Received: 11 December 2021 | Accepted: 6 January 2022

DOI: 10.1111/resp.14211

Official Journal of the Asian Pacific Society of Respirology
Respirology APSR WILEY

LETTER FROM ASIA-PACIFIC AND BEYOND

SPECIAL SERIES: LEADING WOMEN IN RESPIRATORY MEDICINE
Series Editors: Natasha Smallwood and Fanny Wai San Ko

Advancing leaders and leadership: New Zealand women in respiratory medicine

The 19th century saw many notable events unfold in the history of Aotearoa New Zealand (NZ) women (wāhine), highlighting the importance of gender equality to this nation even in those early years. NZ women became the first in the world to vote in 1893. In the medical field, Grace Neill led major nursing and midwifery reforms establishing a series of state maternity hospitals 'for mothers, managed by women and doctored by women', whilst Dr Emily Siedeberg became the first female NZ medical graduate in 1896 (Figure 1).[1] Together, they defended this innovative women-focused model from medical colleagues and tradition, creating a new care paradigm. Globally, many pioneering women in medicine shared Neill and Siedeberg's experiences of challenging societal norms that discriminate against women's rights and rise to leadership. Has the foundation laid down by these courageous, determined women paved an easier path for women today in medicine in Aotearoa NZ? This article reflects on the status of NZ women in multidisciplinary respiratory care teams including respiratory physicians, physiotherapists and nurses 125 years later.

Similar to some other countries, NZ has achieved early medical workforce gender parity, with predictions of women junior doctors outnumbering men by 2025.[2,3] This trend is not sustained with role seniority; only 33% of 95 respiratory specialists[3] and 17% of respiratory clinical director positions are currently held by women. Similarly, only six women respiratory nurse practitioners (NPs) and no respiratory physiotherapy clinical specialists exist in NZ despite 91% of nursing workforce[4] and 76% of physiotherapy workforce represented by women in 2018.[5] It would appear that the poor rise and retention of women into senior roles as they progress through their career, also known as the 'leaky pipeline',[6] is pervasive across health professions regardless of the gender mix.

Barriers to women in healthcare leadership are described in the medical literature[2,6] but deserve more open discussions. Societal expectations of women mean working women continue to carry a disproportionate burden of domestic and parental responsibilities, resulting in career interruptions at times of career progression. System-wide policies, such as limited parental leave and inflexible working structures, further compound these difficulties. These challenges contribute to unequal gender distribution by specialty where women gravitate to specialties offering more regular and predictable hours to balance other non-work commitments. Within respiratory medicine in NZ, lung transplantation and interventional pulmonology are subspeciality areas traditionally dominated by men. Gender stereotypes, in addition to high acuity and unpredictable after-hours work, may be contributing factors to singular female representation in these fields. Implicit bias, whereby women are prohibited from advancing to positions of authority simply because of their gender, is a dominant barrier that was highlighted in the Harvard Business Review titled 'What's holding women in medicine back from leadership',[7] and a key finding of the 2017 American Thoracic Society (ATS) equality workshop.[6] Consequently, women fail to put themselves forward for leadership roles perpetuating a self-fulfilling prophecy and, by association, are not visible or role models to others. Specific to female-dominated professions is the 'glass escalator' phenomenon whereby males who enter these occupations tend to be promoted at a faster rate than their female counterparts,[8] which is thought to be partly related to career interruptions. The average age of NZ NPs of 51 years[4] likely reflects the long, perhaps staccato, journey to attain clinical leadership in this field, compounded by ill-defined leadership pathways, resource-heavy promotion criteria and lack of leadership role models, also identified as issues within respiratory physiotherapy.[5] In addition, challenges may continue beyond leadership

FIGURE 1 Dunedin St Helens Hospital maternity staff, 1907. Dr Emily Siedeberg (first NZ woman medical graduate) surrounded by midwifery staff. Dr Siedeberg is distinguishable by her central position and black clothing. All the midwives are holding recently born babies (source: Kerryn Pollock).[11] Reproduced with permission of the Otago Daily Times

appointment as women leaders can often be judged more harshly compared with male counterparts.

The responsibility to enact change should not be left to individual woman; instead, a multi-prong, top-down strategic approach is required to evoke transformational change and gender equity. Conscious of global and local issues, the Thoracic Society of Australia and NZ (TSANZ) established a Diversity and Inclusion Task Force in 2017 to embed gender and minority group parity within their strategic plan. Following this deliberate tactic, the visibility of women across health professions as invited speakers (59%) and chairs (57%) at the 2021 TSANZ Annual Scientific Meeting was more evident compared with under 50% in both groups in 2018. Female executive representation of the NZ TSANZ branch also increased from approximately 45% in previous years to 62% in 2020. Additionally, in 2019, the first female NZ TSANZ branch president was elected. The positive imagery in these roles not only acknowledges and celebrates achievements of women in respiratory medicine, but also provides role models for aspiring women respiratory leaders. Benefits extend to minority NZ TSANZ branch members, that is respiratory physiotherapists (4%) and nurses (14%), whereby an inclusive and progressive specialty society can effectively challenge embedded barriers to professional leadership for women and minority groups.

Healthcare organizations must also strategically promote balance and equity in leadership to align with the increasingly complex healthcare systems of the 21st century. Diverse gender representation in teams has been shown to raise team collective intelligence and performance,[9] which has clear benefits for patients and healthcare delivery. Furthermore, team orientation and inclusivity, identified as core individual and team leader attributes in health,[10] are synonymous with traditional female characteristics. These findings provide strong arguments against bypassing women from leadership roles which limits access to the full talent pool; more importantly, the leadership traits women bring to the table can enhance the governance of complex organizations.

As individuals, women in health care face unique stressors and challenges which can be mitigated by different strategies. Formal leadership programmes (e.g., Women & Leadership in NZ) provide educational frameworks to enhance leadership qualities. Implicit bias training for promotion committees to address gender-based prejudices can widen leadership opportunities whilst ensuring transparency of promotion processes.[6] Same-sex mentors, preferably in senior positions, can provide supportive networks. Wāhine Connect offers a NZ wide matched mentorship programme for all women in health care and the NZ Women in Medicine (NZWIM), a closed Facebook group, utilizes social media to facilitate mentorship and collegial discussions. Women in senior leadership positions, as role models, mentors and sponsors, are in a unique position to foster the next generation of well-balanced, successful health professionals and enact systemic change to futureproof respiratory healthcare delivery.

Here, we have highlighted the current position of NZ women in three health professions allied to respiratory medicine, and their efforts in pursuit of parity in career and promotion opportunities. The need for collective leadership and a diverse and inclusive workforce with both genders is more important than ever, to serve our increasingly complex patient base. Conversations on leadership equity are incomplete without acknowledging minority and ethnic groups. While beyond the scope of this letter, gender diversity and representation of demographic groups, specifically Māori and indigenous peoples, are equally important. We encourage all women respiratory health professionals as a collective to become more visible, audible and strategic to ensure the pivotal changes advocated by our pioneering and contemporary colleagues are not merely a discourse, but embedded in individual, team and organizational strategies.

KEYWORDS
leaders, respiratory medicine, women

ACKNOWLEDGEMENTS
The authors thank TSANZ for provision of membership and gender balance records and Betty Poot for NZ Nurse Practitioner data.

CONFLICT OF INTEREST
None declared.

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How to cite this article: Yap E, Mooney S. Advancing leaders and leadership: New Zealand women in respiratory medicine. Respirology. 2022;27:239–41. https://doi.org/10.1111/resp.14211