing, and analysis of the data. I utilized a constructivist understanding of the experiences of my participants. Their interpretation of their experiences was just as important as my interpretation of their recounting of their experiences. I initially developed this project as a comparison of gender but I did not know what I would find. I did not set out to study meritocracy in academic physicians. But through analyzing their statements, themes emerged that I was previously unaware of based on my reading of sociological literature. Therefore, my work represents a sociological contribution using grounded theory as a methodological approach.

For this project I interviewed fully promoted medical faculty at a large midwestern medical school. Academic physicians possess two high status positions, as medical doctors and as professors. Researching privileged groups can put the researcher in a disadvantaged position. If high status people do not want to be studied, they don't have to. If a researcher does get access, participants may not reveal their most candid thoughts in order to protect the image of their own status and that of the institution that affords them their high position. Feminist researchers have called for building "nonhierarchical relationships" between researcher and participants, but that is not always possible to do when the researcher is the one who holds a marginalized status (Sohl 2018). I was legitimated by my tangential "insider" status as a Ph.D. student from the same institution. Additionally, my presence was vetted by one of their respected colleagues. A dean supplemented my request for participation by emailing introductions to each physician.

However, I found that as I am not a physician or a professor, I was a benign outsider to the institution of academic medicine. As I am not a member of their ranks, I was not threatening to them. My participants reacted to my presence cordially but also candidly. These participants treated me as an innocuous student doing a project. My embodiment was seemingly non-threatening to them. I look younger than I am while these senior promoted faculty were in the later years of their careers. As a poor grad student, I was dressed in business (very) casual and senior faculty, especially in a medical school, dress much sharper (men were often in suits and ties, which you don't always see in non-medical academic departments). When I interviewed the women, some of them would ask me if I had children, and I would respond that I did. I found that when they knew I was a mother, they would make statements implying that I understood "what it's like," Women without children and men never asked me if I was a mother.

A handful of physicians displayed in their own body comportment relaxation into the interview as it went on. One woman started the interview leaned back away from me in the chair, arms crossed. By the end of the interview, we were almost nose to nose (she had scooted her chair closer to me, Dr. style, as the interview progressed). A man who I had been warned about as "tough" became slightly emotional when talking about looking back over his career. He told me, "I don't interview people for a profession, but in my opinion, you're damn good at it." I said yes, that's what I've been told.

Not all of the participants were this relaxed with me, but that's to be expected. But I found that my participants found talking about their experiences to be somewhat of a catharsis. A female physician told me, "wow, I haven't thought about this stuff in years." Some women showed sadness about how they had been treated. One woman acted fearful when talking about someone who had treated her badly. The varied reactions both men and women had showed that they were genuine. Studying up may be difficult, but it's not impossible. I argue that my data speaks to my ability to make my participants comfortable with my presence.

Additionally, an important note on my particular sample. The data for this research was collected before the now famous #METOO movement, in which women from all walks of professional life came forward, some anonymously and some not, to state the ways in which they had experienced blatant or subtle sexism, sexual harassment, or denied opportunities based on their sex. Therefore, this study shines a light on a time capsule of sorts: how men and women spoke of their experiences and perceptions of their academic medical careers without the mind frame of a world that is hypervigilant on gender and sex in the workplace. Arguably, asking the same questions now would garner participant responses that were, perhaps, less candid, more guarded, or more speculative of gendered experiences. In my sample, both the men and women

surveyed had an assorted range of the association with gender as a process in their own and other's experiences climbing the ladder of academic medicine. These responses are particularly insightful for academic study of the institutional and cultural climate of academic medicine.

Gender Diversity in Academic Medicine and Beyond

Sociological theorists of gender have consistently asked while interrogating institutions, interactions, and cultural processes of society, "How, if at all, does gender matter?" Lorber (1984) investigated how women physicians experienced their careers. While Lorber's work is a seminal piece in the sociological study of gender and medicine, it was not comparative of both men and women. Without aggregate comparison of experience and beliefs, a mechanism of inequality reproduction cannot be found (Reskin 2002). This study builds on Lorber's important work to move forward an explanation of organizational mechanisms by demonstrating how gender matters in the advanced promotion of academic physicians under the guise of meritocracy by comparing men and women. Bendl and Schmidt (2010) advanced the idea of the "glass escalator" (Williams 1992) (where men glide to advancement smoothly while women are relegated to the bottom tiers of organizations) to suggest that a better metaphor may be the "glass firewall." The glass escalator was said to operate for men in female dominated professions. The terminology of the glass firewall communicates that it is not just a linear mechanism of inequality that holds women back, and not just in female dominated professions, but instead that organizations have gender inequality permeating them like a web. The mechanisms, based on ascriptive inequality, of meritocracy belief and differential experiences for men and women in academic medicine likely operate in all male dominated and male cultured organizations.

Firewalls are invisible, persistent, and seemingly of no one's doing. Yet choices are made at the organizational level on how they are built and maintained. Reskin's (2002) argument that sociological scholars must interrogate precisely how those mechanisms are maintained and reproduced is a call to action for scholarship on multiple organizations, not just academic medicine. If allocators, such as deans in a medical school, are never made to communicate or justify their decisions, the processes of inequality continue insidiously. All organizations have decision makers at the top who reproduce the institutional culture. "Leaning in" (Sandberg 2013), the advice given to professional women to find their seats at the table, has not been enough. Even if no one acted badly, or women did everything right, the institution itself is built to deny women the same experiences as men based on their ascriptive sex.

The claim that gender matters must be grounded in a second justification of why it matters. A lack of gender diversity in academic medicine permeates each part of society that unfolds from the training of future physicians. Academic physicians represent the reproduction of knowledge and interests of the medical academy, the perspective and scope of tackling society's health needs by practicing physicians, and medical research directives. If the top tier of academic medicine continues to be overrepresented with men, the male perspective will dominate medical research, medical training, and even doctor patient relationships. A well rounded, gender equitable medical academy serves the needs of everyone in society. If senior faculty, who are leaders in their departments and create the organizational culture of their department—albeit not recognizing the embedded gender bias--do not believe that the disparity of senior women is because of institutional, cultural, and social constraints, no change in this trend will be instigated.

Limitations and Future Research

This study has potential limitations. While I've identified gender as the ascription that is most salient in these physician's experiences, race and class are likely also important categories to explore for meritocracy belief and experiences. Previous research on meritocracy argues for less meritocracy belief among those who are marginalized by race. Other research shows more evidence of a "leaky pipeline" for attrition by race. Arguably race and class would be imperative pieces to add to the conversation of how meritocracy belief shapes persistence in a dominant cultured environment.

Age and cohort are two other possible areas for exploration of the experiences of fully promoted physicians. While I didn't compare age or cohort, Richter et al. (2020) showed that more recent cohorts have *less* equity in advancement for female academic physicians. Additionally, comparing the meritocracy beliefs and experiences of fully promoted physicians with men and women who have left medical academia would be beneficial for drawing conclusions about what contributes to female attrition. Therefore, future qualitative research on meritocracy belief in academic medicine utilizing other comparable ascriptive identities would benefit the gender and academic medicine sociological literature.

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Appendix A: Interview Guide for the Female Professor Oral History Project

A. Purpose of the Interview

Provide useful information for young women professionals

Capture information about the challenges the respondent has faced as a woman in a male dominated field.

B. Questions

Part 1: Specialty and Background

1. Scope of Professional Work

I'd like to get a picture of the scope of your professional work. Tell me about your areas of specialization.

What inspired you to choose this specialty? (Was there a person? A life event?)

For young people:
High school students might be listening to this interview.
How would you describe your specialty to a young person?

When did you realize that you wanted to go into medicine?
What experiences led you to science and medicine?
Was there something that happened in high school or before?

Of the many things you have done over your career, what are you most proud of?

- Success statement, successful patient, research, discovery

2. The "Landscape" of Medicine

I'd like to get a 'big picture' overview of what the medical profession was like for a woman when you began your career.

How many women were involved as students? As teachers?

What kind of work expectations were there for women?

What about how school or work influenced family life?

3. Evolution of Career

- Tell me about the key moments in your career. This could be a key moment of growth, transition, change, success, or integration.
  - How did this change your career direction?
  - What did you learn?
  - How did this change your practice (in research, clinical, administrative)?

Part 2: Information for young women professionals.

1. What advice would you give to young women today to help them negotiate professional challenges they may face because they are women?

2. *Mentoring*

What qualities should a young woman look for in a mentor?

What should more senior women think about in order to successfully mentor other women?
What impact can a good mentor have on a woman's career?
Tell me about your significant mentors.
How did this relationship develop?
- Who instigated the relationship?

How did the mentor help your career?

3. Sponsorship

A. Now I want to introduce the idea of a special mentor. A sponsor is a little different than a mentor. New ideas about sponsorship vs. mentorship are changing the way these roles are perceived. A mentor is someone who acts as a sounding board or a shoulder to cry on, offering advice as needed and support and guidance as requested. Mentors might not expect anything viable from the mentee in return. However, a sponsor is much more vested in their protégés, offering not just guidance but actively advocating for them and even taking responsibility for their advancement because they believe in them.

B. Do you think any of your mentors were sponsors?

C. Tell me about her/him. (Was it significant that this sponsor was a wo/man?)

Did you see a gender difference in mentoring styles between men and women?

D. How did that person shape your career? Or manage your career?

4. *Part – Time Work:*

A. Today more women in medicine are working part time.

B. Did you ever consider working part time?

C. What prompted your consideration?

D. What factors were involved in your decision?

E. Did you work part time?

F. How did (would have) part time works affect(ed) your career development?

G. Looking back would you have made the same decision?

H. What advice would you give today to young women who are thinking about part-time work?

5. *Leadership development*

A. How do you think women can best prepare themselves for leadership roles, especially in contexts still dominated by men?

B. How did you develop your leadership abilities?

C. What advice would you give to younger women who have leadership ambitions?

Part 3: Experience as a Woman Professional

1. Handling Challenges and Obstacles

A. I'd like to get a picture of how you were treated as a woman professional.
   a. How were you treated by peers?
   b. By those in authority
   c. By those in lower positions (interns or residents)
   d. Support staff (nurses)
   e. Patients (Were you taken seriously by your patients?)

B. Tell me about situations you recall and how you handled them.
   - Being ignored, being invisible, not make a wave
   - Being ignored in meetings
   - Raising a point only to have a male colleague take credit for it
   - Performance pressure
   - Socialization
   - Birth control

B. Tell me about ways in which you proactively worked against these pressures to build your credibility and visibility as a woman professional.

C. I'd like you to compare your experience with what women face today in the profession. In what ways do women face similar issues? How are things different?

D. What needs to change to bring real gender equality to your field?

Part 4: Looking back at Career and Personal Decisions:

A. There are lots of instances where career affects personal decisions and where personal decisions affect a career. Tell me about a moment when you faced that kind of situation. Looking back, would you still make the same decision? Why?

B. I asked you earlier about accomplishments. What about things left undone. Are there any projects that you wish you could have completed? Roles you wish you could have taken on? Skills you wish you could have developed? Why were you not able to complete fulfill these goals? What was the effect?

C. How do you think being a physician has affected (and still affects) your social and personal relationships. I'm thinking here of the development of friendships, intimate relationships, and connections with family.

D. What impact has your work had on your leisure time? What decisions have you made or had to make about the balance of work and leisure. How has work effected your leisure activities and hobbies.

Appendix B: Email Recruitment Letter for the Male Professor Oral History Project

Dear (Professor),

As you may know, Dr. xxx and I recently collaborated on an Oral History of Female Professors at xxx. This project has generated enormous interest and also questions. To explore these issues further, we have decided to conduct a very similar oral history project, but this time in male professors here at xxx.

I'm writing to invite you to participate in this project. What it will require is about one hour of your time to be interviewed with standardized questions by Emily Morrow. These questions are essentially the same questions posed to the female professors. Emily participated in the original project as the interviewer of all participants. At that time, she was a Master's candidate, now she is a doctoral candidate at xxx and this work will be a portion of her doctoral work.

Our goal is to interview 15 male professors and I hope you will agree to participate. I'm happy to answer any questions and will be in touch. Thanks (Professor)

Appendix C: Interview Guide for the Male Professor Oral History Project

A. Purpose of the Interview

The purpose of this interview is to gain knowledge about your experiences as a medical professor.

B. Questions

Part 1: Specialty and Background

1. Scope of Professional Work

I'd like to get a picture of the scope of your professional work. Tell me about your areas of specialization.

What inspired you to choose this specialty? (Was there a person? A life event?)

When did you realize that you wanted to go into medicine?

What experiences led you to science and medicine?

Was there something that happened in high school or before?

Of the many things you have done over your career, what are you most proud of?

- Success statement, successful patient, research, discovery

2. The "Landscape" of Medicine

I'd like to get a 'big picture' overview of what the medical profession was like when you began your career.

How many women were involved as students? As teachers?

What kind of work expectations were there?

What about how school or work influenced family life?

3. Evolution of Career

- Tell me about the key moments in your career. This could be a key moment of growth, transition, change, success, or integration.
  - How did this change your career direction?
  - What did you learn?
  - How did this change your practice (in research, clinical, administrative)?

Part 2: Information for young professionals.

1. What advice would you give to someone today to help them negotiate professional challenges they may face?

2. *Mentoring*

What qualities should someone look for in a mentor?

What should more senior faculty think about in order to successfully mentor others?
What impact can a good mentor have on someone's career?
Tell me about your significant mentors.
How did this relationship develop?

- Who instigated the relationship?

How did the mentor help your career?

3. Sponsorship

A. Now I want to introduce the idea of a special mentor. A sponsor is a little different than a mentor. New ideas about sponsorship vs. mentorship are changing the way these roles are perceived. A mentor is someone who acts as a sounding board or a shoulder to cry on, offering advice as needed and support and guidance as requested. Mentors might not expect anything viable from the mentee in return. However, a sponsor is much more vested in their protégés, offering not just guidance but actively advocating for them and even taking responsibility for their advancement because they believe in them.

B. Do you think any of your mentors were sponsors?

C. Tell me about her/him. (Was it significant that this sponsor was a wo/man?)

Did you see a gender difference in mentoring styles between men and women?

D. How did that person shape your career? Or manage your career?

4. *Part – Time Work:*

A. Today more women in medicine are working part time.

B. Did you ever consider working part time?

C. What prompted your consideration?

D. What factors were involved in your decision?

E. Did you work part time?

F. How did (would have) part time works affect(ed) your career development?

G. Looking back would you have made the same decision?

H. What advice would you give today to someone who is thinking about part-time work?

5. *Leadership development*

A. How do you think someone can best prepare themselves for leadership roles?

B. How did you develop your leadership abilities?

C. What advice would you give to someone who has leadership ambitions?

Part 3: Experience as a Woman Professional

1. Handling Challenges and Obstacles

C. I'd like to get a picture of how you were treated as a professional.
   a. How were you treated by peers?
   b. By those in authority
   c. By those in lower positions (interns or residents)
   d. Support staff (nurses)
   e. Patients (Were you taken seriously by your patients?)

D. Tell me about situations you recall and how you handled them.
   - Being ignored, being invisible, not make a wave
   - Being ignored in meetings
   - Raising a point only to have a male colleague take credit for it
   - Performance pressure
   - Socialization
   - Birth control

B. (If they mentioned challenges) Tell me about ways in which you proactively worked against these pressures to build your credibility and visibility as a professional.

C. What needs to change to bring real gender equality to your field?

Part 4: Looking back at Career and Personal Decisions:

A. There are lots of instances where career affects personal decisions and where personal decisions affect a career. Tell me about a moment when you faced that kind of situation. Looking back, would you still make the same decision? Why?

B. I asked you earlier about accomplishments. What about things left undone. Are there any projects that you wish you could have completed? Roles you wish you could have taken on? Skills you wish you could have developed? Why were you not able to complete fulfill these goals? What was the effect?

C. How do you think being a physician has affected (and still affects) your social and personal relationships. I'm thinking here of the development of friendships, intimate relationships, and connections with family.

D. What impact has your work had on your leisure time? What decisions have you made or had to make about the balance of work and leisure. How has work effected your leisure activities and hobbies.

Appendix D: Principles of Promotion and Tenure

Principles for Promotion and Tenure
(abstracted from the current version of the Faculty Handbook for the institution being studied—relevant terms have been placed in bold type)

"…The awarding of tenure to a faculty member is the most critical point in the process of selection and reward for achievement that maintains and improves the quality of the faculty…The criteria for tenure and promotion traditionally have been and continue to be **teaching, research, and service**. The award of tenure must take into account any prior service credited but will be based largely on evidence of achievement since joining the faculty. Promotion to a new rank must be based principally upon evidence of achievement since the last promotion or, for a person's first promotion, since the initial appointment to the faculty.

Teaching is a prime responsibility of the University. For promotion to a higher professorial rank, evidence of effective teaching must be furnished. This evidence may take several forms. Student evaluations and peer evaluations are highly desirable. Departments, or schools where departments do not exist, should provide a standard set of procedures to evaluate teaching to ensure an equitable and substantive review process. Individuals in the same field should be evaluated by the same means. However, no specific format or instrument is prescribed at the university level. Good teaching requires continual application and effort. The faculty member must keep abreast of new developments in his or her field and related fields and must maintain credentials as a scholar so that he or she is part of the creative process by which the frontiers of knowledge are continually being expanded. The faculty member should be enthusiastic about his/her discipline and should be able to communicate this enthusiasm to the students, thus stimulating both the faculty member and the students to greater achievement. The University prides itself on having exceptional faculty members whose merit and service to the University in teaching earn them a well-deserved place of honor and respect in the institution. However, this criterion alone, to the exclusion of consideration of the other criteria, does not serve as a basis for promotion or tenure.

Research…Promotion in professorial rank is a testimony and recognition of professional competency and productivity. The standards for measuring scholarly and creative productivity cannot be applied uniformly throughout the University. In many areas, the evidence for competence is research conducted by the faculty member, the results of which are submitted for professional evaluation, review and criticism to peers through recognized processes then disseminated through established media. In those areas, publication in refereed journals and in books is the most significant measure of scholarly productivity. Competitive awards and grants from agencies of national standing are another major index of an individual's success in obtaining recognition for research. Local, regional or internal grants and contracts are also valuable but generally not as prestigious. Scholarly production can also take the form of preparation of published reports, studies, and other material for governmental agencies and non-governmental organizations concerned with the operation, evaluation, or improvement of the discipline. Participation in symposia, conferences, and professional meetings is another outlet for

publicizing and testing the results of one's research. Members of professional or practitioner-oriented disciplines share scholarly obligations with the rest of the faculty. However, in cases where administrative or clinical responsibilities involve a disproportionate amount of the candidate's time, the required extent of written scholarship may be modified. Some measure of scholarly productivity may be demonstrated by results of professional consulting or advice in the practice of the profession being taught, but these activities are insufficient of themselves.

In terms of research, the award of tenure, promotion to assistant professor, or promotion to associate professor should be based on sufficient evidence of scholarly productivity to document a successfully developing career. For **promotion to professor**, evidence must be conclusive that this objective has been realized; consequently, the record of scholarly and creative productivity should be substantially greater than that expected at the lower ranks. Continuing productivity from the time of one's formal entry into a professional academic career is expected. As in the case of service and teaching, excellence in research alone is not sufficient to ensure promotion.

Service is expected and encouraged and is to be recognized. Service is of several kinds. Extramural activities in professional organizations and in public bodies are an important means of bringing prestige to the University…In the University…Medical Center, service also consists of patient care, direct and indirect. Faculty governance and committee participation are other forms of service. Administration is essential to institutional well-being; therefore, administrative service is another form of contribution a faculty member may make to the University. Administrators, however, must meet the standards of academic excellence. As with teaching and scholarship, service must be evaluated as to quality as well as quantity, with respect to its contribution to the University in the performance of its mission. Neither service nor administrative duties alone may serve as the basis for promotion…Promotion and tenure are never automatic for a faculty member. They must be earned.

Guidelines for Promotion and Tenure

Promotion to assistant professor, associate professor, or professor…is made on the basis of meritorious performance as described in guidelines provided by individual schools…It is awarded for achievement, not for mere length of service or as an incentive to greater effort…Recommendations for promotion normally originate in the departments and are forwarded to the promotion and tenure committees of the School of Medicine, the School of Nursing, or the School of Health Professions. These committees make their recommendations to their respective dean or their designee, whose recommendations are forwarded to the Vice Chancellor for Academic Affairs. The Vice Chancellor for Academic Affairs prepares the promotions list and forwards it to the Executive Vice Chancellor. The Executive Vice Chancellor's recommendations are then sent to the Chancellor for final action."