# Women Deans: Carving a Unique Path in Academic Medicine

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Dissertation

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**Abstract**

The purpose of this hermeneutic phenomenological study is to identify and describe the essence of the lived experience of women deans in the leadership of academic medicine in Canada. The scholarly literature documents a multitude of complex career disadvantages that limit women physician's ascension through the hierarchy of academic medicine. According to Robb (1999), it was not until 1999 that the first woman became dean of a Canadian medical school. There have only been eight women full deans of medicine in the 174 year history of medical schools in Canada (Tricco et al., 2021). At this current glacial pace it would take 50 years to reach gender parity among deans of medicine (Jacobson et al., 2021). Prior strategies to ameliorate the career trajectories for women in academic medicine have been deemed insufficient as the gender gap in senior leadership has persisted (Larson et al., 2019) despite decades of women comprising greater than 50% of medical school graduates. Eight women deans were selected via criterion-based purposeful sampling, followed by snowball sampling. Four were full dean and four were vice, assistant, or associate deans. Semi-structured, in-depth phenomenological interviews were conducted, digitally recorded, and transcribed verbatim. The data were analyzed using a phenomenological approach. Six themes were elucidated: authentic self, building a support team, sexism and the culture of medicine, woman dean as agent of change, becoming a dean and getting the job, and success on the job. The participants shared that they presented their authentic selves in all contexts while having a carefully cultivated team of supportive people in their lives. They were successful at walking the fine gender line and navigating a unique path through academic medicine. These features of their lived experience allowed the women to be an agent of change and to attain their decanal position while also being exceedingly successful in their role as dean.

*Keywords:* women, gender, academic medicine, medical education, sexism, leadership, gender gap, phenomenology

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# Chapter 1- Introduction

This dissertation research sought to identify and describe the essence of the lived experience of women deans in the leadership of academic medicine within the Canadian context. This phenomenological research explored the lived experiences of eight women deans and elucidated not only their lived experience as deans but how they experienced their successful path to and through decanal leadership. This investigation explored the lived experiences, from participants' retrospective accounts, of what it was like on their journey to decanal leadership in academic medicine. A dean is someone who is charged with providing strategic leadership for the tripartite mission within academic medicine which is: excellence in education, research, and patient care. Decanal leadership can include someone who is a dean of a medical school while there are also lower level decanal leadership positions such as vice, assistant, and associate dean depending on the university’s structure. This study addressed the gap in the scholarly literature about the experiences of women who hold senior leadership positions in academic medicine in Canada.

## Research Aims and Questions

The purpose of this phenomenological investigation was to identify and describe the essence of the lived experience of women deans in the leadership of academic medicine in Canada. The aim of this study was to develop a “phenomenological nod” (van Manen, 1990, p. 27) in the reader surrounding the experience of being a woman dean in Canada. This phenomenological nod aims to have the reader say, “I understand better what it is like for someone to have experienced that” (van Manen, 1990, p. 27). Additional aims of this

phenomenological research were to explore and develop a deep understanding of how the participants navigated the academic medicine hierarchy to achieve a decanal leadership position in a field where women have historically been seen as outsiders (Cameron et al., 2019).

**Significance of the Research**

For decades, in Canada, the United States, and Australia, over 50% of medical students are women, and yet, there continues to be a staggering lack of women in positions of authority and leadership in academic medicine (Bismark et al., 2015; M. Cohen & Kiran, 2020; Heisler et al., 2020; Sharma, 2019; Tricco et al., 2021). There has been no "critical mass effect" (Etzkowitz et al., 1994, p. 51) wherein by definition, if sufficient numbers of women are present this should result in an increased proportion of women in the field. There is a great deal of scholarly literature documenting the history of women in medicine and the complex career disadvantages that plague women in medicine (Edmunds et al., 2016; Mousa et al., 2021; Tesch, 1995; Trusson & Rowley, 2022). There is also literature that identifies the persistent lack of women in the leadership of academic medicine and calls for methods to remedy that absence (Bismark et al., 2015; Schor, 2018; White et al., 2012). There are only two studies, at the time of this dissertation research, that provided insight on the career paths for women deans; however, neither are focused in the Canadian context (Isaac et al., 2009; Jacobson et al., 2021).Therefore, little is known about how women physicians acquire and experience decanal positions in Canada. At the current pace, according to Beeler et al. (2019), it could take up to 50 years to reach gender parity in decanal leadership, meaning that the medical students currently enrolled will be at retirement age by the time that occurs. Beeler et al. (2019) go on to explain that diversity amongst the leadership in an organization can help "transform the culture of medicine" (p.1510); therefore, it

is imperative to identify how the successful few women deans have acquired their decanal positions to remedy the current situation.

**Why Phenomenology**

Hermeneutic phenomenology was selected for this investigation because it seeks to develop a deep understanding of a complex phenomenon via the lived experiences of those who have actually experienced the phenomenon under investigation. Hermeneutic phenomenology, according to van Manen (2014) focuses on the "abstemious reflection on the basic structures of the lived experience of human existence" (p.26). He explains phenomenon to be "that which appears" (p. 27) and logos as "to let something be seen" (p.27). This methodology aims to "describe the meaning of a phenomenon and understand the contextual forces that shape it" (Bynum & Varpio, 2018, p. 252). Phenomenology according to van Manen (2014) "is a way to access the world as we experience it prereflectively" (p.28). I have therefore, employed a "self-styled" (Adams & van Manen, 2017, p. 780) hermeneutic phenomenological methodology which required that I, as the researcher, acknowledge my own experiences and perceptions as they relate to the research process while openly reflecting and attending to those presuppositions (van Manen, 1990). In the section below, I have provided what I call a deconstruction exercise where I have attended to those preconceptions and disclosed my positionality. This has been an essential feature of the hermeneutic phenomenological methodology that was employed for this investigation. To pursue this dissertation, I have engaged with the research via a cultivated thoughtfulness and phenomenological attitude (van Manen, 2014) where questions like "what is this experience like" (p. 31) and "how do we live through an experience like this" (p.31).

A hermeneutic phenomenological methodology was well suited to enable us to learn from the experiences of others and is sensitive to the social and historical context within which

participants experience their lifeworld (Neubauer et al., 2019). From the lived experiences of the eight deans, I have gained a deeper understanding of their path to and through decanal leadership; thus, providing a glimpse of a future where women may see a way past the complex career disadvantages that are documented and abound in the scholarly literature, and subsequently outlined below in this dissertation's literature review.

**Positionality: Take a Walk in Her Shoes**

Phenomenological research is said to have a transformative effect on the researcher; therefore, it has been important to disclose my positionality and presuppositions at the outset of this project (van Manen, 1990) via what I called a deconstruction exercise. I began this journey out of personal relevance with a sense of wonder, asking the phenomenological question of what it is like to be a woman in the leadership of academic medicine. What is it like to be woman dean in medicine. I am a 40-year-old cis-gender woman who identifies as lesbian. I am married to the love of my life, a cis-gendered highly educated, white woman from rural Nova Scotia. We have a 16-month-old son whom we love dearly. I am a white, Jewish, feminist, and devout women's health advocate who was born and raised in the nation's capital. I am a qualitative researcher who subscribes to a phenomenological research orientation. I identify as a wife, mother, teacher, and student. I am an obstetrician gynecologist who practices medicine in a rural community in Atlantic Canada. This multifaceted identity anoints me with certain privileges and a lens with which I bring to my research and everyday life.

During medical school and residency, I was exposed to very few women who were surgical residency program directors, academic department chairs, or deans of medical schools. Those elite few were inspiring and exceedingly effective teachers, clinicians, and leaders. Women's progress has been stunted due to a multitude of complex career disadvantages such as:

sexism, gender stereotypes, informal hiring and networking practices, the glass ceiling, the sticky floor, and the leaky pipeline (Cameron et al., 2019; Cohen, 2009; Ruzycki et al., 2021; Sharma, 2019; Shrier, 2004; Tricco et al., 2021; Van den Brink, 2011). I was curious about how the few women physicians who have become deans have been able to scale the hierarchy of academic medicine when women have historically been seen as outsiders in the leadership of academic medicine. I had suspected that there would be some answers as to how we may ameliorate the career trajectories for women who aspire to be dean of a medical school from the lived experiences of the few successful women deans.

As a physician who does get the intermittent opportunity to teach students while on elective in rural communities, I am somewhat of an insider in that I appreciate some of the culture within medicine; however, I am also an outsider when it comes to the realm of senior leadership in academic medicine. I had no insight, prior to conducting this research, into the lived experience of the few women who have successfully gained decanal leadership positions in academic medicine in tertiary academic teaching centres. This deconstruction exercise has enabled me to "make explicit [my] our understandings, beliefs, biases, assumptions, presuppositions, and theories" (van Manen, 1990, p. 47) about the phenomenon that has been investigated with this dissertation research. Rather than bracketing my positionality, as Husserl suggests (Reiners, 2012), I have thoughtfully and deliberately attended to my own subjectivity, thereby using my own experience as the initial point of orientation to the phenomenon under investigation (van Manen, 1990). This is an imperative feature of my research process because, "[a] the phenomenologist knows that one's own experiences are also the possible experiences of others" (van Manen, 1990, p. 54). From this process I allowed myself to diligently and deliberately "hold these presuppositions at bay" (van Manen, 1990, p. 47) and attend to each step

of the research process with fresh eyes. I also had the opportunity, while conducting this dissertation research, to speak with Dr van Manen himself and participate in a phenomenological reading group that has further strengthened my orientation to this phenomenology and pursue a "self-styled" (Adams & van Manen, 2017) phenomenological methodology.

This dissertation is presented in five chapters. The first chapter outlines the purpose of the study, research aims, as well as the significance of the study. It also presents a brief statement of my positionality and introduction to the hermeneutic phenomenological methodology that was employed. The second chapter of the dissertation presents a comprehensive review of the literature documenting the history of women in medicine, complex career disadvantages, and what is known about women in the leadership of academic medicine. The literature review demonstrates the gap in knowledge surrounding women deans in the Canadian academic medicine context. The third chapter outlines the methods employed in this dissertation research including details about the study design, participant recruitment, data collection and analysis as well as ethical considerations for trustworthy qualitative research. The fourth chapter presents the results of the study including the six themes and multiple subthemes that were elucidated from the data. The fifth and final chapter documents the discussion, conclusion, and limitations of the study, as well as directions for future research.

# Chapter 2 - Literature Review

A generative scholarly literature review (Hart, 2018) was performed. The three major themes that emerged from the literature review to situate this research included: the history of women in medicine, complex career disadvantages for women in academic medicine, and women in the leadership of academic medicine. To complete this review, Boolean searches were performed using the library databases available from Acadia University, St. Francis Xavier University, and the University of Manitoba. Multiple databases were employed, including Google Scholar, PubMed, SCOPUS, and Web of Science. The primary search terms included: "women" OR "women physicians" OR "women doctors" AND "academic medicine" OR "medical education" OR "clinician educator" OR "physician educator." Additionally, terms such as "sexism," "hidden curriculum," "gender" and "women deans" were also applied. The articles that were identified were saved in PDF format, printed, and then read in their entirety. Then hand-searches were undertaken via the reference lists of the commonly cited articles as well as articles with relevance to the research purpose. Approximately 450 articles were reviewed. The articles were read, annotated, and then grouped via an inductive thematic analysis. Three major themes were identified within the scholarly literature that situated this dissertation research, as described below.

## The History of Women in Medicine

Women's historical journey to gain admission to the professional field of medicine and medical education has been well documented in the scholarly literature (Bickel, 1997; Cameron et al., 2019; Heggie, 2015; Jefferson et al., 2015; Lefford, 1987; More & Greer, 2000; Shrier, 2004; Strong-Boag, 1994). This journey has been often fraught with struggles including sexism, gender stereotypes, the "Old Boys' Club," exclusion from informal networking and hiring

processes, and the requirement to be a "superwoman" to be seen as simply adequate in comparison to male peers. These are only a few of the complex factors that have resulted in women's struggle to acquire a medical education and be seen as legitimate practitioners. According to Strong-Boag (1994), medicine became a professionalized field at the hands of men in the 19th and 20th centuries which resulted in the formal and informal exclusion of women from medical training. Women now account for more than 50% of medical school graduates in the United States (Jacobson et al., 2021), Australia (Bismark et al., 2015), and Canada; and yet, they continue to be stifled by complex career disadvantages resulting in slow or no career advancement in academic medicine (Carr et al., 2015). Medicine and the field of medical education serves as a microcosm of the greater society such that, the struggles and societal pressures experienced by women in general society may be magnified within medicine as it has historically been a male-dominated field where women were seen as outsiders.

### *A Herstory of Struggles: Women Striving for a Medical Education*

Prior to medicine moving to the public sphere as a professional vocation, it took place in the home, the private sphere, where women provided such care (Jefferson et al., 2015; Pastena, 1993). Historically, "women have always been healers, but when medicine became established as a formal profession in Europe and America, women were shut out" (Shrier, 2004, p. 253). Thus began the battle for women to gain back their access to be considered legitimate healers and garner a medical education. Women would care for sick family members through a process of trial and error passed down through tradition from one generation to the next. Formal medical education for women in North America began in the United States in the 1850s (Brunton, 1992). The first wave of feminism brought the first women physicians including Dr Jenny Kidd Trout and Dr Emily Stowe. Then, women's-only medical colleges developed between 1883 to 1906.

From 1906 to the 1960s, women attended, albeit in small numbers, formal medical education institutions and thus their history followed the developments of the feminist movements.

Pastena (1993) described a depiction of women's involvement in surgical procedures as early as 3500 BCE in the grave of ancient Sumerian Queen Shubad of Ur, near Tutankhamen's tomb. There were ancient drawings from approximately 1500 BCE portraying women students attending medical training in Heliopolis in Egypt. At that same time, tombs depicted women performing medical and surgical procedures with specific references to caesarean sections and women's health conditions. In some countries during the Middle Ages women were allowed to continue to practice medicine and perform surgeries so long as they took over their deceased husband's practices. However, between the $11^{th}$ and $14^{th}$ centuries women were formally excluded from medical training and surgical practices because of regulations forbidding them to do so (Pastena, 1993). Henry VIII stated that "no carpenter, smith, weaver, or woman shall practice surgery" (Wirtzfeld, 2009, p. 318), thereby formally excluding women. Though there were regulations barring women from medical and surgical practice and training, women continued to practice without formal training or recognition for the next few centuries.

An interesting story within the history of medicine is that of Dr James Barry who graduated in 1812 from a medical school in Edinburgh. This physician joined the army and ascended to the rank of Surgeon-Major in 1827 and was awarded the position of Deputy Inspector-General for the army hospitals in Canada. This physician was known as an outstanding physician and surgeon who was dexterous and clever, but also short and unable to grow a beard (Brunton, 1992). It was later discovered at the time of *her* death via autopsy that Dr Barry was a woman. This woman was so drawn to the study and practice of medicine she impersonated a man for her entire life because she had to defy gender norms to be a physician at that time.

According to Brunton (1992), Dr Elizabeth Blackwell was the first woman admitted to a medical school in the United States. She was originally refused entry from all of the schools that she applied to and then one medical school in New York finally accepted her. They put her acceptance to a vote and the entire student body voted in her favour. It was the medical school's original plan to reject her based on her sex, but after the unanimous student vote of acceptance they could not refuse her admission. She went on to graduate at the top of her class but was denied a residency spot/internship, thus she travelled to Europe to further her medical education. She returned to New York and had to open her own practice in 1853 because she was rejected from joining any institution. Due to the public's distrust of a female doctor, Dr Blackwell eventually travelled back to England to be registered and recognized as a physician in 1858. Eventually, in 1889, she was recognized as the first woman physician in the United States (Wirtzfeld, 2009).

Another pioneering woman in medicine was Dr Lucy Wanzer, an American who applied to medical school in San Francisco in 1873. The dean of the medical school advised her fellow students to haze her and make every effort to make her uncomfortable, in hopes that it would force her to leave because they could not refuse her admission. Despite this, she was the first woman to graduate from a medical school in California and garnered the support and respect of her fellow students. This was not the case for English-born Dr Elizabeth Garret who was asked to keep her excellent grades to herself and subsequently she was dismissed from her medical school because she outperformed her male peers in the mid 1850s (Brunton, 1992). She then attended the University of Paris which opened its doors to women in 1866. She married a ship owner named James Anderson in 1871, taking his name, becoming Dr Anderson. Dr Anderson joined the staff at the London School of Medicine for Women. She ascended to the position of

dean and was cited the first female dean of a medical school for women. Her career path was a challenge at every turn which was typical for women in medicine at that time.

Dr Emily Jennings Stowe, the first female physician in Canada, was rejected from the University of Toronto in 1865 and had to train at the New York Medical College for Women. Dr Emily Stowe made it her life's mission to advance the plight of women desiring to acquire a medical degree in Canada. She was originally told by the University of Toronto in 1865 that "the doors are not open to women and I trust they will never be" (Wirtzfeld, 2009, p. 319). After training in the United States, she returned to Canada to practice without residency or internship and became the second woman to be granted a license to practice medicine by the College of Physicians and Surgeons of Ontario. Her daughter, Dr Augusta Stowe-Gullen, was the first to be given a license and graduate with a Canadian medical degree in 1883. The first female surgeon in Canada was Dr Jennie Smillie Robertson, who graduated from the University of Toronto medical school, but was granted neither a residency nor internship in Canada. She completed her medical training in the United States prior to returning to Canada where she performed surgery in a private home. Dr Jessie Gray who graduated from the University of Toronto in 1934 was the first female general surgeon in Canada. She served as the chief of surgery at the Women's College Hospital.

Canadian Sir William Osler, historically called the father of modern medicine, was one of a group of doctors who founded the world-renowned Johns Hopkins Hospital. He had a significant impact on the trajectory of professional clinical medical education. Dr. Osler was cited in 1891 in *Century Magazine* as saying:

> If any woman feels that this medical profession is her vocation, no obstacles should be placed in the way of her obtaining the best possible education and every facility should

> be offered so that as a practitioner, she should have a fair start in the race. (Brunton, 1992, p. 955)

Despite this vote of confidence, women continued to struggle to gain access to formal medical training due to a number of reasons including, but not limited to, sexism, gender stereotypes, the "Old Boys' Club," exclusion from informal networking, and the requirement to be superwomen and outperform their male peers to be seen as adequate. The outstanding women who were successful in gaining a formal medical education prior to the 1960s are considered "trail-blazers" (Strong-Boag, 1994, p. 336). From 1906 to the 1960s there were formal and informal quotas for female medical students. Dr May Cohen, one of the best-known Canadian feminist physicians who trained in the 1950s, recalled that there was a 10% quota of women permitted to be accepted to medical school. She explained that "those of us who succeeded in getting through that barrier could only feel extremely grateful for our good fortune" (p. 338).

***Sexism and Gender Stereotypes***

Lorber (2005) describes sexism as a system that privileges men and subordinates women. This subordination is based on the social construction of gender wherein the binary category of male masculinity is privileged over female femininity. Often times, women applying to medical schools in the 1800s and early 1900s were told that "medical school was no proper place for a woman" (Brunton, 1992, p. 959). From the very beginning of women's attendance in medical school training programs, they contended with sexism. Strong-Boag (1994) explains, "the medical education system has been created for and by men" (p. 338). Sexism exists as blatant sexist remarks, sexual harassment, hazing of female students (Feinmann, 2019; Manzoor & Redelmeier, 2020; Watson, 2014), being considered invisible when professors directed comments to males only in the class (Strong-Boag, 1994), and quotas on the number of women

permitted to be accepted in the post-World War II era between 1945 to the 1960s (Duffin, 2012; Lefford, 1987). From the 1970s onwards in Canada great gains were made in the struggle for equality for women in education and employment where in 1960 9.4% of Canadian medical students were female and now the current rate is over 50% (Bickel, 1997; M. Cohen, 1997; Feinmann, 2019; More & Greer, 2000; Ruzycki et al., 2021; Shrier, 2004; Tricco et al., 2021). This gain has not extended to women in the leadership of academic medicine (Ruzycki et al., 2021; Sharma, 2019)

As an addition to sexism which privileges men over women, gender stereotypes limit the socially acceptable behaviours and presentations for men and women. Historically, a woman's place was in the home, tending to and nurturing family life in the private sphere. Therefore, with the professionalization of medical education and the practice of medicine "at the hands of male physicians in the 19th and 20th century" (Strong-Boag, 1994, p. 336) it was taken outside of the socially acceptable domain of women's work (Vogel, 2019). Medical education was situated outside of the socially constructed gendered norm of behaviours for women. It was considered that women had a "natural incapacity for rigorous, scientific study, and the threat to normal femininity represented by medicine's knowledge of the intimate details of the body" (Strong-Boag, 1994, p. 336). This sexist social construction of the gendered nature of medical and scientific knowledge acquisition and creation continues to exist (Lundine et al., 2019).

Negative attitudes to women in medicine have persisted over time (Feinmann, 2019; Kaye, 2021; Manzoor & Redelmeier, 2020; Tricco et al., 2021). This is not a new finding, as evidenced by Engleman's (1974) study that surveyed 500 clinic patients to investigate their attitudes towards women physicians. This study identified that a significant number of patients reported that they would not discuss certain subjects with a female physician and considered

women to be less competent than their male peers. Patients also reported that they would prefer a male physician and considered a "typical doctor" (p.96) to be male. Although this is quite dated, it outlined the negative impact that gender stereotypes had on the perception of female physicians. This finding has been reproduced in the current timely literature where there continues to be the gendered assumption of women's incompetence (Cameron et al., 2019).

In the mid to late 1800s, it has been well documented that women were excluded from residency and internship positions which limited their ability to practice medicine as recognized physicians. This was a means of social control to retain medical education and its associated behaviours in the domain of male medical students and future male physicians. This occurred at an administrative level as well, where women's admission to medical school was either denied or placed on a quota. It also occurred at the hands of male student peers; as described above, Dr Elizabeth Garret outperformed her male peers on examinations and was able to answer questions that her male peers could not and thus her entire class petitioned successfully for her dismissal. Dr Garret defied what was socially acceptable for a woman and was penalized for being outstanding. This same narrative persists to this day and the continued misogyny that women physicians experience can range from overt sexist discriminatory behaviours but more often than not, "presents as microaggressions compounded over time" (Kaye, 2021, p. 2268) such as exclusion from networking opportunities within the "Old Boys' Club."

### *The "Old Boys' Club" and Informal Networking*

Formal medical education was historically thought to be no place for a woman such that, "the elder statesmen of the profession encourage young male colleagues to succeed them [women] and ignore, or discourage women…institutional sexism is a pervasive force" (Lefford,

1987, p. 1255) further limiting the opportunities for women to gain a medical education. The "Old Boys' Club" is a concept where nepotism occurs with men supporting other men to gain privilege and power while actively excluding women. Historically, medical education was cited as a domain where women reported experiencing fewer career and skill development opportunities than their male peers (Bickel, 1997). This continues to be the case today (Lautenberger & Dandar, 2020; Paturel, 2019; Sharma, 2019). Women are often responsible for more household chores than their male peers and thus are often excluded from informal networking and learning opportunities as they often occur after work thus interfering with family and household responsibilities (Mobilos et al., 2008).

***Only a "Superwoman" Gains Admission***

Sexism, gender stereotypes, and "The Old Boys' Club" have fostered the concept that women are inferior to their male medical peers (Tricco et al., 2021; Vogel, 2019; Watson, 2014). The women who have been able to acquire a medical education and pursue medical practice in the 19$^{th}$ and early 20$^{th}$ century have had to outperform their male peers and be "superwomen" (Cameron et al., 2019) while also not defying gender boundaries for acceptable female behaviours. For some, this resulted in success and graduation as medical professionals, yet for others in the 19$^{th}$ century, it resulted in negative social repercussions and dismissal from medical school. This concept of women having to outperform their male peers to be considered adequate has repeatedly been described in both the historical and current literature documenting women's experiences in medicine and medical education (Cameron et al., 2019; Feinmann, 2019; Manzoor & Redelmeier, 2020). Strong-Boag (1994) described the historical standards for admission to medical school for women to be more rigorous and demanding than for their male peers. This ensured the exclusivity of medical education where women were seen as outsiders

and less qualified with the exception of the few exceedingly talented superwomen who carefully walked the fine line of appropriate gendered behaviours.

Another subtle yet immensely strong hidden process involved in achieving enculturation in the field of medicine via the domain of medical education is termed the hidden curriculum. The hidden curriculum within medical education describes a "set of influences that function at the level of organizational structure and culture" (Lempp & Seale, 2004, p. 770). Hafferty and Franks (1994) describe the informal process as "a process of moral enculturation" (p. 861), which results in the passage of normative rules, behaviours, and emotions to be expressed by medical trainees, thus "replicating the culture of medicine" (p.865). Interestingly, medicine and medical education perceives itself a "culture with no culture" (Taylor, 2003, p. 557), to be considered an insider within medicine there are informal learning processes that need to occur. Lempp and Seale (2004) explain that one develops a "loss of idealism, adoption of a ritualized professional identity, emotional neutralisation, change of ethical integrity, acceptance of hierarchy and the learning for less formal aspects of good doctoring" (p.770). Becker et al.'s (1961) *Boys in White* is a classic document that still resonates with the cultural climate in medicine and reiterates the persistent presence of a hidden curriculum as a feature of the socialization process into the culture of medicine. A process that has historically been exclusionary to women. Mobilos et al. (2008) reported that despite the greater proportion of women in medicine and medical education the fundamental challenges for women remain unchanged since the mid 1970s. The socialization process into the culture and profession of medicine is the product of "tradition, ritual, culture…[and] practices [that] are reproduced and passed down" (Hodges & Kuper, 2012, p. 25). Balmer et al. (2020) suggest considering the theory of gendered organizations in evaluating the context of academic medicine wherein they

identify that Acker's theory of gendered organizations as a lens to identify features within an organization that produce "cumulative disadvantages to career success for women" (p.467).

An often unexplored area of academic culture is how it perpetuates itself and how specific environments like medicine bring in new inductees and reproduce them to make clones. Social scientists have identified that medical education has historically brought in very privileged candidates and in association with the hidden curriculum this facilitated an exclusionary culture. More overtly, privileged people bringing in and training privileged people which further maintains the patriarchal status quo. Strides have been taken by forward thinking administrations in an attempt to correct this and statistics have been collected regarding individuals accepted to medical school (*Queen's University Admission Statistics*, n.d.) including cultural backgrounds, socioeconomic status, and gender. MacLeod (2014) explained that medical education in recent years has uncovered and problematized what has historically been described as the hidden curriculum. The hidden curriculum is identified as "a set of influences that function at the level of organizational structure and culture" (Lawrence et al., 2018, p. 1). Those "often subversive practices" (MacLeod, 2014, p. 539) that occur in an educational setting include issues related to race, social class, and gender but as aforementioned have been identified and perhaps are less hidden than when they were first described by Hafferty and Franks (1994) in the medical context.

Acker (1990) explained "the most powerful organization positions are almost entirely occupied by men" (p.139). She goes on to explain that power in the upper echelon remains in "all-male enclaves at the pinnacle" (p.139) of organizations, much like what is seen in the realm of medicine wherein very few women gain access to the upper ranks. Medicine and medical education, like many organizations operates on the premise that they are "gender-neutral social

phenomena" (p. 144) however they are in fact gender blind because there are deeply embedded gendered systems in place that are exclusionary to women. This concept echoes the above mentioned perspective that medicine exists within the perspective of being a "culture without a culture" (Taylor, 2003, p. 557). There is no such thing as a culture without a culture just as there is no such thing as a "universal worker" (Acker, 1990, p. 150) abstracted from the humans who exist in those systems/organizations. Balmer et al. (2020) utilized the Theory of Gendered Organizations as an analytic lens to demonstrate that academic medicine centers exist as inherently gendered organizations. This study simply echoed Acker (1990) who suggested employing the Theory of Gendered Organizations in "an attempt to find new avenues into the dense and complicated problem of explaining the extraordinary persistence through history and across societies of the subordination of women" (p.145). Unfortunately, despite these articles being written 30 years apart, a solution has not been generated to effectively ameliorate the dearth of women in leadership.

The common theme is one of exclusion and banishment to the position of outsider in the historically male dominated field of medicine and medical education. Women now account for more than 50% of medical school graduates, yet this critical mass of female students has not resulted in equal numbers of women achieving leadership in academic medicine. The literature demonstrates that there are complex career disadvantages limiting their professional advancement (Carnes et al., 2008; Heisler et al., 2020; Kaye, 2021; Rochon et al., 2016; Tricco et al., 2021; Van den Brink, 2011).

**Complex Career Disadvantages**

It has been decades since there were medical school quotas and the overt exclusion of women from admission. The scholarly literature on women in academic medicine focuses on the

gender pay gap, the leaky pipeline phenomenon, the sticky floor, and the glass ceiling, all of which are a product of a system of medicine which limits women's abilities to advance their careers and acquire positions in the upper ranks of academic medicine (Begeny et al., 2020; A. Brown et al., 2021; Heisler et al., 2020). Women who acquire elite positions in academic medicine are considered at the top of their field (Jacobson et al., 2021). Seemingly, to acquire those positions they have had to be superwomen and outperform their male peers, while not threatening the patriarchal status quo in medicine.

### ***Gender Pay Gap***

The income disparity that exists between male and female physicians is known as the gender pay gap (Bravender et al., 2021; Cohen & Kiran, 2020; Heisler et al., 2020; Whaley et al., 2020). The gender pay gap disadvantages women in comparison to men and is well documented in the scholarly literature (Bates et al., 2016; Bleakley, Alan, 2013; Cameron et al., 2019; Carnes et al., 2008; Carr et al., 2015; Cohen & Kiran, 2020; Dossa et al., 2019; Freund et al., 2016). Dossa et al. (2019) sought to evaluate, via a population-based, cross-sectional analysis, if female and male surgeons have similar earnings based on their fee for service billings on each hour they spent operating. They determined that female surgeons earned 24% less than their male peers on an hourly basis. Men appeared to have greater opportunities to perform more lucrative surgical procedures than their female peers. The researchers noted that there were no differences in the time it took for male vs female physicians to perform the same surgical procedures. What they did discover is that women performed more procedures that were remunerated less. Fee for service means that a procedure pays the same regardless of who is performing the procedure; therefore, despite controlling for procedure type, hours worked, and specialty, women were paid 24% less than their male peers per hour worked.

The gender pay gap negatively impacts female physicians both in the non-academic community practice as well as academic medicine. One study found that the inequality has not improved since 1995 despite controlling for seniority, speciality, hours worked, publications, and research grants wherein women still earn significantly less than their male counterparts (Carr et al., 2015). Freund et al. (2016) found that women are compensated less than men despite performing the same tasks. Bleakley (2013) also identified that some women physicians earn at least 25% less than male physicians and are rewarded less for doing the same job. Women are also more likely to be in less well remunerated specialities including family medicine, gynaecology, and pediatrics. In Canada, 42% of physicians are female; however, of those, only 19% are surgeons (Dossa et al., 2019). According to Bravender et al. (2021), the more women there are in a given speciality the less well remunerated that speciality is. For every 10% increase in women physicians in a certain speciality there is an average of $8255 decrease in mean salary. This demonstrates a devaluation of women’s work and highlights complex systemic issues that negatively affect women physicians. This demonstrates a devaluation of women’s work and highlights complex systemic issues that must be resolved. Another complex systemic issue highlighted below is the lack of women physician educators in senior leadership, despite that, women, for decades now, account for more than 50% of medical school graduates. A critical mass is not enough.

***Leaky Pipeline Phenomenon***

In academic medicine, reaching the rank of dean, academic department head, or residency program director demonstrates that someone has reached the top of their professional field (Carr et al., 2015; Jacobson et al., 2021). Men continue to hold the vast majority of leadership positions in academic medicine (Carnes et al., 2008; Heisler et al., 2020; Rochon et

al., 2016; Sharma, 2019; Van den Brink, 2011). The “pipeline theory” (Rochon et al., 2016, p. 3) posits that increasing the number of women in medical schools has not translated to more women in academic leadership positions. This failure has been termed the “leaky pipeline” phenomenon (Carr et al., 2015, p. 193) and is clearly multifactorial.

According to Cameron et al. (2019), “women’s leadership within academic medicine unfolds within complex layers of highly gendered assumptions about success, knowledge, authority, and expertise” (p.3). As of 2017, women accounted for only 23.2% of full professors in Canadian medical schools. Women are more likely to leave academic medicine having only reached the assistant professor rank (Carr et al., 2015) and it appears that the challenges are, again, multifactorial. Informal networking and hiring practices as well as challenging sociocultural environments and institutional barriers (Helitzer et al., 2017) are some of many complex factors impacting women’s lack of progress in academic medicine (Rochon et al., 2016; Van den Brink, 2011). To study this issue, the Association of American Medical Colleges (AAMC) conducted a qualitative study with the purpose of “explore[ing] the gender climate in academic medicine as perceived by representatives of the group on women in medicine and science group on diversity and inclusion” (p.190) they interviewed 44 senior academic medicine leaders. The study identified that women experience significantly slower career advancement in comparison to their male peers in academic medicine, are limited by the “Old Boys’ Club” (p.191), and are plagued by the “leaky pipeline” (p.193).

***The “Sticky Floor”***

The sticky floor metaphor is used to describe women’s experience of slow, or no, career advancement in academic medicine in part due to being given fewer institutional resources early on in their careers such as protected or funded research time (Carnes et al., 2008). Tesch et al.

(1995) conducted a cross-sectional survey of 153 women and 263 men physician faculty members of the Association of American Medical Colleges to identify why women hold fewer full professor ranks than men in academic medicine. Only 59% of women compared with 83% of male physician educators, after a mean of 11 years as faculty, achieved associate or full professor rank. Their progress was not explained neither by differences in research productivity nor by numbers leaving the profession early. One main feature that women participants identified as playing a major role was being granted fewer academic resources early in their careers, which resulted in them stagnating at the lower ranks of academia. This concept is defined as the sticky floor where women remain in the lower ranks longer and have greater difficulties ascending the career ladder. According to Tricco et al. (2021), the first woman in Canada to become dean of a medical school was appointed in 1999, nearly 200 years after the first medical school was established; astonishingly, only 8 women have been deans since.

***The Glass Ceiling***

The glass ceiling is a metaphor that refers to women's lack of professional advancement despite no visible barriers (Carnes et al., 2008). Those women who are able to overcome the challenges still find themselves reaching lower limits of career advancement compared to their male peers. Cohen (1997) explains that the glass ceiling is one of many complex factors limiting women's career advancement in academic medicine. Carnes et al. (2008) cite unconscious gender bias as one factor that may play a role in the stability of this invisible barrier limiting women's advancement to positions of dean, residency program director, or academic department head. Additionally, "microbarriers" (Cameron et al., 2019, p. 11) which are subtle everyday barriers, as well as informal hiring and networking practices that exclude women, can formulate the glass ceiling that limits women's career advancement. A seemingly protective feature

identified in the literature includes a mentorship relationship, which seem to elude many women. Hansman (2002) explains mentorship as a person who serves as a professional guide and promotes learning in a protégé and this can be via formal and informal learning processes. She outlines that there are many different definitions and types of mentors (Hansman, 2016). Women most commonly have psychosocial mentors and peer mentors however career-related mentors who provide career advice may also serve a sponsorship role (Hansman, 2002). A sponsor, for the purpose of this study is someone who takes an active role and is committed to a sponsee's professional career advancement. Additionally, the concept of a sponsorship relationships appears to be even more important than mentorship for women's career advancement (Bates et al., 2016; Cameron et al., 2019; Tricco et al., 2021). Sponsorship occurs when leaders and those in positions of power are actively committed to the career advancement while also advocating for more junior women. This can occur via speaking up for them and providing career advancement and hiring opportunities. Sponsorship for women is often not the norm; in comparison, male peers often receive stronger reference letters (Tricco et al., 2021) and benefit from the intersection of informal hiring based on "who you know" (p.12) and social networking where "hiring [occurs] based on social comfort" (p.12). Cameron et al. (2019) affirm that gender parity in academic medicine is still lacking and call for research to fill the gap in our understanding of how to aid women's advancement in this historically male-dominated field.

**Women in the Leadership of Academic Medicine**

The final theme within the scholarly literature situating this dissertation research focused on what is known about women in the leadership of academic medicine. There have been studies examining, as described above, the slow progress for women in academic medicine secondary to multifactorial complex career disadvantages; however, fewer studies exist regarding women's

experiences in the upper ranks of academic medicine. There are no studies to the researcher's knowledge specifically examining the experience of women deans in the Canadian academic medicine context. Therefore, little was known about the experiences of the successful few who have managed to achieve decanal leadership in this Canadian context prior to the current dissertation research.

For more that 30-40 years, studies have identified the dearth of women in decanal positions and the upper ranks of academic medicine leadership. Studies such as Isaac (2009) and more recently Jacobson et al. (2021) state that the trend has continued in that women deans of medicine are a significant minority in comparison to their male peers. In their study cohort, Jacobson et al. reported that women deans of medicine accounted for 16% of the study participants and the rest were men. They found that the "proportion of women decreases as one ascends the ranks of academic medicine" (Jacobson et al., 2021, p. 2). Their study, among other studies, were not focused on the Canadian context. Studies have looked at strategies for remedying this decanal gender gap or so called "decanal divide" (Schor, 2018, p. 240) while only two studies have discussed common pathways to decanal leadership (Isaac et al., 2009; Jacobson et al., 2021). None have specifically evaluated the Canadian context, and none have used a phenomenological methodology. It has been well documented that the current strategies proposed for ameliorating the gender gap in academic medicine leadership have thus far been inefficient and ineffective (Monteiro et al., 2022). The remainder of this literature review will focus on these topics as the current dissertation research is situated within this gap in the literature; as it has, developed a deep understanding of the lived experience of women dean's journey to and through decanal leadership in Canada.

***Proposed Remedies for the Decanal Gender Gap in Medicine***

Multiple strategies have been proposed to remedy the well documented dearth of women in the leadership of academic medicine, yet none of those suggestions have been entirely effective in producing significant, sustained, nor rapid change (Larson et al., 2019; Monteiro et al., 2022; Schor, 2018). At the current pace it would take nearly 50 years to reach gender parity within the decanal leadership of academic medicine (Jacobson et al., 2021). This would translate to the current cohort of medical students reaching retirement age before gender parity would be a potential reality (Jacobson et al., 2021). Some of the proposed remedies include: increasing the critical mass of women in medicine, mentorship and sponsorship opportunities (Grass & Latal, 2022), encouraging women to pursue more research and leadership activities, and term limits for department chair positions (Jacobson et al., 2021). These proposed solutions do not take into account the influences of personal and systemic barriers (Bismark et al., 2015) nor the culture within medicine and stereotypical societally sanctioned gender roles (Trusson & Rowley, 2022).

For decades, women have outnumbered men in medical school matriculants, yet few women seem to successfully pursue academic medicine leadership; therefore, the critical mass of more women in medicine has not directly translated to more women acquiring senior leadership positions. This concept, as described above constitutes the leaky pipeline theory. Edmunds et al. (2016) described that there are multiple disadvantages to women not pursuing or being successful at ascending the hierarchy within academic medicine including a waste of intellectual capital. This lack of diversity also results in less innovation (Dannels et al., 2008) and more bias in research agendas and subsequent future practice (Trusson & Rowley, 2022). Organizational productivity increases when more women are mobilized into senior leadership (Mousa et al., 2021). Much of the research has focused on fixing the individual rather than shifting to tangible

organizational and systemic changes. Enhanced innovation, healthier workplace climates, and improved patient care have also been ascribed to more diverse departments in academic medicine (Cameron et al., 2023). Another reason why the critical mass theory has succumbed to the leaky pipeline with respect to the dearth of women deans is the concept of "minority tax" (p.2). Minority tax results in burnout and women leaving academic medicine. They experience a multitude of complex career disadvantages and as the minoritized group in leadership they are expected to shoulder the work and stress related to creating a more diverse organization. Larson et al. (2019) suggested if 30-35% of medical school faculty were women, this would create a critical mass and translate to a change in the culture of the workplace and subsequently result in women's advancement. This has obviously not been the case, and they went on to further explain, "the problem is not the pipeline--it is the process" (p. 603). Finally, there has been a lack of research on effective strategies to remedy the persistent gender gap while also accelerating sustainable change (Mousa et al., 2021).

Encouraging women to seek mentorship and sponsorship opportunities are two suggested solutions to remedying the decanal gender gap. Grass and Latal (2022) explain mentorship in academic medicine as providing general career advice and guidance; whereas, sponsorship occurs when someone in a position of power endorses a "sponsee" for a position or role. Universally, women have reported fewer mentorship and sponsorship opportunities in comparison to their male peers (Hansman, 2016). Although mentorship has been shown to increase women's likelihood to remain in academic medicine (Onumah et al., 2021) there is limited research evaluating the positive association specifically for women deans. Han et al. (2022) identified that career advancement and success were closely associated with access to opportunities for career development. Career advancement opportunities and promotions to

leadership were associated with increased social capital and interpersonal relationships; however, women physicians were less likely to have successful promotion and were negatively impacted by sexist organizational culture. Sponsorship has been identified as highly effective for career advancement and promotion in the business world and if extrapolated to medicine, this may assist women's access to promotion opportunities (Grass & Latal, 2022). Allyship may also be helpful in remedying this dearth of women in academic medicine leadership (Monteiro et al., 2022). Monteiro et al. (2022) call on men who hold a significant power to engage in allyship. Allyship occurs when someone who is not a member of a specific minoritized group but advocates on behalf of that marginalized or minoritized group. Monteiro et al. go on to explain that men can, via allyship, advocate for women's advancement and fight for gender equity. Grass and Latal (2022) state that further study is required to better understand why women choose or reject careers in academic medicine while also carefully evaluating evidence-based solutions to closing the gender gap.

Although research is an important component of academic medicine's tripartite mission many women are either not encouraged to pursue research or are limited by the sticky floor and the Matilda effect, whereby men deny or do not acknowledge the contributions of women and take credit for their work. Women also have less time to devote to research activities due to the socialization of domestic roles where they have to dedicate more time to home life activities rather than advancing their research portfolio (Monteiro et al., 2022). Women are also expected to perform tasks that are not visible on a CV, do unpaid work, and perform more administrative tasks. This has resulted in limited success in simply encouraging and recommending that women perform more research to advance their career. Aptly stated, "women are slower to advance their careers because they have less time to spend on well recognized and compensated research and

self-promotion/tenure seeking activities" (Monteiro et al., 2022, p. 5). The additional H-index metric, a research impact device, may also be a limiting factor for women especially if they have taken a maternity leave or worked part time (Trusson & Rowley, 2022).

Similarly, just inviting women to step up and take on more leadership positions has not translated into career advancement to the senior levels of decanal leadership (Monteiro et al., 2022). According to Trusson and Rowley (2022), women are plagued by stereotypical views of gender roles and leadership within the male dominated culture of academic medicine. Larson et al. (2019) and Schor (2018) confirm that women are less likely to hold decanal positions in areas where clinical, research, or corporate decision making occurs and are more likely to be in areas focused on mentoring, education, and institutional image. Personal factors such as the imposter syndrome and lack of self-promotion have also been identified as limiting the success of simply encouraging women to "step up" and "lean in." Jacobson et al. (2021) identified that male department chairs remain in those positions much longer than their female counterparts which has a negative impact on the progression to decanal leadership. Department chair was described as a stepping stone position to decanal leadership (Jacobson et al., 2021) and lack of diversity in this role is a systemic barrier to women gaining access to decanal positions where the vast majority of department chairs are men. Jacobson et al. (2021) identified that 81% of department chairs are male in U.S medical schools and without term limits this will be a limiting factor in creating diversity in the applicant pool for dean.

### ***Common Pathways to Decanal Leadership***

Only two studies, at the time of reviewing the literature, specifically focused on common pathways to decanal leadership within the context of medicine. First, Jacobson et al.'s (2021) prospective cross-sectional study reviewed the Curriculum Vitas (CVs) of medical school deans,

and provided some insight into the 16% of their cohort that were female. Although the study was not specifically designed to review issues of gender in decanal leadership career advancement it is the only available study to review the pathway taken by women deans prior to their first dean of medicine appointment. Another study by Isaac et al. (2009) specifically focused on women deans was entitled “Women Deans: Leadership Becoming,” but this was less helpful, as explained below. It is included here as there were only two studies that met the inclusion criteria for this literature review that provided insight on women deans’ career pathways.

Jacobson et al. (2021) found that 15 of 95 CVs that they reviewed belonged to women deans, accounting for 16% of participants. Of those participants, women were more likely to have been an associate dean before becoming dean, whereas men were more likely to have been a department chair. Both men and women had on average 30 years of experience before their first decanal appointment and their H-index was at least 40. The deans also had advanced degrees. They identified that department chair was the stepping stone position that more commonly led to dean. Their data identified that men were more likely to remain in a department chair position for a longer duration and therefore create fewer vacancies for women to ascend to decanal leadership. Jacobson et al. (2021) suggested that without term limits this would be a disabling factor for career advancement and maintain a lack of diversity in the hiring pool for dean. Only 8 deans of the entire cohort did not hold department chair prior to advancing to the dean’s role; 7 of those 8 were men. Women have had to ascend through the clinical, department, and then institutional pathways to reach dean and often this means being associate dean prior to being dean. Jacobson et al. (2021) was not specifically designed to evaluate issues of gender and career advancement; however, by virtue of the small subset of women in the cohort, it did provide useful information on their career paths. Jacobson et al. (2021) also identified that it has

taken cohort respondents longer to reach dean of medicine than in previous years. The researchers suspect this is either due to decreased turnover in the leadership or increases in expected experience for prospective deans.

"Women Deans: Leadership Becoming" by Isaac et al. (2009) is a qualitative study focused on women deans in higher education settings. It employed a rhizoanalysis theoretical analysis to:

> Deconstruct the term leadership by examining patterns of discourse, subjectivity resistance and power and knowledge through a feminist poststructuralist lens among women administrators who worked in male-dominated versus female-dominated fields (p. 135).

This study employed the methodology of rhizoanalysis in an effort to create "new territories of knowledge" (p. 136) The researchers interviewed women deans from the USA. This study uncovered how the participants' identities unfolded with the context that they worked. They also provided commentary on what was described as good leadership identifying gendered characteristics of leadership as well as the participants' individual leadership identities. The rich detail that the researchers provided included their participants' hopes of being able to broaden people's views, motivate and inspire others, and "see the big picture and move in that direction" (p. 142). Isaac et al. (2009) uncovered the gendered nature of leadership where women were seen as using a collaborative leadership approach and men would use "power over" (p. 143) others to get things done. This study outlined that leadership appears different on men and women. According to Isaac et al. women "are considered successful when they behave like a lady, a pattern of heteronormativity" (p. 147) and have to adapt to social norms and gender roles. One of their participants described using humour as a tool of negotiation. Finally, the researchers

explained that participants employed what they called their masculine identities to scale the hierarchy of academic medicine and employed “feminine language [which] blurred the masculine binary” (p. 148). This was how the women navigated being dean within the “vertical masculine framework” (p. 150) of academic medicine. While this study is helpful, it raises the question of whether such a clear-cut difference between male and female leaders always applies.

### Literature Review Summary

Women experience limited progress in comparison to their male peers in academic medicine. The literature has identified that women are impeded by complex career disadvantages including, but not limited to, the gender pay gap, the leaky pipeline phenomenon, the sticky floor, and the glass ceiling. Women are also expected to outperform their male peers and be “superwomen” (Cameron et al., 2019) yet navigate the fine line of socially sanctioned gender roles for women, without defying them. As Onumah et al. (2021) succinctly explained, a multipronged approach for addressing the lack of retention and promotion of women in academic medicine is likely required and few studies have actually examined the outcomes and impact of the previously suggested solutions to remedy the ongoing problem.

In summary, the purpose of this literature review was to identify what is known about women deans in academic medicine. This literature review has identified research gaps specifically in our knowledge of women deans in the Canadian context. The current dissertation research is situated within this documented gap wherein, we know very little about the lived experience of the successful few women deans. No studies to the author’s knowledge have looked at this population specifically within the Canadian context.

# Chapter 3 – Methods

## The Study and Research Design

The purpose of this phenomenological investigation was to identify and describe the essence of the lived experience of women deans in the leadership of academic medicine in Canada. A qualitative research design was selected for this endeavour because I was interested in uncovering the lived experience of the participants and this is best undertaken via the "interpretive naturalistic approach" (Creswell, 1998, p. 15). The essence of the lived experience of the participants was elucidated via a self-styled interpretive hermeneutic phenomenological methodology with an appreciation of my feminist lens, which is described below. It must be clearly stated that a feminist phenomenological methodology was not employed for this study (Käll & Zeiler, 2014). The self-styled approach to phenomenology that was employed does not subscribe to "an idiosyncratic and simplistic recipe-based program" (Adams & van Manen, 2017) but rather calls on a phenomenological attitude and sense of wonder. According to Van Manen (2014), the method "refers to the way or attitude of approaching a phenomenon" (p.26); therefore this section of the dissertation recounts the approach that was taken to pursue the essence of the lived experience of the phenomenon under investigation, being a woman dean in the Canadian academic medicine context with a view of how the participants navigated their path to and through decanal leadership.

### Situating This Investigation Within the Researcher's Feminist Lens

Feminism was succinctly defined by hooks (2000b) as "the struggle to end sexist oppression" (p.28). hooks explained that the purpose of feminism is not to benefit women over men or any one group over another but rather to struggle to eradicate the ideology of domination

(p.26). Long before Crenshaw articulated the concept (Carastathis, 2014; Crenshaw, 1989), intersectionality was broached by hooks (1984) who described the impact of the intersection of sex, race, class, and sexual orientation as sites where the patriarchal status quo enacted domination. Crenshaw elaborated on this, providing an explanation of interlocking system of oppression. Feminism and intersectionality were impactful in considering this dissertation topic as women in the upper ranks of academic medicine were a minoritized group in comparison to the dominant male presence. In 2019, *The Lancet*, a well-known medical journal, opted to highlight feminism and its importance in medicine and medical education (Sharma, 2019). A few years prior *The British Medical Journal* came to the conclusion that "medicine still needs feminism" (Watson, 2014). Feminist theory is described as "a revolutionary blue print" (hooks, 2000b, p. xi) for the movement to end sexist oppression. Sharma (2019) suggests that medicine and medical education are neither gender blind nor value-free contexts, although they appear to believe themselves to be "value neutral"(p. 571). There has been a lack of insight in these contexts and they have served as sites that reproduce the patriarchal status quo (Acker, 1990; Balmer et al., 2020; MacLeod & Frank, 2013; Sharma, 2019).

Sharma (2019) outlines that there is not just one feminist theory or one feminist methodology. She explains that feminist methodologies share a goal which is to strive for an exploration of the lived experience of gender from the perspective of the individual actually living that experience. Additionally, this can include how gender is experienced as well as how that lived experience intersects with other aspects of an individual's identity/identities. In agreement with MacLeod and Frank (2013), feminist theory provides a framework for critically analyzing issues of gender in education and, beyond that, issues of domination, hierarchy, and subordination.

**Feminist Lens**

As a qualitative researcher, I appreciate that there is no one *true* definition of feminism; however, a powerful definition that reaches to my core is “a movement to end sexism, sexist exploitation, and oppression” (hooks, 2000a, p. 1). Feminist theory is actually a conglomerate of many theories that can be employed to critically analyze how patriarchal power operates and thus can be applied to an analysis of medicine and academic medicine. The many feminist theories that exist have been a product of the many feminist movements. These include the first wave focused on female suffrage, the second wave focused on reproductive rights and workplace equality (Sharma, 2019), and the third wave focused on social constructions of gender, intersectionality, and beyond (English, 2006). The common thread has been gender and patriarchal oppression.

The establishment of medicine and medical education has historically considered themselves to be gender neutral and value neutral (Balmer et al., 2020; Sharma, 2019). This demonstrates a historical lack of insight surrounding the plethora of complex career disadvantages that women experience, the historical exclusion of women from the leadership in academic medicine, and the ongoing systemic oppressive features of the culture of medicine are steeped in, and maintained by, the patriarchal status quo (Begeny et al., 2020; Cohen & Kiran, 2020; Heisler et al., 2020; Manzoor & Redelmeier, 2020; Ruzycki et al., 2021; Tricco et al., 2021; Vogel, 2019; Watson, 2014). MacLeod and Frank (2013) and subsequently Sharma (2019) purported that the application of feminist theory to an analysis of medicine and medical education may be a way to address the challenges that medical education and medicine on the whole are facing. This harkens back to hooks’ (2000b) definition of feminist theory as a revolutionary blueprint to end oppression. Kaye (2021) calls on women to speak up and speak

out as misogyny persists and many women are unwilling to speak out for fear of negative personal and career consequences. She goes on to say that “one story [of sexism and misogyny] can be discounted as an outlier. But waves upon waves of stories, saturating the airspace and literature and seeping into institutional dialogue, compels action” (p.2269). Moving from theory to action wherein change is made, for example in medical education, would be considered praxis and this could be another goal of dissertation research; where, from the knowledge gained from the lived experience of the few women deans we may find a way past the complex career disadvantages. The primary goal however of this phenomenological study was to identify and describe the essence of the deans’ lived experiences within the Canadian context of academic medicine and appreciate how the women navigated their path to leadership.

hooks (2000b) suggests that feminist education should be offered to everyone and without a mass-based movement, feminism’s power will be usurped by the negative connotations that it is ascribed by the mainstream media and patriarchal status quo. Feminist pedagogy which encourages critical feminist teaching, learning, and reflection may result in what English and Irving (2015) describe as “political mobilization of women to engage in projects in their own freedom” (p. 107) while challenging the patriarchal status quo that maintains inequality. This dissertation may have this intended effect as the researcher ascribes to a feminist lens. To combat sexist oppression, hooks (2000b) states that feminist education is significant in the lives of everyone. English and Irving (2015) call for collective activity being required to challenge the inequity, and they charge feminist pedagogues with the “responsibility to provoke, stir, and to challenge the status quo” (p.112). With this feminist lens I believe that feminist knowledge and creating the space to engage in critical analysis and discussion can have a profoundly positive effect for everyone and medicine is lacking this in many spheres including, the upper ranks of

academic medicine. Importantly, having an appreciation that my feminist lens did have an impact on the analysis of the data because no experience is uninterpreted (van Manen, 1990); however, this methodology asks the researcher to "push off theoretical frames, shake off the captive constrains of concepts, and penetrate and deflate the suppositions that are wittingly or unwittingly adopted by theory" (van Manen, 2014, p. 66).

**Qualitative Research: The Obligatory Defence in Health Professions Educational Research**

Qualitative research is an inquiry process that explores 'how' and 'what' problems rather than attempting to define a cause, effect, or predict an outcome (Merriam & Tisdell, 2016). Qualitative researchers are interested in identifying how people understand, interpret, and construct meaning in their lives. Qualitative research is a naturalistic inquiry where the phenomenon under investigation is studied in the real-world setting and is allowed to unfold naturally rather than being manipulated in a laboratory setting (Patton, 2002). Qualitative research is also inductive and discovery oriented rather than engaging in hypothesis testing (Merriam, 2009).

The phenomenological doctrine of Verstehen is foundational to much of qualitative research, as it speaks to a human being's empathetic understanding of human behaviour (van Manen, 1990). This unique type of consciousness in comparison to other forms of life results in, and requires that, the study of human beings be different from that of other forms of life and nonhuman phenomena (Patton, 2002). Verstehen "places emphasis on the human capacity to know and understand others through empathetic introspection and reflection based on direct observation of, and interaction with, people" (p.52). Accordingly, in qualitative research the researcher is the instrument employed for the investigation and acts at all levels of the research process. The researcher is the instrument of data collection, analysis, synthesis, and the one who

conveys the product of the investigation (Creswell, 1998). Qualitative research is an emergent form of investigation and as such, interpretive hermeneutic phenomenology as it is interpreted by the researcher will be explained in the next section closely followed by a statement of the researcher as the instrument, as well as methods of data collection and analysis.

**Phenomenology**

Phenomenology is well suited for health professions educational research as it seeks to learn from the experiences of others (Neubauer et al., 2019). Interpretive hermeneutic phenomenology goes beyond simply describing participants' experiences to the interpretation of the phenomena under investigation. Researchers must acknowledge their preconceptions of the topic under study, reflect, and engage in iterative reflection (Adams & van Manen, 2017) and writing processes to create rich descriptions while maintaining a deep focus on the purpose of the proposed research. This ensures the quality and trustworthiness of the research endeavour (Merriam & Tisdell, 2016; van Manen, 1990). A phenomenological investigation is not a disembodied endeavour, but rather is a project created by a real person who exists in a certain social, historical, and political context. Van Manen (1990) explains: "A phenomenological description is always *one* interpretation, and no single interpretation of human experience will ever exhaust the possibility of yet another complementary, or even potentially *richer* or *deeper* description" (p. 31).

This section will be divided into two major subdivisions. The first will address the researcher as the instrument and the second will outline the methodology, sampling, method of data collection, analysis, and ethical considerations. Merriam (2009) and Merriam and Tisdell (2016) provide a detailed outline of the usual components of a methodology section in a qualitative research study. Additionally, insights gleaned from Patton (2002, 2015), Creswell

(1998), Creswell and Poth (2018), van Manen (1990), Moustakas (1994), and Neubauer et al. (2019) have served as introductory texts for the development of this methodology chapter. There are many variations of phenomenology that one can employ as a research methodology; yet, all have their philosophical beginnings in Europe in the early 20th century. Phenomenology emerged as a counter movement or protest to the positivist paradigm that valued empiricism and devoutly subscribed to objectivity while denouncing subjectivity. Phenomenology came to fruition within a naturalistic paradigm such that, a researcher studies a phenomenon of interest in the uncontrolled setting of the real-world rather than in a controlled laboratory setting. Phenomenology aims at "understanding social phenomena from the actor's own perspective" (Patton, 2002, p. 69). The foundational question of phenomenology is "what is the meaning, structure, and essence of the lived experience of this phenomenon for this person or group of people" (p.104). Phenomenology is also a philosophical tradition that is valuable when investigating issues concerning the lives of marginalized, invisible, nonnormative, and oppressed people (Käll & Zeiler, 2014). It has the power to highlight the taken-for-granted and hidden assumptions and beliefs by enlarging the field of describable experiences. Phenomenology makes visible "that which constitutes the nature or essence of the phenomenon" (van Manen, 1990, p. 122) and gives us a momentary view of what it truly means to experience that which is being investigated. Phenomenology also allows a researcher to interpret the narratives of participants and develop an "understanding of being and how that shapes the decisions made by the individual" (Neubauer et al., 2019, p. 94). The researcher's choice of methodology, interpretive hermeneutic phenomenology, is a complex attitudinal disposition that had an impact on all stages of the dissertation research process (Adams & van Manen, 2017; van Manen, 1990, 2014). Peoples (2021) succinctly explains that phenomenology is concerned with meaning-

making and understanding the lived experience from those who have experienced a phenomenon and then, a researcher can make certain generalizations about that lived experience. Phenomenology has its foundation in philosophy.

The origins of phenomenology are credited to the mathematician Edmund Husserl (Neubauer et al., 2019). Husserl's phenomenology is a descriptive transcendental phenomenology which focuses on the epistemological process of exploring *eidos* or the essential meaning of objects as they appear in our consciousness. Husserl believed that one could suspend all suppositions by bracketing off preconceptions and employ intentionality to answer the foundational question of "what do we know as persons?" (Reiners, 2012, p. 1). He believed that the researcher's goal should be to reach a state of the "transcendental I" (Neubauer et al., 2019, p. 93) whereby the researcher's own subjectivities were removed from the research process via bracketing. His focus was on the description of everyday experiences while bracketing preconceptions. Husserl's student, Martin Heidegger, advanced phenomenology towards interpretive hermeneutic phenomenology which seeks meaning and strives to answer the question of "what is being?" (Reiners, 2012, p. 2), thus an ontological question. Heidegger's phenomenology does not employ bracketing because he believed that one cannot suspend prior experience (Neubauer et al., 2019). Hermeneutics is defined as a theory and practice of interpretation (van Manen, 1990). Heidegger's interpretive hermeneutic phenomenology is based on a philosophical tradition that appreciates that researchers are embedded in the world within which they work and study and thus cannot be separated; furthermore, all experiences are subject to interpretation (Dowling, 2007). Hermeneutic phenomenology appreciates that researchers and the phenomena that they study exist in the lifeworld and are subject to the culture and history within which they exist (Neubauer et al., 2019). Both Husserl and Heidegger's phenomenologies

were steeped in complex philosophical perspectives and have laid the foundation for the multitude of self-styled phenomenological perspectives that have emerged since (Adams & van Manen, 2017).

Patton (2002) outlines the confusion surrounding a succinct operational definition of phenomenology noting that it has been defined as: a philosophical orientation, major qualitative tradition, research method framework, inquiry paradigm, interpretive theory, human science method, a social science analytical perspective or orientation. To add to the complexity and the multitude of applications, phenomenology has been employed in education and educational research as a philosophy of education, a phenomenological approach to professional practice, a utility for curriculum scholars, and as described above, a human science research method (Phillips, 2014). The researcher deems this methodology as the most appropriate methodology for the investigation of the lived experience of the elite few women in the upper ranks of academic medicine. This methodology is much more than a simple naturalistic interpretive methodology---it represents an orientation, overall philosophy for the researcher, and thus a phenomenological attitude (van Manen, 1990).

The researcher's perspective of interpretive hermeneutic phenomenology, in combination with components gleaned from van Manen (1990) where he described it as a human science, will be outlined below. Components of phenomenology as described by Edmund Husserl, Martin Heidegger, as well as that of Moustakas (1994) were briefly reviewed in preparation for this dissertation. The researcher agrees with van Manen's statement that "a real understanding of phenomenology can only be accomplished by actively doing it" (p.8). I, the researcher, identify phenomenology as an all-encompassing research orientation which addresses method, methodology, theory, and positionality. Hermeneutic phenomenology is used interchangeably by

van Manen with the term phenomenology and human science research. He goes on to describe phenomenology as focused on the study of lived human experience and strives to garner the meaning and significance of that experience which is being investigated and culminates in a phenomenological description. Phenomenological research begins with the researcher's orientation to the topic under investigation and demands that she come to this work with a sense of wonder, curiosity, and dedication to be "presuppositionless" (p.29) enabling the researcher to return to "the things themselves" (Husserl, 1911, p. 116). Phenomenology aims to gain a deep understanding of the essence or *eidos* of the lived experiences of everyday life via a retrospective account; therefore, the researcher must gain access to the retrospective accounts of human beings who have directly experienced the phenomenon under investigation. The essence of an experience of a certain phenomenon is believed to be a mutually understood core meaning (Patton, 2002). The essence or essential nature of a thing is that which makes a thing, a thing, and without which it would be something else (van Manen, 1990). This is what the phenomenological researcher strives to identify and describe. This research employed a phenomenological methodology to gain a deep understanding of the lived experience of women deans in the Canadian academic medicine context.

## The Researcher as Primary Instrument

Merriam and Tisdell (2016) outline that a commonality amongst qualitative research includes the researcher as the instrument of data collection and analysis as the researcher endeavours to achieve an understanding of how people make sense of their lives. Hermeneutic phenomenology goes beyond simply describing a phenomenon, such as the lived experience of women deans in academic medicine. This dissertation research moved to explore, interpret, and convey meaning and sought to find the central structures, or the essence, of the participants'

lived experience of being women deans in medicine. The interpretive hermeneutic phenomenology that was employed in all aspects of this research process began with me as the researcher acknowledging my own past experience (Neubauer et al., 2019) as well as existing knowledge of the phenomenon under study. In addition to this, I engaged in a deconstruction exercise to identify, reflect, and disclose my positionality and preconceptions as this was essential in the interpretive research process and aided in protecting the trustworthiness of the entire investigation (Peoples, 2021). Synonymous with positionality is reflexivity which is a process where I explored and sought to explain my presuppositions, commitments, dispositions, and assumptions about the research and then address my subjectivity (Bynum & Varpio, 2018; Macbeth, 2001; Merriam, 2009; Merriam & Tisdell, 2016; Patton, 2002; van Manen, 1990).

**Deconstruction Exercise: From Epoché to Bracketing. Seeing Past This with Fresh Eyes**

Bracketing was initially described by Husserl as a means of placing the phenomenon under investigation outside of our own experience to allow the researcher to suspend their own experience and come to the research with a sense of wonder and awe and be presuppositionless (Reiners, 2012). I see epoché as a method of identifying explicitly my beliefs, assumptions, and experiences of the phenomenon under study. Merriam (2009) describes this processes simply as a researcher exploring their own experience, prejudices, and assumptions prior to embarking upon the interview portion of data collection; however, it is an integral component at all levels of the research process under the guise of hermeneutic phenomenology. I do not subscribe to an attitude of scientific disinterest nor a positivistic religious fervor for objectivity because it would be fallacious to believe that one can suspend all presuppositions or knowledge of the topic under investigation. Van Manen (1990) recommends using our own personal experience as a starting point for phenomenological research. Firstly, because our own experiences are immediately

accessible and secondly, because "the phenomenologist knows that one's own experiences are also the possible experiences of others" (p.54). He then goes on to explain that we do not forget our presuppositions but identify them and then deliberately hold them at bay. Transcendental phenomenologists employ the epoché as a means to refrain from judgement to allow the researcher to see the phenomenon under study "freshly, as for the first time and is open to its totality" (Moerer-Urdahl & Creswell, 2004, p. 21). Interpretive hermeneutic phenomenology does not subscribe to this rigid process of epoché nor bracketing but rather appreciates that "an individual cannot step out of this/her lifeworld" (Neubauer et al., 2019, p. 94). Macbeth (2001) describes reflexivity as a deconstruction exercise through which the researcher can identify her positionality and subsequent intersectionality (Carastathis, 2014) to enable her to come to the research process and analysis with "fresh eyes" but not necessarily a "tabula rasa" (Neubauer et al., 2019, p. 93) or blank slate. This deconstruction exercise allowed me to appreciate my subjectivity and subjective experience and in relation to that of the participants.

**Implementing a Phenomenological Study**

Van Manen (1990) recommends against using his text as a how-to manual or methodologic guide to undertaking interpretive hermeneutic phenomenology. As a doctoral student, though, it is irresistible to employ his text as foundational in the creation of a self-styled interpretive hermeneutic phenomenology because it does provide a simplified and succinct explanation of six research activities that may be involved in human science research.
Adams and van Manen (2017) stresses that phenomenology is not a prescriptive methodology nor a step-by-step form of inquiry. Rather, it is an inquiry that lies within a phenomenological attitude and disposition. This attitude and disposition are woven, like a thread in an ornate tapestry, through all aspects of the research process. This hermeneutic phenomenological attitude

and disposition are interpreted by the researcher to be discovery oriented where the researcher acknowledges her own existing knowledge and then attends to the phenomenon under investigation in a presuppositionless manner; thereby, the researcher can turn "to the things themselves" (Husserl, 1911, p. 116) with fresh eyes. Then, through a thoughtful process of reflection, writing, and rewriting during data analysis, the researcher will arrive at a unified essential meaning of the phenomenon under investigation. Hermeneutic phenomenology "relies on cultivated thoughtfulness to present phenomenological themes or the structure of the lived experience that shape[s] the phenomenon" (p.253). Although hermeneutic phenomenology is not rule-bound, it is not random either (Neubauer et al., 2019). The six research activities presented below in Table 2 are adapted from van Manen (1990, p. 30) and are interpreted by the researcher as important features of a phenomenological attitude when undertaking human science research.

**Table 2**

*van Manen's Six Research Activities*

| Turning to the phenomenon which seriously interests us and commits us to the world |
|---|
| Investigating experience as we live it rather than as we conceptualize it |
| Reflecting on the essential themes which characterize the phenomenon |
| Describing the phenomenon through the art of writing and rewriting |
| Maintaining a strong and oriented pedagogical relation to the phenomenon |
| Balancing the research context by considering parts and whole |

Adding to the complexity of this methodology is that phenomenology is an approach, an attitude, and a philosophical orientation that cannot be reduced easily to a "cookbook set of instructions" (Hycner, 1985, p. 279). Despite this warning, I have attempted to describe an interpretive

hermeneutic phenomenological approach as a philosophical orientation, theoretical framework, and methodology as it was employed to suit this dissertation research.

**Interpretive Hermeneutic Phenomenology: From Theoretical Framework to Methodology**

Grant and Osanloo (2014) explain that a theoretical framework provides the foundation from which all knowledge is constructed in a dissertation just like a blueprint serves as a guide for building a house. The analogy of the blueprint for building your dream home fits well with the idea of the labour-intensive once-in-a- lifetime achievement of creating a dissertation. A theoretical framework provides structure to a dissertation where it informs the research: philosophically, ontologically, epistemologically, as well as the methodology, methods of data collection and analysis procedures, and dissemination of the findings. A theoretical framework impacts the entire research process. Phenomenology is a unique entity. As alluded to above, phenomenology has multiple definitions and has enacted many roles in the research process since its inception in the early 20th century. By virtue of its evolution, breadth, and depth, phenomenology ‘wears many hats’ and thus it serves all of the above purposes guiding all aspects of the research process including, but not limited to, the development of the research question(s), data collection, data analysis, as well as the writing process. Phenomenology is more than a simple retrospective interpretive inquiry paradigm. Phenomenology is an attitude and disposition that is woven through all aspects of the research process. To continue with an explanation of the interpretive hermeneutic phenomenological approach, I weave this orientation through the remaining method section of this document.

## The Study Methods and Procedures

### Participants

Once I had received research ethics approval, the eight participants were contacted by email to request their participation in the study. Participants were selected via criterion-based, purposeful sampling followed by snowball sampling until the data was saturated (Patton, 2002). The criteria for each participant were as follows: they must self-identify as a woman who has a decanal position at a Canadian medical school. Jacobson et al.'s (2021) US based study sought to identify common pathways to becoming a Dean of Medicine which they described as constituting "the very top echelon of academic medicine's hierarchy" (p.2). The rationale for purposeful sampling is the goal of gaining an in-depth understanding of the lived experience of a specific phenomenon from information rich cases (Creswell, 1998; Merriam, 2009; Merriam & Tisdell, 2016; Patton, 2002).

The first participant who was contacted was known to me and began the process of snowball sampling wherein additional participants were identified and contacted. Saturation was reached at 8 participants wherein the participants shared markedly similar experiences.

### Method of Data Collection: The Interview

One 60-to-90 minute semi-structured in-depth interview was conducted with each participant by Zoom. The semi-structured in-depth interviews (Merriam, 2009; Merriam & Tisdell, 2016) were conducted using an interview guide containing open-ended (Patton, 2002) and probing questions based on themes identified within the scholarly literature. This format of interview allowed me to gain access and develop an "understanding of the deeper layers of human experience that lay obscured beneath the surface awareness and how the individual's lifeworld, or the world as he or she pre-reflectively experienced it" (Bynum & Varpio, 2018, p.

252). The interviews were digitally recorded, transcribed, read, and then inductively coded to identify themes as they emerge from the data. The data analysis process will be described in the next section in detail; however, the acts of data collection and data analysis occurred simultaneously (Merriam & Tisdell, 2016; van Manen, 1990). The "data of human science research are human experiences" (van Manen, 1990, p. 63). Through the participants' retrospective accounts and in response to questions posed, the salient points of the participants' lived experience as dean were captured and seemed to be appropriately represented. Prior to undertaking the formal data collection process, I conducted a pilot interview to test out the interview questions as well as sharpen my interview skills.

The questions contained in the interview guide were created with an attitude steeped in my hermeneutic phenomenological orientation. The goal was to ask questions that attempted to identify what the nature of the lived experience was for with women deans (Patton, 2002). I strived to approach the interviews with a sense of wonder and asked: what is it *really* like to be a woman in the leadership of academic medicine and, how did she experience her journey to and through decanal leadership? How did she navigate her path to decanal leadership? During construction of the interview guide as with all aspects of the research process, I was continually cognisant of the purpose statement of this dissertation research which was to identify and describe the essence of the experience of being a woman dean in academic medicine. During the interview I attempted to remind myself of my presuppositions, assumptions, and biases and deliberately keep them at bay as described by van Manen (1990) to allow the participants' lived experiences to speak for themselves. I strived to come to this research with fresh eyes. As a researcher I ensure that I am open to, and reflect upon, my own subjectivity throughout the process.

**Data Analysis: A Dynamic Process of Reflecting, Writing, and Rewriting**

The phenomenological task of reflection is required when attempting to explicate the essence of a lived experience from the interview transcripts that were digitally recorded and transcribed (van Manen, 1990). I, the researcher, and one other coder read the transcripts in their entirety and then each assigned descriptive and interpretive codes to the data thereby allowing for a richness of understanding to be demonstrated. Using an external coder added to the richness of meanings that were explicated from the data while also helping to ensure the trustworthiness of the analysis process (Merriam & Tisdell, 2016).

The external coder was an individual who was familiar with phenomenological methodology and qualitative research methods but not a medical practitioner nor physician educator, which was helpful for me as I negotiated my position as an informed insider. Coding is described as a way of identifying patterns and classifying data (Saldana et al., 2011). Descriptive codes are words taken directly from the transcripts and deemed by the researcher and coder to be salient. Interpretive codes are terms or phrases that the researcher and coder create and use to interpret certain feelings or thoughts shared within the transcripts. Once the descriptive and interpretive codes were developed and written into the margins of the paper transcripts, I made a comprehensive list of the 292 codes (James, 2013; Merriam, 2009). The comprehensive list of codes was both written on individual sheets of paper for the purpose of analysis as well as in an excel spread sheet with associated transcript page references which was helpful in creating the results section of this dissertation. The individual codes on paper were then grouped together and categorized based on patterns that emerged (Taylor-Powell & Renner, 2003). These became the themes that emerge from the raw data (Merriam & Tisdell, 2016). I was aware that the external coder and I must interpret the transcripts in an effort to unearth the essence of the experience

being investigated (Bynum & Varpio, 2018). This interpretation is integral in the production of themes wherein the codes were grouped together. Varpio et al. (2017) points out that many health professions education researchers use language that claims objectivity from their subject of investigation and "impl[y] that the themes reside in the data and somehow lift themselves off the page, fully formed, and present themselves to the researcher" (p.43). The interpretive hermeneutic phenomenology that was foundational for this dissertation research required that I, the researcher, not take a stance of the disinterested scientist (van Manen, 1990). Van Manen explains that hermeneutic phenomenology:

> tries to be attentive to both terms of its methodology: it is a descriptive (phenomenological) methodology because it wants to be attentive to how things appear, it wants to let things speak for themselves; it is an interpretive (hermeneutic) methodology because it claims that there are no such things as uninterpreted phenomena (p.180)

My subjectivity and feminist lens are present at all points of this dissertation research including the data analysis process. I attempted to be true to the phenomenological tradition and attended to my presuppositions and analyzed the data with fresh eyes and a sense of wonder allowing the data to speak for itself (Adams & van Manen, 2017; Moerer-Urdahl & Creswell, 2004; van Manen, 1990). The goal of the data analysis process was to identify themes that may represent a universal essence in the lived experiences of the participants. To gain an understanding of whether the essence, being defined as that which makes a thing, a thing, was present, I engaged in what van Manen (1990) called free imaginative variation. This imaginative variation required the researcher to consider whether the phenomenon under investigation would be the same if we deleted a certain identified theme (Merriam, 2009; Moustakas, 1994; van

Manen, 1990). If removing that theme did not change the essence of the experience, but rather left it the same in its interpretation and being, then the true essential structure had not been sufficiently identified nor described. The interpretation of free imaginative variation that is described above is a combination of the researcher's creative reflection on her own proposed research process as well as components described by van Manen (1990).

Data analysis in most qualitative research methodologies is inductive and comparative, as described by Merriam (2009). There are a few nuances associated with the interpretive hermeneutic phenomenology that was employed for this investigation including: the importance of returning to the research purpose frequently throughout the analysis process which was performed in an effort to ensure orientation to the phenomenon under investigation. I also used a deconstruction exercise to identify my positionality, appreciate my subjectivity, and engaged in imaginative variation (Dowling, 2007). Finally, I undertook the arduous task and dedication to writing and rewriting as part of the reflective process of creating a hermeneutic phenomenological description. I kept notes and journaled after each interview.

**Writing: A Means of Fixing Thought to Paper and Making Visible the Invisible**

The aim of phenomenology is to transform the participants' lived experience of a phenomenon into a textual expression of that experience in a precise and complete way. Writing requires the researcher to engage with her data in a reflective way; accordingly, phenomenology is a "mode of reflection done traditionally by scholars who write" (van Manen, 1990, p. 124). Historically constructing the research report, from a positivistic stance, is used to demonstrate methodologically rigorous scholarship and few consider the act of writing as an integral part of the research methodology. Writing itself is not often discussed from a methodological perspective, but rather, is taken for granted as something that must be done, a means to an end,

when the research is complete. Interpretive hermeneutic phenomenology as it is employed by the researcher is an act of writing, a creative process that employs both the researcher's reflection and artistry of writing through which, while allowing the data to speak for itself, aimed to present a strong phenomenological description. The researcher's goal with her phenomenological description, once the data were analyzed and presented, was for the reader of this dissertation to say that they [we] better understand what that lived experience is like for that person or group of people.

The phenomenological description makes visible the essence or the nature of the phenomenon under investigation so that we may better understand what it is to be a woman holding a senior leadership position in academic medicine. Essence is that which makes a thing, a thing. The task of the phenomenological researcher is to strive for the "phenomenological nod" (van Manen, 1990, p. 27) which allows the reader to identify the experience as "something that we can nod to, recognizing it as an experience that we have had or could have" (p.27). Once we gain an understanding of the lived experience of women at this level, we may be able to facilitate change and ameliorate the inequitable experience for women in academic medicine who strive to be a dean. Describing their lived experience, may improve the career trajectories for other women and effect change in the patriarchal environment of the upper strata of academic medicine. Constructing a complete and strong phenomenological description of how the participants navigated their path to and through decanal leadership may make the invisible, visible and thus impact change in this manner.

**Ethical Considerations: Trustworthiness and Rigor—The Struggle to Measure Up**

Qualitative research both in the field of health professions education (HPE) and more generally in academic literature has, over the past few decades, appropriated positivistic

terminology in an attempt to prove its legitimacy. Interestingly, the philosophy of phenomenology was birthed as a naturalistic interpretive methodology in a form of protest to the positivist paradigm (Reiners, 2012); however, to be seen as legitimate since that time many phenomenologists and qualitative scholars have fallen into the trap of what Varpio et al. (2017) calls the "cobra effect" (p.40). The analogy developed from a situation where there were too many cobras in Delhi, so the city offered citizens money for every cobra they killed and turned in. When the citizens realized they could make money from the city's offer, they began to farm cobras, kill them, and turn them in for the financial reward. The city then stopped offering a reward for dead cobras and then people let their farmed cobras loose, increasing the population and subsequently worsening the cobra overpopulation problem. The cobra effect occurs when one attempts to find a solution to a problem and then actually makes the problem worse or even creates other unintended problems along the way. This is demonstrated when qualitative researchers feel compelled to use terms such as thematic emergence, saturation, and member checking as a means to make their research methodologies palatable to the masses of HPE researchers who subscribe to the positivist and postpositive paradigms. These terms may not be in alignment with the epistemological nor ontological perspectives of a specific qualitative researcher's methodology and are thus used inappropriately to appease the intrinsic and extrinsic positivistic pressures. Merriam and Tisdell (2016) and Patton (2002) use the term trustworthiness, rigor, and reflexivity as alternative criteria to judge the quality of qualitative research rather than submitting to the positivistic terms validity and reliability and thus addressing this "legitimization crisis" (Merriam, 2009, p. 211) that some qualitative researchers struggle with.

The trustworthiness of a study depends on the credibility of the researcher (Merriam, 2009; Merriam & Tisdell, 2016). In qualitative research, the researcher *is* the instrument and therefore to secure the trustworthiness of an investigation one must conduct the study in an ethical manner. The credibility of a researcher depends on a multitude of factors including but not limited to: their experience, training, intellectual rigor, integrity, and methodological competence (Patton, 2002).

The concept of reflexivity requires that a researcher "reflect on how the researcher is located in a particular social, political, cultural and linguistic context" (McNair et al., 2008, p. 2). This is a means by which researchers demonstrate rigor and protect the trustworthiness of their research process including data collection and analysis. One of the many ethical considerations for this dissertation research was the fact that I am a physician and interviewed participants who were also physicians. I had somewhat of an insider view and perhaps shared some common values with the participants. Some may question whether there was a risk to the research process where the boundaries may have been blurred between the participant and researcher role; however, it must be stated that I am and continue to be an outsider because I am in clinical community practice and do not have a leadership role in academic medicine. Therefore, I did not have the same conceptual understanding nor the same lived experience in academic medicine as the participants. Additionally, as a researcher who has completed several major qualitative research projects, I have experience with qualitative research and am dedicated to the professional conduct required of scholars to produce rigorous trustworthy ethical studies.

In qualitative research, the researcher is the instrument of investigation; therefore, self-awareness and reflexivity are considered "sharpening [of] the instrument" (Patton, 2002, p. 64). The act of deconstruction described above allowed me, as the researcher to question "how I

know what I know" and attend to the participants' depictions of their lived experiences. A researcher's competence, thoroughness, and integrity are among the many features that protects the trustworthiness and again demonstrates rigor within a study (Merriam & Tisdell, 2016). Reflexivity requires the researcher to be conscious of her cultural, social, political, and ideological perspectives as aforementioned. I challenged myself to shed the compulsion to use positivistic terms to prove the worth of my qualitative research methodology. At times, I must repeat to myself that it is okay that my "self-styled phenomenology" (Adams & van Manen, 2017, p. 780) of interpretive hermeneutic phenomenology subscribes to the premise that "subjectivity and objectivity are not mutually exclusive" (van Manen, 1990, p. 20). My role as the research instrument was to uncover the essence and deep meaning within the lived experiences of the participants who were interviewed. Varpio et al. (2017) explains that we should abandon the language of "thematic emergence" (p.44) unless we acknowledge that themes do not spontaneously leap from the page fully formed, but rather emerge from the data through the reflective interpretive process of the data analysis.

Another term that is often used to demonstrate rigor that an appropriate amount of raw data has been collected is saturation. The statement commonly used is: interviews were conducted with participants until saturation was achieved. If data collection and analysis do not occur concurrently it may be difficult to identify a point of saturation. Some advocate for researchers to use the term "thematic saturation" (Varpio et al., 2017, p. 45) to better explain that collection of further new data will not result in new themes nor insight. There does come a point when, despite interviewing more and more participants, few new insights or themes are gleaned.

The final term that is often touted as a requirement to ensure good quality phenomenological research is "member checking" (Merriam, 2009; Patton, 2002). I do not

employ member checking because I believe that it is in fact incongruent with interpretive hermeneutic phenomenology (McConnell-Henry et al., 2011). Some qualitative researchers feel the compulsion to include member checking in their methods without providing a critical analysis as to why they are including this in the first place. Member checking involves bringing data transcripts and or data interpretations back to the participants for validation with the hope of increasing the credibility of the data. Lincoln and Guba (1985) first recommended this as an integral step in establishing credibility which seems to be rooted in positivism/post positivism and stems from a time when qualitative research methods and methodologies had to prove their worth. I do not employ this validation tool for this dissertation as interpretive hermeneutic phenomenology is a philosophy that posits that truth is multiple and context specific. As such, if the transcripts are revisited by the participants the meaning at the time of the revisit will likely be altered. McConnell-Hery et al. (2011) explains the goal with interpretive hermeneutic phenomenology is not to generalize nor prove anything to be true or not; therefore, validation is illogical and unnecessary. Some participants may even find it retraumatizing if they are asked to revisit sensitive transcripts or data which adds another level of ethical complexity to this issue.

**Summary of the Methods**

This dissertation research addressed the identified gap within the scholarly literature surrounding the lived experiences of women deans in academic medicine in Canada. Participants were selected via criterion-based purposeful sampling followed by snowball sampling. After research ethics board approval, semi-structured phenomenological in-depth interviews were conducted. The interviews were digitally recorded, transcribed, and then inductively coded. Being true to the hermeneutic phenomenological tradition, I came to the data, after undertaking a deconstruction exercise to explicate my presuppositions, and attended to the data with fresh eyes

and a sense of wonder. While being truly oriented to the phenomenon under investigation, I reflected, wrote, and rewrote in an effort to create phenomenological description within the results and remainder of this dissertation that aimed for the reader to be able to give a phenomenological nod and appreciated better what it is like being a woman dean navigating a path to and through academic medicine leadership in Canada.

# Chapter 4 - Findings

The data were organized under six themes: authentic self, building a support team, sexism and the culture of academic medicine, woman dean as an agent of change, becoming dean and getting the job, and success on the job. These six themes and associated sub-themes identify and describe the essence of the lived experience of the women deans in the leadership of academic medicine in the Canadian context who were interviewed. These results illustrate the participants' lived experiences as their authentic selves and how they navigated their journey to and through decanal leadership. The first major theme, authentic self, described how the participants presented their authentic self in all circumstances while also knowing themselves, projecting an image, and having specific personal qualities that led to their success. The second major theme was building a support team where the participants networked strategically, experienced sponsorship, positive medical education experiences, while also having role models and mentors. The third major theme was sexism and the culture of medicine. Participants were sensitive to societal expectations and gender roles and had the sense that they were sometimes an outsider in the realm of academic medicine leadership. The fourth major theme was dean as agent of change. The women wanted to lead change, help others, speak out, and at times had to pick their battles to get things done. The fifth major theme was becoming dean and getting the job. The women felt that they had traversed a unique path to their decanal position, while they all had exceptional credentials, participated in research, and developed a leadership track record and applied for positions; yet some, described having no specific plan to become dean. The sixth and final major theme was success on the job, where the deans learned on the job, prepared for meetings, set goals, and overcame the imposter syndrome.

**Participants**

Eight participants were interviewed. Four of the participants were full deans and four of the participants held lower-level decanal positions such as assistant, vice, or associate dean. Many of the women described the difference between being a “baby dean” as opposed to a “dean dean.” A baby dean, according to the participants, was any lower level decanal position, especially positions focused on education and student affairs; in contrast, the participants considered dean-dean to be the top tier of decanal leadership. Some of the women shared that they had children and partners, while others did not. Some identified as married, single, or divorced. The mean age of the participants while holding their decanal position was 60 whereas the median age was 61 and the mode was 61.

Pseudonyms, such as Dr Carlson and Dr Stewart, were ascribed to each participant. The title Dr was used as this is common practice when referring to physicians. Additionally, given the exceedingly small population of women deans a detailed description of each participant could not be shared as this would make the participants easily identifiable in the landscape of academic medicine in Canada. What can be shared is that all of the participants were Canadian trained physicians who undertook their undergraduate medical education and residency/internships in Canada. They have all practiced in tertiary care centres and were affiliated with medical schools. The participant pseudonyms are: Drs Vincent, Stewart, Carleson, Jamison, MacDonald, Marshall, Dawson, and Isaac. Their years in academic medical leadership ranged from four to more than 20 years. It is common practice in dissertation research to outline the participants and provide a story of each individual; however, as described above, given the small number of women deans and the phenomenological approach employed for this research I have attempted to weave together their shared experience of being a woman dean in an effort to

protect their anonymity while also develop a phenomenological nod. Hundreds of pages of transcripts were painstakingly examined, analyzed, and coded and the resultant six major themes were elucidated from the data and represents the lived experience of the participants as they traversed their journey to and through decanal leadership.

**Authentic self**

The first major theme elucidated from the data was authentic self. This theme had three subthemes: know yourself, image, and personal qualities for success. The participants described the importance of knowing themselves while also being aware of the image that they displayed on their journey to decanal leadership and while they were dean. They were also asked questions regarding qualities for successful leaders and then what qualities they possessed which subsequently allowed them to, from a prereflexive state, describe the personal qualities that they identified as being helpful in their successful acquisition and function in the role of dean. The women shared that being their authentic self was a key factor in their lived experience as dean.

*Know Yourself*

The eight participants described the importance of knowing oneself including their limits, strengths, and their personal values. They also explained that being their authentic self and following their passion was important both on their journey to becoming dean as well as facilitating success and enjoyment while they held their position as dean. Dr Carlson explained what this meant for her lived experiences was, “What you see is what you get. How I’m talking to you today is how I’m going to talk to you next week” (C7). She said that it was important to know oneself and be one’s authentic self in all circumstances. She went on to say, “You need to want me for who I am and what I do and if I’m not a fit for what you’re trying to do then it’s better we find out now because as I say, I am what you see” (C8). This was a common sentiment

and lived experience expressed by the participants when they described pursuing their decanal leadership as well as other prior leadership positions. Another commonly shared experience expressed by the participants was, in knowing themselves, they spoke their truth. What this meant for Dr Dawson, a dean of 20 years, was that, “I say it like it is” (D7) and “I am who I am, I don’t have any back doors” (D15). The participants explained that this approach assisted them in persevering challenging situations while sharing their values on the job.

Participants described that knowing one’s strengths and weaknesses and core values allowed them to be more confident in their decision-making leadership roles. Dr Carlson stated:

> I mean you need to know your limitations, but you need to also be brave, like brave enough and absolutely committed to making a difference, so brave enough that if in order to make a difference you have to stretch beyond what you’re comfortable [with], you stretch. (C18)

Being able to use one’s strengths and manage weaknesses was key in moving forward professionally for the participants. Dr Vincent stated you must “know who you are and what your capabilities are” (V12). She and the other participants went on to say that they cannot know everything nor be the best at all things; therefore, when they were aware of their limitations, they could find others to provide support and mitigate their weaknesses which would fill the gaps in their capabilities while pursuing certain projects and decanal duties. Dr Carlson explained:

> You’re either a Teflon- you don’t want to be a Teflon dean, or a Velcro dean, it’s probably a good or bad statement now but Teflon deans you know, everything goes to the dean’s office, slides off their desk and goes to someone else…but the Velcro deans are the most dangerous. They are the guy who thinks that only he can make the decisions and so stuff goes in, and it just stays there. You’ve got to be able to let it go. (C19)

She explained that a Teflon dean deals with nothing themselves, whereas a Velcro dean does everything themselves and does not delegate nor trust the team. Beyond that, the Velcro deans do not know their limits and ultimately are not as effective as leaders.

In addition to knowing yourself and your limitations, having a deep “understand[ing of] your values, [and] understanding [of] what drives you” (M13) was described as an important component of being one’s authentic self. Dr Carlson went on to say, “You are then the person where the buck stops and if you’re not prepared to do that and if you’re not values driven, don’t take the job because it’s not going to be an easy job” (C16). The participants explained that knowing and doing what “you think is right” is a key factor in their position as dean. Dr Vincent said that it was important for her to go “somewhere where they have the same values that you have and make sure that they’re good people” (V17) because it will be exceedingly challenging to be successful otherwise. The deans described their jobs as satisfying work and at times challenging, but when they were their authentic selves and value driven, they could be successful and enjoy their job. Dr Carlson shared a commonly held perspective that:

> you have to know the values that you hold, you have to be again forthright and direct and open and honest about the values you hold and then you have to stick to them, and you cannot change those values even when you know, it’s hard (C15).

Another component of knowing oneself is following a passion both in life and career. Following one’s passion and doing what you love is essential for success and enjoyment both on the journey to and through their decanal leadership. Dr Stewart, who had spent 20 years teaching medical students and residents, stated that she “loved teaching” (S5) and “loved being dean” (S6). These were sentiments shared by the other participants. Dr Isaac, who also had many years of teaching experience, explained, “I am still very happy to get up every morning and come into

work and that includes my clinical work, my research and laboratory work and my leadership work" (I15). What this meant to the participants was that they truly enjoyed their work, and this was further facilitated by following their passion. As Dr Marshall said, "Figure out the stuff that you actually are passionate about" (M11) and that will facilitate enjoyment and success in both life and career. Dr Jamison succinctly summarized the subtheme of knowing yourself by saying, "Do what you love, follow your conscience and curiosity, know who you are, understand what sort of core values and priorities are" (J9) important to you.

*Projecting an Image*

A feature of knowing yourself included an awareness of the image that the participants presented to the world around them. The image that they strived to portray was described as being poised, modeling appropriate behaviour, being and presenting their authentic self. To present their authentic self you have "to understand yourself and your impact on others and how to communicate with others" (M13). The participants explained that being in a leadership position such as dean, they were very visible, and it was important to have an awareness of that because it impacted the university, departments, and groups within which they worked and led. There was an expectation they described of being poised and presenting oneself with grace.

Dr Steward explained what this meant was that one must "model appropriate behaviour all the time. And like you have to watch what you say, especially being in a dean's position." (S6). This image both extended to in-person interactions as well as the "need to be mindful with social media" (S6). Being dean, according to Dr Stewart, meant presenting an image that was poised and graceful whether that was at the gym, grocery store, or at work because there was a specific "leadership phenotype" (S6) that was expected. She described this as presenting her true self, but also being mindful to not make "off the cuff" statements.

Dr Vincent told a story about a time when she was in a decanal leadership position at one institution where she would try to fit in by purchasing expensive clothing and attempting to fall within the feminine gender norm, which she reported was not being true to her authentic self at the time. She did not find success in the form of academic advancement in that position and explained that likely it was partially because she was not presenting her image as her true authentic self. She went on to say that once she presented herself, as her true self, she did find further success in decanal leadership. This anecdote demonstrates the challenges and pressures that the women deans experienced on their journey to and through decanal leadership with respect to their image wherein, as women leaders, they felt that they were expected to be poised and present themselves with stereotypic feminine grace (S6).

Dr Carlson also experienced failure when she applied for a decanal position and did not present her true authentic self to the selection committee. She explained that she did not get the dean position she applied for because she "played it too cool" (C12). In her words:

> I think my fatal flaw in my competition for that first position as dean was [that] I said, I love what I'm doing, I can continue doing what I'm doing, I don't need to be dean. I think I could bring something of value, but I don't need to be dean, you know. (C12). [Although I did truly want to be dean, I] didn't want to be seen as the tall poppy so I wasn't selected, I was second. (C12)

From that day forward, she vowed to present her true self because she "really did want to be dean and I did think I could be the best dean of the four, … I wanted to make change at the level of a medical school and beyond in medical education, and so I now was interested, I was now in the game" (C12). Presenting their image authentically to the outside world was important to the

participants and it appears to have assisted them, from their lived experience, with personal and professional success as well as job satisfaction. It was who they really were.

*Personal Qualities for Success*

Another component of the participants' lived experience in describing their authentic self included qualities and characteristics that they believed enabled their success in acquiring and functioning in the role of dean. The participants were asked to describe qualities of successful deans and then subsequently to describe what qualities they thought they had that enabled their success both in acquiring and functioning in their decanal position. The participants listed extremely similar characteristics and qualities and there was no significant variation amongst the women's responses. Participants described having qualities such as self-confidence, self-esteem, self-efficacy, emotional intelligence, excellent interpersonal skills, being humble, perseverance, and identifying as an educator.

Three important characteristics that the participants suggested enabled their success both on their journey to becoming a dean as well as their performance in that position were self-confidence, self-esteem, and self-efficacy. Dr Carlson said, "You have to be confident, self-confident. At the top echelon, self-confidence, and as broad experience as possible in terms of working with other humans [is important for success]" (C18). Dr Dawson, who was very forthright, explained that confidence and believing that she could be successful were helpful in facilitating further success both in life and career. Similarly, Dr Issac described self-confidence and self-efficacy as being important because as a leader she had to believe she "actually could do this [lead] and you know, there was nothing magic about it, it was like practice, practice, practice" (I3). Dr Vincent and Dr Carlson both summarized this concept in reference to other deans by saying, "I think it is realizing that not only could you do the same job, you could

probably do it better than some of the people that you see who are in those positions" (C8). The participants explained not only did successful leaders possess these qualities, but eventually they too achieved a level of self-esteem and self-confidence while remaining humble.

Being humble while having emotional intelligence and excellent interpersonal skills were also essential to the participants' success. The women appreciated that on their rise to the decanal position they did have skills and attributes that enabled their success; however, they did have to demonstrate emotional intelligence and excellent interpersonal skills as without these, they would have challenges ascending the academic hierarchy.

Dr Carlson explained that she was "self-confident but at the same time humble enough to recognize what you know and what you don't know" (C18). This sentiment about knowing what you don't know and being prepared to ask for help was a commonly held position by the deans. Beyond that, sharing the attention and recognition for successes with others was also described in the context of being humble. Dr Marshall said, "So, I have to be very humble and again not worry about where things get attributed, but just be glad that things are moving in the right direction and to have a fierce resolve, an understanding that sometimes it takes 5 years or 10 years [to get things done]" (M11). In addition to being humble, Dr Vincent, explained that "having emotional intelligence" (V5) was essential in leadership and being successful in navigating academic medicine's hierarchy. The participants shared anecdotes that demonstrated their emotional intelligence and humility as well as their interpersonal skills.

Dr Stewart outlined the importance of interpersonal skills and emotional intelligence by saying, "I think interpersonal skills [are important] so I can really hold the conversation for people and then try to work out some sort of solution" (S11). She went on to say, "I've had lots of experience in it right [networking], but it comes intuitively. But I think that's a critical tool

that you can kind of go to different groups and make the connection but be strategic about it" (S11). In addition to their emotional intelligence and interpersonal skills, using humor in certain circumstances was also highlighted. Participants articulated the importance of carefully employed humor. Dr Vincent saw herself as having "the wickedest sense of humor that you would believe. I actually do think that mockery is my favourite sport and even secretly in my own mind I have kind of like a Mr Bean moment" (V13). Dr Stewart told a story about when she spoke out against a sexist event in the department and attempted to make change amongst a group of physicians, using humor to make her point:

> I would always stick up for, you know, being women and women needed to be involved and stuff, but I tried to do it with humor and you know I think they respected me for the most part, I would say they all respected me but it does, you know, there are comments that are made about women or things like that. (S10)

Dr Macdonald and Dr Carlson also shared anecdotes about the careful use of humor on their leadership journey. What this meant for their experience was that they could connect with people both by being direct and using humor. This was one of the many desirable qualities highlighted by the participants.

Being a hard worker, problem solver, person who perseveres, and the concept of being a superwoman were characteristics of the participants' lived experience as dean. For the women, being a hard worker began prior to their medical school days and then carried on through to their decanal positions. The experience of working long hours through medical school, residency, and in practice were expressed. The challenges with work-life balance were also described. Some of the participants had children and partners while others did not. All of the participants identified

themselves as hard workers and this was an integral factor in their success. Dr Steward described herself by saying:

> I have a pleasant personality, I'm incredibly hard working, I'm very committed, I volunteer for things, I get things done you know, I'm not somebody who has all the ideas and then just delegates everything. I do delegate, don't get me wrong, but I make sure the team or myself is accountable and I role model to being accountable and transparent. (S10)

Dr Vincent explained being a dean meant that "there are going to be times where you're going to be working all the time and you're going to be exhausted, and if you are the hub of the institution and the risks are sitting with you" (V13). She then went on to say, "There's a good chance you're not always going to be able to make it to that yoga class" (V13). She shared that it is not popular to say that there are challenges and a lack of work-life balance as a dean. She said that this is the truth of her experience and that of other deans. This is because they need to be reachable, and this is the nature of the job. Dr. Issac explained that:

> I've always worked long hours and have never resented it. I have always just assumed that that was part of the package if you wanted to do all these things in academic medicine, not to give up your clinical career if you wanted to have a research programme if you wanted to do leadership. (I5)

For her, being a leader and being dean require one to accept long hours because "you're not going to punch the clock at nine o'clock in the morning and again at five o'clock in the afternoon that is unrealistic" (I6). The deans shared anecdotes to demonstrate that they were hard working and had a strong work ethic. For example, Dr Dawson described herself as "the type of person if I'm going to do something I will do 101%, so for me that meant learning how to do research on

my own and so I signed up to do a master’s in clinical epidemiology as a totally separate graduate programme. There was no clinical investigator program [at that time]” (D3).

Dr Jamison shared that she was organized and a problem solver and known for getting things done. Similarly, Dr Carlson said she approaches problems by saying, “What’s the problem that needs to be solved, okay, what’s the part I can do, who else do I need, what other skills do I need, and then you go out and you find those skills in one way or another” (C12). Dr Vincent, Dr Macdonald, and Dr Dawson explained that their job often involves conflict resolution, problem solving, and people management. This was a commonality amongst the shared lived experiences of the women deans. The participants described perseverance as integral to being an effective leader and problem solver.

The women told stories demonstrating perseverance at one time or another on their decanal journey. Dr Marshall described a challenging situation that she had been managing wherein:

> The issues that I’ve been dealing with in the last while, I found I have to have the resolve, the patience, the understanding that sometimes I’ll trip over my feet and have to get myself up and dust myself off and keep going, not to lose sight of the end goal and persevere. (M11)

To be successful, as demonstrated by the participants’ lived experiences was that doing your best in all circumstances was important in association with perseverance.

Dr Dawson described the importance of excellence, and stated that she “was not going to settle for mediocrity … I’m going to do something it’s going to be done to the best of my ability, to the top of the category that it can be” (D12). Similarly, Dr Carlson explained that one must be comfortable with uncertainty and having to make good decisions in the moment. She said that

she would have a conversation with herself and say, this is “the best I can do at the moment” (C19) and know she was being honest with herself and others in that she was doing her best. Some of the participants used the term “superwoman” to describe what it was like to be the hardworking, organized, problem solving person who persevered. Dr Carlson was one of the participants who used the term “superwoman” to describe women deans with families and children. She said, “You’re a superwoman when you’ve got kids” (C22) in reference to those deans who had children. When asked to explain the term superwoman in the context of academic medicine and leadership, she went on to say, “The superwoman thing is where you go into the phone booth, you change into your costume before you go home and from the clinic, right, and you have to be able to do that” (C22). Whether they had children, spouses or not; they described the requirement of having to be “on at all times” and manage many responsibilities and roles. The deans described their job as extremely challenging, rewarding, and at times all-encompassing and it was within that context that they use the term superwoman.

In addition to identifying themselves as women who could “get things done” and who persevered on the decanal journey, they also identified themselves as educators who loved teaching. Participants identified themselves as either a teacher or an educator using those terms while describing their love for teaching the next generation of physicians. Dr Marshall stated that her involvement in academic medicine “really came from my love for teaching and those were the first major activities and roles I took on… I organized student electives, moved to program director, and then actually set up a residency program” (M3). Dr Carlson described herself as “a natural teacher” who knew that she “wanted to be involved in teaching and academic medicine but wasn’t sure how or when; but it was a given that I was going to teach” (C3). She and other participants indicated that she began teaching when she entered into practice. They recognized

that they were teaching as senior medical students, interns, and residents while on their journey before they were involved in academic medicine as attendings. Dr Dawson explained that teaching in medicine is not highly rewarded nor visible and "90% of what you do will not actually show up on your CV" (D6) and that is why many people will not take on teaching roles, but she did because she enjoyed it. She also described how much she loved being an academic by saying "I love being at a university and being able to create that knowledge and generate that knowledge and educate people" (D15). This was a common statement wherein the participants "loved teaching" (S5) and identified as educators both on their journey to leadership in academic medicine as well as in their role as dean.

The first main finding elucidated from the data was authentic self, and this major theme had three subthemes including know yourself, image, and personal qualities for success. The participants candidly shared stories about who they were and how they navigated their journey to their decanal position as their authentic selves.

**Build a Support Team**

In addition to presenting their authentic self in all contexts, the participants described the importance of having and building a support team, the second major theme identified. This team was present as they navigated the path through the hierarchy of academic medicine to their decanal position. Beyond that, the women described either being sought out by, or actively seeking, supports which resulted in building a group of people who were present while they held their position as dean. This second major theme, build a support team, has six sub-themes including: networking, sponsorship, supportive relationships, positive medical education experiences, role models, and mentors. The participants described a carefully cultivated team of supports rather than just one or two individuals, and this was a universal finding among the

participants' experiences. This is also a novel finding not documented elsewhere in regards to decanal leadership aspirants.

*Networking*

The women deans spoke about networking strategically, knowing who you could trust, building a successful team of allies to work with, and having "the meeting before the meeting" as features of their lived experience being women in the leadership of academic medicine. Participants gave examples of how they would connect with multiple different people from different departments at their university, other universities, hospitals, government, and the general public. Dr Vincent explained, "I think we have a system where if you're powerful and you appear to be on the rise to become very popular…I think you [need to] know who your support is and [who] your friends are" (V12). She explained further that it was important to know who you could trust both to tell you when you are right and when you are wrong. Dr Vincent, like the other participants, described networking strategically and building a strong team of allies which was important for her success both in her decanal position but also while ascending through the hierarchy of academic medicine. Poignantly, Dr Carlson explained her approach to networking:

> I mean I made visits once I was appointed, met with as many people as possible trying to figure out who the players were because it doesn't matter where you go, they're the same players, they've just got different names and different faces. You know that some of the people who you make contact with and the people who [make] contact with you immediately [when] you're appointed as a leader, some of those people will be your best allies, some of them are going to be your problems and you don't know which ones they are at the outset. So, you do a lot of listening, a lot of question asking. (C13)

Dr Stewart also described a similar approach to Dr Carlson, but also explained that:

> Networking … comes intuitively [to me]. Now I’ve had lots of experience in it right, but it comes intuitively. But I think that’s critical too that you can kind of go to different groups and make the connections but be strategic about it. You’re not going to meet with everybody, but you want to be strategic about who you contact and who you do things with. I think be a team player recognizing that you’re not always right, recognizing that- I mean, I don’t have all the ideas like working with teams and really listening to what they say. (S11)

Being strategic about making connections and maintaining relationships was described by all of the participants as integral to being successful in their decanal position, as well in their ascension through the hierarchy of academic medicine. One example provided by Dr Marshall was that she would “strategically place her boardroom” (M10). What she meant by this is that she would seat women closer to the chair of the meeting to ensure their voices were heard. She would also engage in “the meeting before the meeting” to find allies around the table to help bring up important points required to move forward in a project or mission. She stated, “I think still today in my environment, a woman will make a suggestion and then a man makes the same suggestion and ‘my goodness, Johnny, that’s a great idea, let’s do that.’ The clout that is given to a males compared to female, there’s still an issue in the world with that” (M10). She described having conversations outside of the meeting time to gain allies and “if I can suggest that somebody else say something that I know that will be listened to, that’s fine 'cause all I want to do is get to the end point. So, I’ve learned to understand that” (M10).

As Dr Vincent explained, the Old Boys' Club exists wherein male associate deans, deans, and CEOs would go play golf or go out for drinks and the women deans were not invited. She said, "There is a hidden curriculum mostly for women leaders and we don't have the same club, right?" (V16). She also noticed that sometimes women were part of enacting that isolating behavior to other women aspiring to leadership. "We don't have the same solidarity that we need to have, and I think sometimes the women were more destructive than the men" (V16). Dr Marshall and Dr Macdonald described the importance of networking strategically with other women. They stated that "women tend to be more collaborative and tend to be team players, seem to require less space, take up less space, seem to have the greater good in mind" (M10) and networking among other women was a helpful practice. Participants expressed networking among supportive women leaders in their lives. Dr Steward shared a story about a group of women that she would meet with on a conference call once per month and then attend a leadership weekend once per year with that same group of supportive women deans. The participants actively sought out networking opportunities, built a team of allies, maintained strategic relationships, and engaged in networking with other women leaders. This in many cases resulted in sponsorship opportunities which helped them on their journey to their decanal position, as well as provided assistance while they were deans and navigating the challenges while functioning in that position.

*Sponsorship*

The participants' support team included a host of sponsors both within and outside of medicine who helped advance their careers. The term sponsor was used by the participants to describe individuals who advanced their careers by encouraging, appointing, nominating, recommending, and creating leadership positions for the them. The sponsors they named

included male and female deans, male and female assistant/associate deans, members of the AFMC (Association of Faculties of Medicine of Canada), division heads, and department heads to name a few. The sponsors would identify leadership positions and then encouraged and invited the women to apply for those leadership positions including their decanal positions. The sponsors assisted them in networking with other deans, department chairs, and division heads which then further advanced their career opportunities. The participants were also encouraged by their sponsors to see themselves as leaders, though they, at times, did not see themselves as traditional leaders nor deans. When asked to elaborate further on what she meant by non-traditional leaders, Dr Isaac described how she:

> Did not see myself [herself] as a leader, I don't [didn't] think I was a natural leader. She saw something in me that I didn't see in myself and so first she hired me which was nice. I had a job and then within 4 years of coming on faculty as a junior member in my section there was a great turnover of people and she [her sponsor] became department head and then…she was calling me into her office telling me that she wanted to make me the next division head. (I4)

She described how she did not feel ready to be in such a leadership position but was encouraged to apply and then was supported by her sponsor in acquiring the position as well as while doing the division head job. This is only one of the many stories shared by the participants wherein they were encouraged to apply for leadership and decanal positions and were also recruited for those positions, oftentimes by their sponsors, in addition to recruitment hiring firms.

Dr Issac shared how her sponsor "not only opened the door for me, she pushed me through it or dragged me through it and having done that, she supported me in the position that I didn't think I was ready for and so she gave me a huge opportunity which in fact once I got into

it I actually enjoyed [the job]" (I4). Dr Isaac, like many of the other participants, expressed that once they were in their leadership positions, both lower-level leadership positions and then their decanal positions, they realized that they did have the ability to perform exceptionally well. The women also noted that they were well supported by their sponsors and other members of their support team and "when I [they] thought I was having trouble or I didn't know what to do, her door was always open for me to go and hash this out with her, whatever the issue was" (I4).

Dr Dawson described how one of her sponsors was a department chair and "he very much believed in me and very much would try to, I think, to position me at tables where he thought my academic side would excel, and he would have been one that would have gotten me to some of those advisory tables" (D9). Often a dean, department chair, or other leader in academic medicine would nominate, recommend, or appoint them for both lower-level leadership position as well as their decanal positions. It was a common finding that the current dean would nominate the participants for a decanal position and perform that sponsorship role.

*Supportive Relationships*

The participants also described other members of their support team which was comprised of individuals from within medicine as well as outside of medicine who were not identified as sponsors, mentors, nor role models. These individuals were their parents, family, partners, friends, peers, and other physicians. The participants did not describe nor identify these individuals as sponsors, mentors, nor role models but did share anecdotes to express how they were important and supportive. These relationships spanned from childhood through to adulthood and it was clear that the women felt that they had a positive impact on their development as a leader. They explained that these were people in their lives who provided

encouragement and support during their professional development and facilitated their personal growth throughout their lives.

The participants shared a positive relationship with a parent or family member as being important in their lives. For example, Dr Vincent described her mother as a strong capable woman who was a single mother who was always supportive along with her siblings with whom she was very close. Dr Vincent explained that "a sense of citizenship and desire to be part of making a difference, and that's the way I was raised by my mother, single mother family, very Methodist and very committed to being a good Canadian citizen, first generation immigrants, so that kind of theme" (V1). She felt that this background affected her development as a person and as a leader. She explained when her mother passed away, she and her siblings, whom she was close with, "went on a pilgrimage type journey back to India and we took her ashes to a number of places in including parts of the Himalayas and we really learned a lot more about her and the culture of our family" (V9). Dr Vincent expressed the importance of family and knowing your heritage and reiterated that the support of her mother and family has influenced her leadership style and approach to life. Her mother, she said, ensured that this was "so deeply ingrained" (V9) in her children. The participants shared stories about either a parent or other family member who was present in their lives both prior to and during their tenure in the decanal position that had demonstrated a positive impact on their development and performance as a medical leader.

Dr Carlson described how her parents raised her and her four sisters: "We were raised to believe we could do anything we wanted, we should you know, plan to be whatever we wanted to be, but we should also plan to get married and have children" (C5). She said this family support was integral to her early development as well as her outlook while in her decanal

position. She also explained that having a supportive family is “incredibly helpful if you’ve got relationships where you feel loved and valued” (C19). She then clarified this by saying that:

> It doesn’t necessarily mean you have to be married or you know have a partner and a life partner in that way, but it is very helpful if you have close friends if you don’t have a partner. You need a partner who is supportive for sure if you’re in a partnership. You certainly need friends who’ll be supportive. (C20)

She spent a great deal of time describing how her family and friends were supportive to her; in her words, these are people who will tell you if you are “missing something and are not always going to agree with you” (C20) but will always be there for you.

Not all of the participants had partners, some were widowed, some divorced, but the majority did have a significant other. Dr Macdonald and Dr Marshall told anecdotes about how supportive their partners were both prior to, and during, their decanal roles. Both women had spouses who worked outside of the home and neither of them took paternity leave, which was a significant point of discussion for the participants. They both described their partners as supportive at different points in their career development, but for Dr Macdonald, during her early career, paternity leave was not something that “people did in those days.” Similarly, Dr Marshall described going part-time early on in her career to look after her children as her partner was very career motivated. She explained that at times it was a challenge to balance responsibilities outside of her professional life, but they managed. She noticed that maternity leave did impact her productivity and “I couldn’t have dreamt that I would end up where I am, but for 10 years I had zero productivity when you look at it from a career staging [perspective]” (M10). Dr Dawson’s husband did not take paternity leave either, as any leave would have negatively impacted both of their careers. She remembered:

> As much as he was a good husband, he could not do that and for me that really burned my ass and what I would say, really made me sort of bitter to the gender inequalities for professional women… you can become dean, you can get it back on track, but you will definitely be 5 years behind your colleagues. (D12)

Dr Carlson described her husband as very supportive as they had to move across the country for her decanal position. The women all recounted circumstances where their partners bolstered them and appreciated the importance of their professional career advancement.

Friends and peers were described by participants as providing emotional support. These relationships developed both prior to and during their role as dean. Dr Steward stated, "I'm very connected with my friends 'cause I don't have any family here, but I've made some very close friends and I keep in touch with my friends across the country" (S7). Dr Steward also described a group of eight women dean peers who have become close friends that meet on a monthly basis to provide each other with both friendship and career support.

The participants named other deans, department chairs, and physicians who have been supportive peers who encouraged their professional advancement while also providing a listening ear. There was a formal leadership course for women called ELAM (Executive Leadership in Academic Medicine) where many of the participants met their peers, but there were also local physicians, chairs, and deans at their universities who provided supportive relationships. This was a group of supportive people that they did not describe as sponsors, mentors, nor role models. One participant noticed that her "peer group is starting to retire, but I'm not ready to retire— I love coming to work" (I14). Dr Issac explained that she discussed professional work-related challenges on a regular basis with her peers. Similarly, Dr Dawson said, "People [her peers] encouraged me to continue to do what I was doing and try to impact

those changes. I think I had a pretty powerful voice. You know I could come to the table, and I had a lot of credibility” (D7). She expressed that her peers support her and this allowed her to feel confident, but also to effect change. Beyond friends and peers, the women described colleagues in professional organizations, board of directors/CEOs, department chairs, and deans as sources of unwavering support.

Many of the participants were members of the FMWC (Federation of Medical Women of Canada), an organization that provides networking opportunities, professional advancement, and continuing medical educational opportunities for women. The FMWC has been in existence for over 100 years. Some women, such as Dr Marshall would seek “counsel from a prior board chair for example, a female… I [she] could trust who would help navigate challenging situations” (M9) and be a listening ear. Similarly, Dr Carlson identified her female department chair as an important person in her life who encouraged her research and projects. When she wanted to start a new research program the department chair said, “If you want to start something, I will stand behind you” (C11). Clearly, there were more than just one or two individuals standing behind them on their journey through academic medicine. The women were clear when explaining who their sponsors, mentors, and role models were therefore the above-described supportive relationships existed in their experience outside of those other specified roles and provided unwavering personal support.

*Positive Medical Education Experiences*

The participants identified positive experiences either in medical school, internship, or residency which had an impact on their perception of medical education. All of the participants were Canadian medical school graduates, and they had both positive and negative experiences during their education. Although not all of the participants described negative experiences, many

recalled positive experiences as a learner during their training. These experiences ranged from inspiring teachers to supportive classmates. Dr Issac stated that “there were aspects of the experience in my medical school that I loved, for example I loved my classmates. I met a lot of very inspiring teachers” (I2). Dr Marshall described medical school, as did many of the participants, as a challenging environment where they applied themselves diligently in order to be successful. Although they did have some negative experiences in medical school which impacted their desire to facilitate “a learning environment that was positive” (M2), they also spoke about some very positive experiences with classmates and inspiring teachers. Dr Jamison remembers having “a bit more of a life outside of the fence by then [in residency] and had a positive residency experience” (J1). Dr Carlson also described the positive impact of having “fabulous teachers” (C9) in medical school and that having “charismatic and student centered” (C9) teachers and preceptors allowed her to thrive.

This common feature among the participants of having a positive experience during their medical training at some point in time allowed them to see how they too could create a positive learning environment for others. Their positive experiences spurred their interest and passion to be involved in academic medicine, leadership, and participate in those positive spaces.

*Role Models*

At first, many of the participants stated they did not have any role models, but as the interview progressed, they usually recalled someone that they specifically identified as a role model, using that term to describe someone whom they looked up to. Their role models were both male and female and existed within and outside of medicine. A common experience shared by the participants was that there were very few women role models in the upper ranks of academic medicine as this realm was mostly populated by men. Dr Dawson said, at first, “I’ve

never had a female role model or mentor. As I said, I was the first female professor in my department. I sat at so many tables over the past 20 years where I've been the only female" (D9). She then recalled a past male department chair and a female university president that she looked up to and specifically identified them as role models. The women deans listed role models such as their mother or father, people outside of medicine in politics or social activism, other physicians, department chairs, deans, and university presidents. However, some participants required probing questions to recall these individuals. One participant stated when asked if she had any role models in her life responded, "No, I mean my role models in life and in residency and medical education were not related to the practice of medicine." (V3). She went on to describe her mother as being a woman with a strong work ethic whom she looked up to, as well as Stephen Lewis, "ambassador to the UN and NDP party person" (V3). Her mother and Ambassador Lewis both appealed to her as they had a sense of social responsibility and a strong work ethic. She then went on to explain that she would want to emulate Stephen Lewis. Dr Jamison described her parents as role models by saying:

> My parents were both in sort of public service roles, my dad was a Presbyterian church minister, my mom was a schoolteacher, and they were both leaders in their own fields and respected people in our community. I just learned their style of being available to people, listening to the whole spectrum of their peers as well as the people in our community that needed help and just saw how they took their work really seriously…those were probably my best role models. (J6)

The participants also identified fellow physicians as role models both during their training, early practice, and during their decanal leadership. Dr Marshall shared an example from her training:

> I think I really didn't start to feel like I had role models until residency, and they were some of the more senior fellows who I really respected as clinicians because of the way they treated patients and because they took the time to teach and to actually ensure that you're understanding what was going on with the patient and they really took the time basically. (M2)

Dr Carlson described a female surgeon whom she looked up to, at a time when there were few women surgeons. She stated that her "primary role model was … the only female surgeon in Vancouver at the time. She became THE person for breast surgery, but she was very cool. She was single, wore tight boots, she was, you know, again she was a bit of you know…I admired her very much" (C5).

Some of the participants described looking up to deans and university presidents when they were in lower-level leadership positions. One participant even explained that she learned "how I didn't want to lead" (V4), but for the most part the participants explained that they admired and had hoped to be like their role models when they reached the upper ranks. Dr Issac remembered a department chair who she admired because "he modelled not only expert clinical care but the always questioning mind" (I3). She went on to say that she "also got to see his leadership skills because he was running a very large division and I'm sure there were a lot of challenging personalities" (I3). In her view, he was an excellent role model because he was able to manage people with grace and was a gentle leader who led by example. She valued his leadership style and explained that she tries to lead with those qualities as a dean because they are effective.

Dr Jamison recalled a dean who she looked up to as "a strong leader in family medicine…I don't know whether he--I don't think there was any formal mentorship ever, but

just watching him as a leader was helpful" (J2). She went on to explain that she aspired to be able to lead with the qualities that he displayed. Some of the participants used the term role model to describe individuals who they hoped to emulate and then those individuals eventually went on to directly mentor them, for example one dean stated:

> My primary role model when I began to rise in leadership was the professor of pathology, the head of pathology who was involved in the Dean's office over four different, four or five deaneries… he was a major influence on me. He encouraged me to see myself as a leader at all levels which again, in those days was you know it was I mean becoming department chair seemed like a stretch but beyond that it was… there were occasional women in associate dean roles, but not many across the country. (C6)

Role models were described by the participants as individuals who they looked up to and hoped to emulate, whereas mentors served a different purpose wherein they took an active role in encouraging and assisting the participants in developing their clinical and leadership skills on their leadership journey. A common feature among the participants' experiences was that their role models and as described in the next section on mentors, existed in their lives both before they gained their position as dean and then persisted and supported them while they were in their decanal position. Dr Carlson spoke about the significance of visibility and role models because "seeing someone who looks like you, my God, it's really hard to imagine that it could be you" (C24) especially if there are so few women leaders in the upper most ranks of academic medicine. The participants expressed the detrimental impact of the lack of women role models on the future of women in leadership and how they were fortunate to have role models in their own lives. For some of the participants their role models became mentors and there was a shift in

that relationship from being someone they would like to emulate to someone who actively took on the role of mentor.

*Mentors*

The women deans noted that in general there were very few female mentors in the upper ranks of academic medicine, but they were all fortunate to have mentors, both male and female. Dr Isaac stated, “I feel I’ve had a whole slew of outstanding mentors” (I4) and this was a common experience amongst the participants. Their mentors included preceptors during medical training, physician peers, department chairs, and deans who shared their wisdom and provided guidance. Mentors actively helped them learn to navigate their path through the hierarchy of academic medicine and supported their development as leaders by sharing their knowledge. Their mentors not only actively helped them develop from a clinical perspective, for example during medical school, but also encouraged the women to see themselves as leaders in academic medicine.

The participants expressed that they worked very hard during medical school, and some even reported that they struggled; however, they had preceptors who took a keen interest in their development and then became lifelong mentors for them. These mentorship relationships continued through their medical training into their medical careers, and for most, this relationship persisted through to their decanal leadership. Dr Isaac stated that she “met a lot of very inspiring teachers. I did find my clerkship years very challenging and actually at one point as a third-year medical student did have a brief period of time when I wondered whether I had actually chosen the right thing to do” (I2). Thanks to wonderful mentors, she “got back on the path of knowing this is really what I wanted to do” (I2). Dr Marshall described being in “survival mode” (M2) in medical school, and fortunately a mentor who was a clinical teacher took an

interest in her and helped bolster her confidence and clinical skills. She went on to say it is imperative for people to have mentors because it is integral to one's clinical development. That is a statement that was shared by all of the participants, and they all believed that mentorship had a positive impact on their development as physicians, educators, and leaders.

The participants also described physician peer mentors along their professional journey as being influential. Some of the peers were physicians whom the participants worked with while others were peers who were deans at the same time that the participants held their decanal positions. The women explained that their peer mentors were approachable, available, and able to assist them by being a listening ear and actively providing advice which helped them, for example, navigate challenging situations. According to Dr Jamison, "Some of the most important people have been peers, so the other deans at the university we have a really collaborative collegial group of deans from other faculties, and they have been really great peer mentors" (J10). She went on to say that "just having people that you can kind of sit down with and kind of commiserate and share ideas, that's been very helpful, so peer mentorship is always helpful along the way" (J10). She explained, in her experience, that they support and mentor one another on their individual leadership paths.

The women spoke about department chairs and deans who had mentored their development as leaders in preparation for their lower-level leadership positions as well as their decanal positions within the context of academic medicine. They described how their mentors helped them develop skills for running meetings, think about succession planning, manage people, as well as complete the financial aspects involved in academic leadership positions. Dr Isaac recounted that her "first real woman mentor…was an incredible clinician and scientist and curious, and all of those things, but she was my first real role model of a woman leader" (I4). She

went on to say that this department chair provided a listening ear and “her door was always open to me, to go and hash things out” (I4). This person began as a role model and then took on an active role in her life as a mentor. Dr Issac also identified a department chair who was also a research mentor and enabled her to further develop her skills as a researcher.

Mentoring from a dean was especially significant in the lived experience of the participants. They each provided examples of both male and female mentors who held decanal positions and mentored them in the skills required for functioning as a dean. These mentorship relationships then persisted while the participants themselves became deans. This longitudinal relationship was cited by the participants as not only helpful, but necessary, because being dean was both a gratifying and very challenging job.

Many of the participants cited one specific woman dean as a mentor, but to protect her confidentiality, her name has not been included here. This woman dean provided support to many of the participants and mentored them prior to their decanal position as well as while they served as dean. The participants who engaged with this same dean mentor described her as a positive force in their lives who they all continued to be in contact with to this day. Dr Vincent described this female dean mentor as encouraging her when she was a “junior faculty member and she was someone who I - again, accessible, talk to, run things by but even now honestly I often think I need to talk to” (V3). Whether their dean mentor was male or female, the same sentiments were shared that their mentors were accessible, acted as a sounding board, and mentored their leadership skills via sharing their knowledge. The participants had mentors who were deans and that relationship persisted during the course of their journey through the hierarchy of academic medicine as well as while they held their decanal position.

In summary, the second major theme outlined that the participants was the need to build a support team around themselves which allowed them to thrive and assisted in mitigating some of the challenges on their journey to and through decanal leadership. These relationships were longitudinal and spanned both personal and professional domains.

**Sexism and the Culture of Academic Medicine**

The third major theme that emerged from the data was a commentary on the culture of academic medicine as the participants noticed it was rife with sexism. The two subthemes that comprised this major theme were firstly, gender roles and societal expectations and secondly, being an outsider. The participants all described experiencing sexism at one point or another on their journey to their decanal position. They also noticed that there were gendered assumptions of behavior for them in general as women physicians, as well as for being a woman dean. At times, they also noted feeling like an outsider in the context of academic medicine where the Old Boys' Club was prevalent (V16). Two of the participants at the onset of the interview stated that they were not aware of any discrimination based on their sex; however, during the course of their interviews they both recalled events that they had not initially remembered (I13) and then acknowledged them as sexism. The women explained that they had to prove themselves and demonstrate their credibility. Some of the participants even described being blatantly underestimated (S10) in comparison to their male peers who were simply given the benefit of the doubt. Some of the women recalled experiences of blatant sexism that occurred during their training in the 1960s to1980s. "In those days it was just pay[ing] your dues" (I2) for being a woman in medicine. They recognized that this was unacceptable but commonplace at that time. They also acknowledge that sexism and gendered assumptions of their behaviour persist today but have become more subtle. The women deans also shared that they had to monitor how they

communicated so that they did not seem overly emotional or aggressive in their communication styles while holding leadership positions. They noticed leadership looked different on male deans versus female deans. They often watched younger male colleagues being promoted ahead of them (I6) and those male leaders were seen as "easy going" (V5). The participants said they felt like an outsider, were excluded from meetings, and felt isolated at the top within the Old Boys' Club which was persistently present and powerful in the leadership of academic medicine.

*Gender Roles Societal Expectations*

The participants shared experiences where they were negatively impacted by societal expectations of gender roles for women in medicine and leadership. While they appreciated that leadership "looks different on men than women." They shared stories about being underestimated and having to constantly prove themselves and their credibility. Some described gender discrimination that occurred when they were medical students while others felt that as they achieved higher levels of leadership, they experienced more sexism. Some of the participants described their male peers being promoted ahead of them. The women also had to police their tone and communication styles so that they were not seen as aggressive or angry while male peers were seen as easy-going and laid-back.

The women deans shared experiences of having to prove themselves and demonstrate their credibility whereas their male peers were simply given the benefit of the doubt. Dr Dawson said, "From what I've seen, the credibility is a given with being a male…I think women still have to prove that they belong" (D14). Dr Stewart recalls going to a university event and sitting with a group of students and staff and having to tell them that she was the dean as "they automatically thought I [she] was the assistant dean, and I said, 'Oh you know I'm Dr Stewart and I'm the dean of the faculty of medicine' and they didn't think I was the dean dean…I think

they underestimated me" (S10). Another participant recounted an example of having to prove herself:

> after the event he came up to me and said, I had no idea you had those credentials. And I thought, if I was a male dean I bet there would have been no comment, it would have just been expected (S10).

These are just a few of the many examples that the deans provided that demonstrated being underestimated and having to constantly prove their credentials because they were women. Dr Stewart succinctly stated, "I think they underestimate you, you know, and I didn't get here for no reason" (S10). The women believed that this was due to societal expectations for women in general and gendered assumptions for women in leadership.

Some of the participants recalled blatantly sexist comments being thrown at them during their training while others such as Dr Steward experienced "more sexism as I got farther in my career" (S10). Dr Macdonald had many stories where sexism was both blatant as well as more subtle during her career in medicine. Some of the participants described sexist microaggressions (I10) as being more and more prevalent. Dr Macdonald explained that she was one of very few women in her medical school class as there was a quota for how many women they would accept. She joked that at least "there were no lines at the bathroom." Dr Macdonald recalled professors in medical school greeting the class by saying "good morning gentleman" and disregarding the women who were present, a commonplace during her medical school and internship experiences in the late 1950s. Later in her career, she shared that a male department chair who had interviewed and then subsequently hired both her and her husband to the same position said: "He actually said to my husband, you know we [you] both had equivalent criteria….If you're upset with your wife earning the same as you I can give you $500 a year

more” (M3). This was an example of blatant sexism in the form of the gender pay gap with an overtone of the Old Boys’ Club and gendered societal expectations for women.

Dr Isaac explained that in the mid 1970s she experienced and witnessed female learners being berated when preceptors would make sexist comments and “it was just considered a rite of passage” (I2). She went on to say that “it’s always like you know, you sort of pay your dues and move on, but it wasn’t alright then any more than it’s alright now” (I2). Another example of the blatant sexism that she experienced occurred “in 1983 in the middle of the ward…he [the preceptor] had actually called me a little girl” (I13). At the time “nobody came to my defence… We all just sort of pretended it didn’t happen” (I13). Finally, she explained that in those days “you were supposed to just suck it up and move on” (I13). Dr Carlson recalled a male preceptor who “did some awful stuff, told a sexist joke and made fun of a couple of [female] graduate students in a way that was just not acceptable at all, and I had to call him on it.” (C16) She identified that the sexism and societal expectations of gender roles continue to be present in the medical context and are particularly evident in the academic medicine environment.

Dr Stewart felt that the sexism was more evident when she gained more senior leadership positions because this pushed the gender expectations and gender boundaries for women. She said:

> When I was more junior, I’m sure it was happening, but I wasn’t aware of it but the more senior I got especially if I was on a committee of finance ’cause women tend not to be on those committees. Often times I was the only woman, and they would razz me and stuff and I would always stick up for, you know, being women and women needed to be involved in stuff. (S10)

The participants shared stories about pushing the boundaries of the gendered assumptions of women in leadership and the sexist environment in the upper ranks of academic medicine. They noted that the culture of medicine permitted sexism and promoted gendered assumptions for women via a hidden curriculum both in their past and current experience. Dr Marshall described the need to "navigate you know, the hidden curriculum of [the] faculty [of medicine] and the university" (M8). Dr Dawson described an experience of applying for a department chair position and not being hired when the current department chair ended up hiring someone more junior. She thought it was because "I tried to bring in EDI [Equity Diversity Inclusion] policy" to the university. "It was very uncomfortable, and I think it impacted my career because that's why I left. I did not become the next department chair; it was somebody way more junior than me" (D11). Dr Dawson pointed out to the department and department chair that "40% of the department or division were women and yet only 3 to 5% of the women actually had academic time" (D11). In pointing out this inequity, she was faced with a sexist backlash from the leadership both in person and via email. She said that the leadership "don't even understand your [their] own bias and to say that you're not biased because you have three daughters" was very hurtful. This event, she reported, negatively impacted her career, credibility, and professional identity. Ultimately, she ended up leaving that department and found a more welcoming and enlightened department with supportive leadership. The participants had similar experiences where there were strict gender expectations for behaviour. By speaking up and/or striving to leadership, they were defying these expectations and subsequently experienced negative consequences.

Dr Marshall recounted an experience that, "Over the years, I have had a handful of people treat me with great disrespect because I'm a woman and some of them have been fellow

CEOs of other national organizations that are partner organizations … and some of them have been [fellow] deans" (M8). The deans identified that sexism was present in their work environments, ranging from the local hospital environment to national organizations. There were challenging individuals that the participants had to work with while in their leadership position as dean. One woman recalled that her boss "was basically misogynistic and would treat pretty much all women that way but, in my case, it was challenging because I was the CEO" (M8). The participants described having to navigate both overt and subtle forms of sexism and the challenges associated with defying gender roles by being a woman in, or striving for, leadership. They also noted that they had to monitor or "police their tone" and ways of communicating because at times this could challenge gender norms and societal expectations for women.

The women deans provided examples of how they had to monitor their tone in how they communicated with others because of the societal and gender expectations for women and being a woman leader outwardly defies those gendered assumptions. Dr Marshall felt that she needed "to be able to support, influence and then implement decisions of the board" (M9) and she went on to explain that careful strategic language and tone is required. She said this was something she appreciated after years of experience being a leader at both the provincial and national levels. Another dean explained that she wanted to be able to get things done so she also had to be careful as she could be thought of as "highly aggressive when I [they] just had opinions" (V4). Dr Vincent noticed that male deans and leaders were seen as easy going and given the benefit of the doubt; however, when a woman used the same tone and actions they were seen as aggressive and unlikeable which would be counterproductive to getting things done. Another participant said:

> From what I've seen, credibility is a given with being a male is what I would say. I think women still have to prove that they belong, and I do think that the gendered communication style…women still have to tiptoe around how they communicate, not having a bitch face, not having the gender things that people will attribute to you as a woman…. (D14)

Dr Dawson described how if she wanted to make change or bring something up at a meeting she had to "figure out how the person across the table wants to hear that information and how best to connect with them" (D13) while being conscious not to "let your emotions change your communication" (D13). The deans described how sometimes women are seen as emotional or aggressive based simply on their tone of voice when sharing an opinion or making a statement. Dr Vincent recalled how a prior female dean was seen as harsh and unlikeable and when it came time for her to apply for a decanal position the selection committee said that "they didn't want another woman after *that* woman" (V4). She shared that:

> There was a lot of gender bias against her and of course the iconification of [the male dean who preceded me]…she was extremely amazing but just harsh, very harsh, and you know very angry, very impatient and again you know you would see this in men and it's fine, I mean the surgeon type men and for a female dean it really was fine, but she was harshly judged. (V4)

The participants all noted, in their experience, that leadership looks different on women than on men. They noted that it was sexism and the strict societal expectations of gender roles which contributed to that difference in how women and men leaders are perceived. Some of the participants outwardly stated that defying those societal expectations and gender roles had a significant impact on them during their journey to becoming dean, especially while in lower-

level leadership positions. Dr Vincent mused: “Kim Campbell, even Hillary Clinton… like why is it that that phenotype is seen to be very threatening? But a lot of leaders who are male will be seen as really easy to get along with.…There’s this perception of what leadership should be” (V5). She went on to say that male leaders are seen as reflecting the status quo.

Dr Jamison explained, “I think people view you differently, I had not only been the first woman dean here, but also coming from the outside you have to take your time and earn people’s trust” (J7). She went on to say that “a man, especially a man from the inside” (J7) would not have to work at earning trust, but rather would be given the benefit of the doubt. The deans also noticed that women were given more support tasks and thus, there were gendered dean roles for women deans versus male deans. Dr Dawson identified that women are given “extra-gendered work” (D14), and women have a different lived experience than male deans where they have to perform more support/administrative tasks. Dr Marshall succinctly elucidated that women have been given the more nurturing dean positions and “we call them baby deans, not big deans, but the baby deans, especially in the roles of undergrad, student affairs, in graduate studies etcetera, the nurturing roles” (M14).

In addition to women taking on the more “nurturing [dean] roles” (M14), some of the participants noticed men were being promoted ahead of them. One participant described a mentee of hers who had done a summer research project as a medical student eventually moved up the ranks of academic medicine “so that person is now my division head, my boss, [and] was originally my medical student” (I6). That participant went on to say that people ask her if she is upset that her student is now her boss. She usually answers that “it was one of the most rewarding things that has ever happened and the only thing [is that] he doesn’t like having to give me my annual performance review” (I6). This was the only participant who did not respond

negatively to noticing that her male peers as well as more junior males were promoted ahead of her. The rest of the participants noted that they were passed up for promotions at times and noticed that men who were more junior and less qualified were moved up the academic medicine hierarchy more efficiently than perhaps their own journey; therefore, demonstrating the power of the Old Boys' Club in action relegating women as outsiders.

*Being an Outsider*

The participants described feeling like an outsider in the context of academic medicine because they were one of very few women in leadership positions. They all described feeling isolated because they were often the only woman at the decision-making tables or were actively excluded from important committees and meetings. At times they felt that their voice was not heard.

The women deans identified the "Old Boys' Club as being ever present" in academic medicine and even more so within the upper ranks and decanal circles which was, in their experience, isolating. The participants who were dean deans, as opposed to associate/assistant/vice deans, noted that they were often the only woman sitting at decision making tables and this had been the case for many years during their academic medicine careers. Dr Marshall said that there is "loneliness at the top" (M9). Dr Vincent explained that it was a very tough environment for women because "there weren't that many women who were in these leadership positions" (V10). Participants used the term "outside" or "outsider" during their interviews when describing how they felt on their decanal journey and then while they were in that position. Dr Jamison said, "Not only being the first woman dean here, but also coming from the outside" (J7). Sometimes the sense of being an outsider was due to casually but intentionally, being excluded from important meetings or social gatherings while other times it was more

blatant; for example, one of the participants was told that she did not get the decanal leadership position that she applied for because she "was not the face of medicine [at this institution]". The participants identified that being one of very few women in the male dominated context of academic medicine perpetuated that sense of being an outsider and being isolated.

Dr Vincent said, "I mean I watch the male CEOs and male associate deans get together … and the women didn't do anything together" (V16). This exclusion also extended beyond the social settings to being excluded from certain important meetings and committees. For example, Dr Dawson said that meetings used to occur at supper time and thus it was very difficult for those who had young families to attend. She went on to say that there was no flexibility in moving the meetings to a different time that would enable her, and other people with young families, to attend. Dr Dawson elaborated on this point, "I would say that yah being left off those committees and not having those needs accommodated" (D11) was detrimental to her career trajectory and those of many other women while also isolating them.

Both Dr Marshall and Dr Jamison shared sentiments that were commonly held amongst the participants where "there aren't many women's voices around [the] table" (M10) and "certain voices were listened to more than others and if you were a woman and especially if you were a woman who was not of the sort of dominant inner circle, and you had ideas that were different you were marginalized" (J6). Being relegated to an outsider was experienced by all of the participants by virtue of being a woman and some of the participants expressed that race, sexual orientation, and other identities further exacerbated their experience of isolation in the upper ranks of academic medicine.

In summary, the third major theme that was elucidated from the data was sexism and the culture of academic medicine. The women acknowledged the presence of sexism at all levels

within academic medicine; therefore, it was their hope to become leaders in the field and improve the context of academic medicine. They hoped to become agents of change and improve the environment of academic medicine, and this partially motivated their journey to their decanal position.

**Woman Dean as Agent of Change**

The fourth major theme, woman dean as agent of change was comprised of four sub-themes including: leading change, helping others, speaking out, and picking your battles while having a thick skin. The women, as described above, were aware that they were one of very few women deans. They described wanting to lead change and remedy the sexist exclusionary culture of academic medicine. They hoped to improve the hostile environment for future learners, leaders, as well as patients. They believed that being an agent of change included leading that change, helping others have their voices heard, speaking out against sexism and discrimination, while also picking their battles. Dr Marshall, as well as the other participants, stated that in their experience, one must have “a thick skin” (M11) to be a woman leader in the male dominated field of academic medicine.

*Leading Change*

The participants described wanting to effect change and improve the culture of medicine. They felt that being in the leadership would allow them to make change and fix the system by sitting at the decision-making tables. They were altruistic and reported wanting to make a difference in the field of academic medicine as this would impact learners, thus the future of the profession and subsequently patient care. Dr Carlson said that she wanted to make change happen and “make things different in the world” (C7) and she realized as a learner and junior staff member that “there’ll be a time when I can make change” (C4). She and the other

participants described wanting to lead change and knew that one day when they were in the upper ranks of academic medicine, they would be able to make positive changes on a larger scale. Dr. Carlson summarized her desire to lead change, a sentiment shared by the participants, in that, “making change, but I wanted to make change at the level of a medical school and beyond [that] in medical education” (C12). Dr Jamison also shared a deep desire to lead change and have “a larger systemic impact on health” (J3). For her, leading change was a powerful way to effect change where she would:

> Recognize lots of systemic problems in health systems and realizing that you can get more done if you are working beyond the clinical interface with patients, that you have to actually look under the covers or look behind the curtain or whatever to figure out how the system works and get involved in changing it (J3)

It was her desire and “overarching goal to make the world healthier” (J4) and that began with making a strong and healthy workforce of physicians who better represented the people that they served, and this began with fixing the system and making the climate of medicine better. All of the participants stated that when they were in a leadership position, they “would have the opportunity to improve the learning environment for learners and teachers” (V5) and this would transfer to improved patient care which was the change that they strived for.

As they gained more senior leadership positions in academic medicine, the women were sitting at “the decision-making tables” (I7) which allowed them to have direct impact on changing the systems within which they worked. They realized that when they were in the upper ranks of leadership they could improve, change, and question the culture of academic medicine. Dr Marshall explained:

> I also realized that when I didn't like the way things were structured or the way things were happening, just complaining about it and standing up on a chair and yelling didn't actually do anything, that if I wanted to enact change, I actually had to be part of the change so hence taking on these progressively larger roles. (M3)

Dr Marshall explained, as she became more involved in the leadership of academic medicine, she recognized that sexism and a toxic environment existed within academic medicine. She, and the other participants, identified that this has a negative impact on learners, physicians, and their subsequent patients and this is what spurred the desire to "really just want to make things better in the environment… [and being dean] was the only way to make things happen." She went on to say, "You had to be the change right, so if you want things to be better you've got to help make things happen and the best way to ensure that is to really be leading it" (M4). The participants expressed that their "social justice consciousness" (C18) and recognition that if they improved academic medicine's culture this would improve the medical system overall and thus patient care. The deans noted that their goal was to help people including learners, physicians, and patients by making the medical education climate less toxic.

*Helping Others*

The deans identified themselves as agents of change and used their position in the leadership of academic medicine to encourage, elevate, and highlight the voices of individuals who were often marginalized. They expressed a desire to help others succeed and said that they did not require recognition themselves, but rather it was their role to support the team (physicians, learners, and academic staff), help develop other leaders, and this would ultimately result in helping patients. By encourage and helping women and marginalized groups who aspire to be leaders they would aim to hire strategically to increase diversity within academic medicine.

The women identified this as part of their responsibility as agents of change in an effort to improve the culture and environment within academic medicine. The women stated with increased diversity in their departments and leadership this would result in an improved more inclusive culture within medicine and improved patient care.

The participants would encourage others to step up for leadership positions and would then mentor them and help develop their leadership skills. The deans would also aim to hire with diversity in mind. Dr Jamison shared that she:

> Recognized how important it is to hear alternative perspective and to recognize that people who either don't fit in or aren't as well represented are often the most important voice to hear and I have tried very hard to elevate certain voices, find them a way to have a seat at the table in various capacities and also trying not to dismiss the ideas of people who have non-traditional views about how things are done. (J7)

She, as well as the other deans, identified that beyond "encouraging people to step up and putting their names in" (C7) for positions, mentoring them and supporting them as part of the leadership team was important in their success while also getting their voices heard at important decision-making tables.

Dr Marshall shared that she would help elevate women's voices at decision making tables by carefully positioning women closer to the chair because "there aren't very many women's voices around my table" (M10). This was a tactic also employed by the other deans in an effort to have more women's voices heard at important meetings. The deans described how they would put individuals who were "not usual leaders" (J4) in positions of leadership and support them to ensure their voices were heard. Dr Carlson said that she was always "looking for people who have leadership potential" (C7) and helped support them so that there could be "change in the

medical culture." All of the women expressed these sentiments and felt that it was their role as dean to help other women and marginalized groups have their voices heard and be present at decision making tables in an effort to be part of the change that they wished to see in the context of academic medicine.

In addition to helping other voices be heard, the women described how they wanted to help others succeed. Some of the participants shared that they did not need recognition for their efforts in helping others succeed while other participants expressed frustration about helping and making great efforts and not getting any recognition for those efforts. Dr Steward said that "leadership is about basking in the glow of other people's success…I don't need to have another research paper and I don't need to have-- do I still get on papers? Yes, but that's not my goal, it's really to empower people" (S11). Dr Dawson noted when she was in lower leadership positions "faced some sexism and gender issues right, in terms of often being asked to do things that other people would take credit for" (D11). She then expressed now while being in a decanal position she no longer "need[ed] that recognition, I don't need external recognition" (D13). She described something known as the Matilda Effect, where men will not acknowledge a woman's contribution and will take credit for their work. She shared an anecdote where her boss would take credit for her work when she was a junior attending physician, and this motivated her to avoid this same behaviour now that she is a dean.

*Speaking Out*

The deans described a component of being an agent of change is speaking out against sexism and discriminatory behaviour. They said that being in a leadership position enabled them to speak out against poor institutional culture, sexism, and have social accountability. Dr Carlson explained that in her experience she was:

> often the only woman in the room or you know there were one or two of us. And, so, one of the things I resolved though as I began to take on leadership positions was that I was interested in changing the system for those [who] would come next…it's an opportunity to have a pulpit. It's an opportunity to make change and that means speaking up about things that happen (C4).

They recognized that the higher they were in the leadership of academic medicine the easier it was to speak out when "things weren't right." Dr Isaac shared that due to her lived experience of sexism as a learner she learned "not to do this to others, to come to other people's defence in the moment if possible which I have always tried to do not always necessarily successfully but and it's a whole lot easier now, where I am now, speaking up and defending people, that it was then and it is easier for me [as dean] than for junior people to do this" (I13). The women expressed that not only did they try to lead change, elevated the voices of women and marginalized groups, and speak out against sexism and discrimination they also recognized that they needed to pick their battles if they were going to successfully make systemic and lasting change.

*Picking Your Battles*

Participants expressed a desire to be agents of change and remedy the sexist and exclusionary culture of academic medicine however they also recognized that they had to choose their battles to enact that change. They recognized this throughout their careers in medicine, beginning with their own experiences as learners. Dr Carlson recalled:

> I was one of seven, I think women in my [medical school] class of you know about 10% of our class was women…it was very much about fitting in and choosing your battles, choosing your battle grounds. I mean it was absolutely

> usual for professors to come in and say ‘gentleman’ you know at the beginning of a lecture (C3)

Dr Macdonald also shared that same experience. Both of those women explained that along their leadership journey they would pick their battles keeping in mind being an agent of change was their desire. Dr Carlson said once she became dean, she:

> Felt strongly, choose your battlegrounds. Some things matter more than others. Some things you can let go and some things you can’t, but when it came down to treatment of learners, a fair and just treatment of learners, that was a line that could not be crossed (C16).

Participants shared that in their experience, change within the culture of academic medicine occurred at a very slow nearly withering pace, but they were leading and making strides to improving the culture of medicine for future generations. To be agents of change they agreed that as Dr Marshall said, “you develop a really, really, really thick skin, you remind yourself why you’re there and learn to let stuff roll off and go around the problem” (M9) and pick your battles.

**Becoming a Dean and Getting the Job**

The fifth major theme of becoming a dean and getting the job was characterized by six sub-themes: the participants’ unique path to decanal leadership, no plan, credentials, leadership track record, research, and applying for positions. All of the participants stated that they had a unique path to decanal leadership; however, the paths turned out to be very similar once the data were analyzed. They all shared that they had an atypical journey to decanal leadership and felt that they were an unusual candidate. The participants described having no plan and their position was a serendipitous event; however, they all had similar credentials, leadership track records,

research involvement, and applied for positions; therefore, demonstrating some element of planning and effort.

*Participants' Unique Path to Leadership*

While participants saw themselves as having an atypical journey to decanal leadership, the data demonstrated that they had very similar paths to one another. The participants had a lack of awareness that they indeed did have similar, and thus perhaps typical, paths for women scaling the hierarchy of academic medicine. The women as mentioned above were isolated in the upper ranks, had no one else to compare their experiences to beyond male decanal paths, and were one of very few women to gain a decanal position so this was their lived experience- a unique path. Dr Vincent spoke about two ways to gain a senior leadership position:

> One is there's a structured way with mentorship and planning your career from assistant to associate to vice to dean or chair of department to CEO whatever, there are ways to do it and you certainly need to take those steps to get experience. You can't leapfrog… but the second route is what I call the carpe diem route which is you have to be able to take opportunities, the risks and at the same time be true to yourself. (V12)

Dr Marshall aptly explained that:

> The biggest barrier for a woman to become a big dean right now is that the most common job to have before being a dean is department chair, and the department chair role is usually a role that is given to someone who has success in research and in health research. The numbers of women that are assistant professors moving up the rank to professor and the number of female department chairs in Canada right now is still way

below the number of males, and there are a lot of women who are, we call them baby deans. (M14)

These two participants described what they have seen as the usual path to decanal leadership; however, they also identified that the majority of deans are men. This path may not be representative of all women aspiring to be dean yet all of participants have held leadership positions within academic medicine on their journey to becoming a dean.

The participants described themselves as unusual non-traditional leaders. They also shared that they did not think they would be selected for the dean position and felt unique for that reason. The participants expressed that they had an unusual path to their dean positions due to many reasons but firstly, because they engaged in activities outside of academic medicine such as fellowships, overseas work, political work, legal work, and financial work. Interestingly, all of the women had engaged in activities and jobs outside of their work as physicians. Not all of the participants started their careers at tertiary care centres, yet all except for one had experience working in rural, remote, or overseas communities at one point in time in addition to their experience working outside of the medical context. Dr Marshall even said, “My path is a very different path from most and I was able to get promoted under the medical education track with minimal number of publications, but I really stretched the description of scholarship” (M12). She went on to say that it took 13 years for her to apply for associate professor because “it wasn’t on my radar” (M12). She explained that one has to demonstrate engagement at a national level and engagement in scholarship. Interestingly, she did engage in both of those activities, but did not acknowledge that engagement prior to being encouraged to apply for promotion. She also shared that “you can’t be dean if you’re not a full professor” (M12). Dr Jamison said, “I had a very weird, atypical journey to becoming dean, I would say” (J2). She went on to explain that she

worked heavily in medical education, worked nationally and internationally, participated in politics, created a residency program, and yet did not recognize that all of these activities facilitated her acquiring her decanal leadership position. The experience that she shared was very similar to the other participants.

The women spoke about climbing "the leadership ladder" as being the usual path to decanal leadership. They felt that they had a unique path to their position as dean and after analysing the qualitative data it was evident that they did not recognize that they did indeed climb a similar leadership ladder to one another. Dr Jamison said that she did not "climb the ladder through the decanal roles, but I was an associate professor" (J4). A probing question asking her to elaborate further on what she meant by "climbing the ladder" elicited this reply:

> there were people who had spent their entire careers like figuring out how to become dean and had climbed the sort of leadership ladder, had been – I was department head of a small department at a community academic hospital but there were people who had been, you know department heads at large academic hospitals and had roles as associate and vice deans and I think they are people who sort of…built their careers around it (J4).

Dr Jamison, like the other participants, did not recognize that she held sequentially larger and more illustrious leadership positions all while building up her credentials. The participants saw themselves as an atypical choice for leader or an unusual candidate for decanal leadership. Some of the participants even described not seeing themselves as leaders nor academics early on in their careers; yet, they held both leadership positions and engaged in academic research, service, and teaching. This resulted in the participants saying that they did not think they would be selected for their decanal leadership position because of their self-proclaimed atypical path and suspicion they were an unusual candidate for leadership. Dr Dawson said, "I think being chair of

a department or head of the department was about as high as I thought I wanted to be" (D8). Dr Vincent explained that she was "chosen [for her dean position] over some of the incumbents who would have been the right guys to choose. They had paid their dues" (V3) by climbing the academic leadership ladder. Again, Dr Vincent and Dr Dawson did not appreciate that they had held department head and/or program director positions as well as lower level decanal roles. Dr Vincent went on to say that she had no plan, but rather her leadership journey that ended up in a dean position was one of "happenstance" (V3). This was a sentiment shared by most of the participants in that they apparently did not have a plan to become dean.

*No Plan*

Dr Vincent frequently used the term "happenstance" (V3) to describe her journey to decanal leadership. Furthermore, she said she "had had a mediocre rise from being program director then being post grad dean" (V3). Dr Dawson said her "career path was very crissy-crossy and I don't know that it was deliberate" (D12). A similar sentiment was shared by Dr Isaac who described her career as "completely unintentional" (I12). Dr Stewart said, "I never planned my career" (S5). It was interesting that participants described having no plan, yet it was clear that they all participated in activities that enabled their career advancement. Some of the participants said that they did not think about being dean while others said that they got to be dean "because I didn't care about being dean, I didn't choose to be a dean because of the position. I chose to be a dean because it would give me access to fix things, systems, and make the world healthier." (J10) Dr Jamison said:

> I have not focused on building up my portfolio or a CV, I mean I have enough of a CV that I was able to get promoted but I didn't ever care what my H-index was for example. I cared about whether my work was making people healthier and

> making our health systems better and so building an academic portfolio was never my goal. It happened because I was doing other things. (J8)

All of the participants described, as explained in the prior major theme, that they had hoped to be agents of change and sought decanal leadership to be able to lead that change. However, gaining leadership positions such as a deanship must have required some forethought, at some point in time, as Dr Jamison shared, she had “enough of a CV to get promoted” (J8). This demonstrates some planning and effort which was a sentiment expressed in a similar manner by many of the other participants who said that they had no career plan.

One of the deans explained that she truly wanted to be dean but was not selected for a decanal position that she applied to because she “played it too cool” she “did not want to be seen as being the tall poppy and so I was not selected, I was second” (C12). This participant seemed to describe a fine line between wanting the position too badly and playing it too cool. Based on the responses of the other participants perhaps they were downplaying their career planning during the phenomenological interview because they shared a vast amount of accrued credentials and accolades that they had acquired on their leadership journey which contributed to their rise to leadership.

*Credentials*

The participants had similar credentials upon applying to their decanal positions and shared these during their phenomenological interview. Specifically, they expressed the importance of taking leadership courses, medical education courses, learning about finances, having an advanced degree or a fellowship, attending promotions workshops, and having a strong H-index. The women deans shared that credentials are important in acquiring a decanal

position where women must prove themselves and gain credibility through formal credentials. For example, Dr Marshall recommended that individuals interested in being dean:

> Consider what letters they may want to have behind their name, so what credentials they believe might be helpful in attaining their goals…getting a master's or let alone a PhD. There is a lot of credibility given to that. You need to have a strong academic dossier, so that means publications, dissemination of knowledge…connect with like-minded individuals…, I would recommend taking leadership courses as appropriate for level. (M11)

The participants recommended taking leadership courses or workshops if one is aspiring to decanal leadership. They all attended a leadership course at one point or another throughout their careers. The most popular and helpful leadership course that the participants attended was called ELAM, which is a program hosted by Drexel University in Philadelphia. This course taught the deans how to see themselves as deans, make goals, achieve the position of dean, as well as be successful in the role of dean. The next most common course that the participants took was the CCPE (Canadian Certified Physician Executive Credential). This is a program aimed at recognizing and advancing physician leadership via the LEADS in a caring environment framework. The third most common leadership courses were put on by AAMC (Association of American Medical Colleges – Dean School). Other than leadership courses, the participants expressed the importance of taking medical education courses on their journey to being a dean. Some of the participants stated that they did not take medical education courses until later in their careers, but all have either attended a workshop or lecture on medical education.

Another important skill that the participants identified was having a good grasp of finances as being dean requires knowledge of how to read a spreadsheet, engage in fundraising,

and balance and allocate a budget. Financial literacy stood out as helpful on their journey to becoming dean. Some of the participants learned about finances from their experience at ELAM while others learned experientially while engaging in jobs and community activities outside of medicine, while others said they read about finances to educate themselves.

The participants either had a fellowship or an advanced degree and felt that this was an important credential to have on their journey to becoming a dean. The participants had degrees ranging from a Master of Public Health to a law degree. Beyond having an advanced degree outside of medicine, the women also had a subspeciality or special focus areas, whether they were family physicians or specialists. They all had an area of medicine with further fellowship training such endocrinology, pediatric emergency medicine, infectious disease, or tropical medicine. There was agreement that advanced degrees and further training is something that future women leaders should consider if they want to become dean as this was something important on their own journey. Dr Marshall, among many of the participants, specifically stated that at least a master's degree is something that is recommended to demonstrated advanced scholarship and research capabilities. The participants also recommended attending either a promotions workshop or academic advancement workshop/course as this was something that all but Dr Macdonald did. She was markedly older than the other participants and likely this was not part of the academic milieu in her time. She did say that later on in her career she attended educational workshops on medical education, but that this was new in the field of medicine as she was nearing the end of her tenure as dean.

Dr Stewart specifically expressed the significance of having an H-index as a potentially important credential. An H-index is a quantitative value ascribed to an author to demonstrate

their scholarly output and research impact. All of the participants engaged in research activities on the journey to their decanal position.

*Participation in Research*

Participating in research was viewed by the participants as crucial to their leadership journey. Some of the women began their engagement with research prior to medical school while others began participating in research during their medical education and residency. All of the women had a track record of publications, presentation, and scholarly activities with the goal of advancing their research program. Some of the participants shared that they were not encouraged to pursue research early on in their medical education. Others such as Dr Dawson stated that she saw the importance of research on her academic medicine journey and thus took a master's degree in clinical epidemiology. She said to be dean you needed to be "very academic and a solid clinician" (D4). The deans enjoyed being able to create knowledge and advance the science of medicine to help people be healthier.

Dr Isaac explained that her mentor encouraged her to engage in research and impressed on her that it was an important component to pursuing any academic medicine leadership position. This research mentor "encouraged the research component of my career, helped me see how I was going to integrate the clinical piece with the research piece even before the leadership piece was there, and again was extremely supportive" (I5). She was encouraged to always maintain a research program. A few of the participants also identified themselves as researchers while others participated in research and continued to do so as dean. For example, Dr Carlson explained,

> I was also a researcher; I mean I'd done biochemistry and I've done bench research. I've done research projects because I wanted to in medical school. I had an interest in asking

> questions…there was very little that was practice based research in the 1970s and it was only as some of us became engaged as practice-based researchers. (C7)

Some of the women participated in national level research committees, for example Dr Carlson said that she was "involved in the National Research Committee… and then I became chair of that committee" (C10). The participants had a research track record during their careers, and they also encouraged future women aspiring to become dean to engage in research activities. Dr Carlson recommended "that people who aspire to be leaders do graduate training … they do at least a masters, do a master's in public health…they do things that are going to give them the ticket that they need, not only the actual education." (C21)

*Leadership Track Record*

In addition to a research track record, the participants demonstrated what Dr Carlson called a "leadership track record." Prior to becoming dean, the women began with lower-level leadership positions and then sequentially gained more significant leadership roles both within and outside of the context of academic medicine. She candidly explained her experience by saying:

> I mean if you want to be dean you do need to have a research track record and figure out how that is going to look and how you're going to do it. I mean most people will know about an educational [track] record and a practice [track] record, but you need a leadership track [record] (C21).

The women held many different leadership roles throughout their careers, including: medical student leadership, residency program director, training program creator/director, department head/chair, as well as leadership in national and international organizations. These leadership

roles spanned their careers beginning prior to medical school and then continued throughout their academic medical careers culminating in their decanal role. The participants documented their leadership track record within their CVs and portfolios.

Dr Carlson, Dr Vincent, and Dr MacDonald shared that they were leaders from childhood onwards and this was a sentiment shared by the other participants as well. For example, Dr Steward shared:

> My leadership journey actually began in my childhood, in my adolescence. I was involved in youth groups, I took on leadership positions. I really did learn you know, I learned to run a meeting when I was 15, I mean you know, and I think it's relevant.

This was just one of many examples where the participants began their leadership journey in their youth and recognized that they developed leadership skills early on. Beyond that, the women discussed the leadership roles that they had early in their careers; for example, Dr Steward remembered that "the first sort of leadership role I took on in medical school was actually leading a mentorship program" (S2). The women moved from leadership roles in their youth in non-medical domains to roles within the hierarchy of academic medicine.

The participants took the initiative to create either a training site or a residency program. These ranged from medical research programs to family medicine and specialist residency programs. The women also shared that they created community health programs; for example, both Dr Macdonald and Dr Carlson created the first sexual assault centre/sexual health programs in their respective provinces. Both of them recognized in their early medical careers they were considered "radicals…and I mean by radicals you're not radical, but it all depends on the company you're keeping and in the late 60s, early 70s— again, I mean the counter-culture doctors were largely family practice doctors." It was a common finding amongst the participants

that they not only created a residency program, but subsequently became a residency or training site director.

Dr Macdonald and Dr Marshall explained that they both enjoyed teaching and thus moved from creating programs and training sites to being program directors. Dr Marshall said that she:

> Eventually moved on to bigger roles such as being the program director and had to actually set up the residency program [in my area] …. and did the whole accreditation and then the whole application for programs so that was success, and then moved into, was offered and moved into the clerkship director role…then subsequently the role of undergraduate dean. (M3).

Dr Marshall's experience was similar to that of the other deans who shared their journey through the hierarchy of academic medicine involved them "taking on progressively larger roles" (M3).

Some of the women went from being program directors to department chair or division head and then assumed lower level decanal positions, whereas others held department chair positions and then were residency program directors and then advanced to their decanal roles. Some of the women, for example Dr Dawson, held "several terms as a research director for residency and then went on to become associate program director" (D5) and then took on department chair positions prior to becoming a dean. The women held similar leadership positions and performed similar leadership tasks within academic medicine prior to becoming dean.

Dr Marshall and Dr Vincent both explained that the department chair role commonly leads to the dean's level; this seemed to be a common finding where the participants held either a department head, division head, or department chair positions and then moved to a lower-level

decanal position. For example, Dr Isaac held the department chair/the division head role prior to her current decanal position. She enjoyed being division head because it allowed her to look after the people in her division and help advance not only her leadership skills but the career trajectories for junior people in her department (I6). The participants also engaged in the leadership of their specialty's national and international organizations as well as the AAMC and AFMC.

Dr Stewart noted that she engaged in her speciality's national and international organizations so that she could advocate for programs and funding. She represented her profession at the AAMC (American Association of Medical Colleges) and AFMC (Association of Faculties of Medicine of Canada) which further allowed her to advocate for support for her program and profession. Once they had participated in these organizations and held department chair, they either moved to lower-level dean positions or dean.

Dr Dawson said in getting her vice dean position, that she "had done minor leadership roles [previously] so this to me was jumping up four ranks in the food chain. So, I was pretty pleasantly surprised when I got offered the job" (D7). She also has been the acting dean at her university and recognized that the lower level decanal positions and prior leadership experiences have helped prepare her to step up into this role. She did acknowledge that she "has never worked harder than what I'm working right now, and I think I've worked pretty hard in my previous career" (D8) leadership roles. The women shared common leadership roles along their career paths. They also said that it was important for future generations of women aspiring to leadership to develop a leadership track record and document it in their CV while also developing a portfolio. In their experience, this was helpful when they applied for leadership positions and academic promotion.

*Applying for Positions*

The participants applied for promotion, as well as for their decanal leadership positions, with the support of a robust CV with educational, research, and leadership track records on display as well as impressive credentials, advanced degrees, and the associated life and work experiences outside of medicine. Often, they were recruited by a search firm, hired by a selection committee, and/or hired based on their credentials, reputation, references, and sponsors. The women stated that they had to apply for promotion to scale the hierarchy of academic medicine. To be dean at most universities they said that they were required to be a full professor and thus actively seeking promotion was an important feature to their career advancement. The sage advice provided by the participants was to apply for leadership positions and apply for promotion because this is an important step in gaining access to the leadership of academic medicine. Many expressed that they wished they had applied sooner for promotion in their careers.

Dr Dawson, like many of the participants, recognized that they “I was [were] the first woman full professor in the department” (D4). There were very few full professors in their departments, but this was an important step in the decanal journey as one must be a full professor at most universities to become dean. This was not entirely necessary to be vice or associate or assistant dean, but it was an important factor in getting a dean position. The women shared that although it was a great deal of work to gather the necessary materials to apply for promotion, it was necessary as without it, they would not be considered for a decanal position. Only two of the eight participants described their maternity leave and having children as having a negative impact on their applications for professional advancement. Specifically, they explained that this may have delayed their career advancement by approximately five years in comparison to their

peers (D12). In addition to applying for academic promotion the participants expressed the importance of applying for leadership and decanal positions as they arise.

Dr Dawson articulated a common sentiment amongst the participants in that it is important to apply for leadership positions. She said:

> The other thing though that I will say is that one of the lessons that I've learned was don't wait to be invited. How many times will I tell you in my career that a job has come up and I've not put my name forward thinking that I'm not qualified enough because I think we as women, what I've learned is that we think we need to be 101% confident that we can do the job whereas a man only needs to be 30% confident and he will put his name forward. So how many times I've not done a role or not looked for a job or not put my name forward and somebody less qualified than I have gotten the job, and that burns I can tell you especially when they then become your boss (D16)

Dr Carlson shared a similar sentiment and added that it is important not to "play it too cool" when applying for positions because she missed out on an opportunity because she did just that and regretted it. The deans all described a point in time when they failed to get a position that they applied for but they either reapplied or moved on to another institution to get their desired leadership position. The take-home point that was shared among the participants via their lived experience is to apply and reapply for those leadership positions. Dr Dawson admitted that:

> You have to sometimes do things that women we don't always want to engage in. Like I don't like conflict but sometimes you have to lean in and address it or put yourself forward in a role that you're not competent in and you know…you learn about failing, failing fast. (D16)

From her experience, women take it very personally when they do not get a position whereas men are able to let it go and say, “Water off a duck’s back, eh I didn’t get the job” (D17) and then move on to the next opportunity.

In summary, the fifth major theme of becoming a dean and getting the job was characterized by six sub-themes: the participants’ unique path to decanal leadership, no plan, credentials, research, leadership track record, and applying for positions. They shared a similar career path on their journey to decanal leadership. The women identified that it was important to create an education, research, and leadership track record and document it in an academic curriculum vitae as without this, decanal positions were off limits.

**Success on The Job**

The sixth and final major theme identified from the data was success on the job. This success was important to them once they attained the position, and it went well beyond the technicalities of their work. The sub-themes in this final major theme included: learning on the job, prepare for meetings, gain trust and galvanize enthusiasm, goals, and imposter syndrome.

*Learning on the Job*

Learning on the job was a key feature in the lived experience of being a dean according to the participants. The participants explained that they were successful because they learned the specifics of their job as well as how to manage challenges and conflict while also engaging with politics, finance, and strategic planning. The women learned on the job by experiential means, listening, watching, trial and error, asking questions, and engaging with other deans and leaders. They also shared that learning from failure was important. Some of the most challenging aspects of their job as dean included disciplining people, firing people, and managing bad behaviour and

conflict. The women said that a great deal of their job included the management of people and therefore learning to communicate well was integral to their success.

Learning on the job, learning as you go, and experiential learning were all terms used by the participants as they expressed the importance of learning to their success functioning as dean. The participants learned on the job about the interplay of politics, finance, and strategic planning all of which enabled them to be successful in their position. Dr Carlson said that "I was more boot strapped than formally trained" (C2) when she shared her experience. She and Dr Macdonald began their decanal journeys prior to the initiation of the ELAM course and felt that experiential learning, or so called "boot strapped" approach was one of their main methods of developing their decanal leadership skills. There was a fair amount of learning "as you go" that was required for being a success as a dean. They said being able to identify what the "organization needed and then being able to plan for that" was imperative to success. Dr Stewart shared that her experiential learning occurred when she "worked up into the leadership…[because] it was really helpful for me 'cause I learned a lot about leadership and how organizations work" (S3). The women also identified that they learned by listening, watching, asking questions, and from other deans. One of the participants said to be successful as dean "you do a lot of listening, a lot of questions, question asking" (C13). Another participant said that she learned "sort of [by] watching and learning by experiment [of] what works and doesn't work just having [to] kind of learning some basic core people management principles" (J7). The participants also described learning from failure. Dr Vincent said, "Failure is a big part of being successful" (V13). Drs Dawson and Macdonald also learned from failure while on the job. Dr Dawson said, "Failure is going to happen, and I can tell you all of the leadership stuff that you learn about failing, failing fast, and all of this stuff about picking yourself up and

learning, when the rubber hits the road it's a hard position to be in" (D16). She shared that learning from failure was integral to success yet at times emotionally challenging. This was echoed in Dr Vincent's statement, "I would say you know success after multiple failures" (V12).

The women learned via the means described above how to mitigate the challenges of their decanal roles, specifically how to manage disciplining people, firing people, and managing bad behaviour and conflict. These were described as the most challenging aspects of being a dean that the women had to learn to manage. Dr Vincent and Dr Carlson's statements echoed that of the other deans, where "the hardest thing for me was disciplining people whom I respected who'd been wonderful in many ways but who had crossed the line in terms of codes of conduct, particularly with learners" (C15). Dr Vincent said that firing people was one of the most challenging aspects of her job. She explained, "I hate doing it, I hate it…" (V15). Dr Marshall said that it was particularly challenging "to manage bad behaviour, not on email. You go and sit in the office and you speak to the professor and you… do conflict management" (M7). Dr Isaac said that, at first, she did not realize that a great deal of her job was people management and was thankful that she learned both on the job and via listening, watching, and from other deans "how to deal with difficult people and this is not a lesson that I haven't had to relearn and relearn" (I9). When asked how she would deal with difficult people and conflict she shared:

> You have to just sit down with people and talk to them, you can't avoid it and you can't let people behave in ways they shouldn't behave…you have to sit them down and you have to draw a box around their behaviour, and you have to name it. (I9)

Dr Isaac went on to say that "these leadership positions [being dean], you know, 90% of the job is dealing with people" (I9). Dr Isaac shared that success came from being good at dealing with

and communicating with people and she, like the other participants, learned that skill for the most part on the job.

To be dean one must understand politics, finance, and how complex systems work as well as strategic planning. The participants learned about these important factors via the methods described above. In general, physicians do not learn about politics, finance, and strategic planning thus the women needed to learn these skills on the job for the most part. The women expressed the importance of understanding politics and Dr Dawson succinctly said, "being politically savvy is critical to these roles [as dean]. I think [you] ignore politics at your own peril" (D14). The women shared that they learned on the job that being involved and connected to federal and provincial politics was important for successful advocacy work and running their organizations. Some of the women spoke about meeting with the health minister and provincial minsters as a routine part of their job as dean. Another unique feature of being a successful dean was having a good grasp of finance and fundraising.

It was evident that "to be a dean you've got to be able to read a spreadsheet and those financial statements" (M13). Dr Carlson said, "Fundraising…is one of the things you have to be prepared to do" (C22). These are two skills that are not routinely taught to, nor managed by physicians unless they are dean. Managing university and department finances and creating budgets are key features of this leadership role and it is not taught in medical school, so the participants had to learn these skills to be successful in their role. One of the deans described the complex process of having to bring her university to financial stability (V7), but eventually she was successful in remedying the financial challenges. Dr Jamison said that she:

> Gained a lot of experience in fundraising (J10) [but also] learned how to read a spreadsheet…always coming to the table with good questions about the spreadsheets

> which made my finance people in my office be on their toes because they knew I was not going to skim over the spreadsheets…I would agree and so I consider myself self-educated in financial statements but this is an area that is important in leadership that a lot of women and men haven't had much experience in. (J10)

In addition to learning about finances, the deans said understanding strategic planning and complex systems was important to being successful in their position. Dr Steward described herself as a "systems thinker and not all people in our field are systems thinkers, right so I can kind of see across different places where they connect and intersect and be able to work within them and /I think that's one thing" that is important to be successful (S11). Dr Carlson shared that "you have to understand complex systems. You must understand that the health care and medical education, health professional education is a complex system, and small things make major changes sometimes" (C19). The deans learned how to manage complex systems and appreciated the impact that finances had on the systems within which they worked. Learning and being excellent at managing strategic planning activities such as managing accreditation, promotions, quality improvement, and succession planning was also mentioned by the deans.

Drs Stewart and Isaac both described how they had been involved in creating two new medical schools and the learning that was required to navigate accreditation occurred on the job most of the time. For example, Dr Stewart said, "We just finished our undergrad accreditation, and we have a very, what I'm proud of- we have a strategic plan called destination excellence, and we actually live our strategic plan" (S7). Dr Carlson said that she learned about strategic planning and succession planning "as much by my experience as I did from mentors" (C6). She said that she "became a systems person before I actually even understood systems or systems thinking" (C6). This helped enable her success as a dean. All of the participants developed their

abilities as system thinkers while on the job. Dr Isaac shared that in her decanal role she helps faculty with promotions which was something that she enjoyed but learned while being in the role. Other skills that the women spoke about were striving for innovation and quality improvement initiatives. Dr Vincent said that as dean she had the "great joy of being able to do really fun stuff and innovate and create" (V7) as well as focus on quality improvement. Being able to learn new skills has been imperative in their success as dean, and much of that learning occurs on the job. Although taking leadership courses was important, experiential learning while in their decanal role helped them to continue to evolve their skills to meet the demands of the job.

*Prepare for Meetings*

A major part of being a successful dean is to ensure you are prepared for and can run an efficient meeting while also ensuring everyone's voices are heard. The participants identified that most people do not prepare for meetings and that is not a means to be successful. Dr Stewart explained that she would read the prior meeting minutes, current meeting agenda, and then engage in conversations with other members of the leadership team in advance of the meeting. Some of the women also described practicing how they would lead the meeting and striving to be very organized in their delivery. Dr Isaac remembered how she "used to practice in front of a mirror before I would have a meeting with this person so I could, you know, I thought that I could get through a meeting, but you know, it's no different than any other skill you just need to practice, practice, practice" (I9). Being able to chair meetings in an efficient and organized manner while also ensuring that people's voices were heard around the table was also an important key to success.

Dr Jamison said that being "inclusive for people to be heard but sort of manage[ing] the meeting" (J5) was something that she felt was integral to being a successful dean and getting things done. She also shared that being skilled at chairing a meeting meant being:

> Engaged, organized, have a good agenda, stick to the agenda, make sure lots of voices get to weigh in but then kind of eventually said [say], okay, I'm going to take four more interventions and then we are going to close the discussion so we can… sort of had that everybody had a chance to weigh in. (J5)

The challenge was to not let the discussion get out of control. The women also described part of preparing for meetings could also include meeting with other attendees prior to the scheduled meeting in an effort to gain support for a certain plan of action or gauge their interest. Earlier on, in their leadership journey, the women described having a "meeting before the meeting" to gain support as described in the aforementioned theme, building a support team. That was described as a means to network strategically. This was less so a feature of their experience when they gained their position as dean.

*Gain Trust and Galvanize Enthusiasm*

A feature of their success on the job was building trust by listening, communicating well, and paying attention to the members of their team; while also galvanizing enthusiasm to motivate and engage the team. The participants described that, in their experience, it was important to be engaged, approachable, available, visible, kind, and brave. It was also significant to "actually practice medicine."

Dr Carlson said that she realized early on when she took her position as dean that she "had to convince them that I was smart enough and experienced enough to do this job" (C14). She said building trust resulted in people's openness to "joining with me and realizing that I

meant it when I said I value you for what you know, and I'll listen to you for what you know" (C15). When trust was built among the people, she worked with including physicians, learners, and administrators, they were able to get things done. The deans who were family physicians noted that, at times, it was more difficult to gain people's trust and buy-in as they felt that certain people valued specialists more so than family physicians. One such example shared by Dr Vincent, occurred while being part of accreditation for a program where she recalled that "I spent half the time convincing, you know, if I was doing an accreditation site survey of obstetrics and gynecology at University X, I'd spent all my time telling the department I was meeting with that I knew what the hell I was doing" (V4). As dean, she said, you have to gain trust by "being honest, transparent and compassionate" (V8), brave (C18), and kind (C15). She went on to say that "invariably as dean you will be the confidante for every possible problem that everybody has" (V8) and so this happens when you gain the trust of your team. Yet, if the people you worked with felt supported and trusted their dean then they were more effective as a team.

The participants recognized that engaging and motivating people and getting buy in was important to successfully getting things done and thus being successful in their position. Dr Dawson commented:

> You'll have a bunch of people that have their own individual needs, but what you have to do is convey what is the organizational need and how you get people to move beyond their individual needs to meet the organizational needs and how do you do that, is obviously clear strategy. You need to tell them where you want to go, how we're going to do it, what and how important they are, the critical skill sets that they bring to it and if they are able to contribute to that, then the greater the work environment will be. (D16)

By earning trust, the participants were able to engage people and get projects done. Dr Jamison said that it takes time to "earn people's trust" (J7) and once the department or team trusts their dean then "people accept that you're there in the best interest of the organization and its beneficiaries and not for yourself" (J7).

Drawing on her own two decades of leadership experience, Dr Marshall shared that "people fear change" (M6) and navigating that fear meant gaining people's buy-in to get projects done. To gain trust and buy-in she "visited every single department meeting at least twice a year" (M6) which demonstrated that she was engaged, listening, paying attention, and communicating with faculty. By being visible, approachable, and kind the participants were able to gain the respect and trust of those who they worked with. Many of the women used the term "open door policy" (V14) when describing how they made themselves available and approachable. Dr Vincent said:

> That you have to make yourself accessible to people, and if you think you're so important that the learners and faculty and your staff can't access you— and there are times where there's too much of it but generally if it's really important and my staff here now know how to triage those issues, you have to make time for those issues and it was really important. (V14)

Dr Isaac also described the importance of having "a truly open-door policy where honestly anybody could phone you up, email, come to talk to you; you should never be too busy to do that. You need to make time. As I said, 90% of this job is people and you need to make time for people to come and talk" (I11). By being visible, approachable, and available (J5) and dealing with people directly, the deans ensured their departments and teams felt heard which enabled

them to successfully move forward with projects. This approach to people helped galvanize enthusiasm and motivate people.

According to Dr Jamison, being successful at galvanizing enthusiasm as dean meant "building trust, understanding your overall purpose, understanding your priorities and values and communicating those well, looking out for the broad interest of the institution but also the people who benefit from the work of the institution." (J8). Dr Jamison was pleased to say that:

> I have developed the ability to build a collective vision and get broad buy-in to that and galvanize enthusiasm around the larger vision.…I have a reasonable track record of trying to actually deliver on things that I say and we're going to do, so that people trust that you really—when you say you're going to do something that you actually follow through on them. (J8)

Dr Jamison recognized that she has "learned to build trust through listening to people, paying attention to people in the entire organization not just the powerful people" (J8). Keeping in touch with people at all levels of the organization was important to the participants. Dr Macdonald and Dr Carlson also noted that they continued to practice medicine while being a dean, rather than strictly doing administrative work, as a means to maintain trust and connection with people. Dr Carlson said that she sought locums in rural communities while holding her position as dean because "I didn't want to lose touch with who I was and what I did, and I also wanted to demonstrate that it [practice and patients] mattered and that I valued it" (C21). Finding solutions to problems (J5), being brave (C18), being kind (V8, D5), and collaborating (S11) with others were features described by the participants as helpful in stimulating enthusiasm further enabling the women's success in their role as dean.

*Goals*

Having a vision and creating goals both personal career wise and institutional was outlined as important to the participants. They explained that vision was “a long view” for their organization; whereas, they described goals as either personal career goals or institutional goals. Dr Marshall said that as dean:

> You need to be a visionary and be able to work well with the community that you’re responsible for, listen well and be able to, again by working together help move people along the vision that everyone has agreed to. So, it's being able to look towards a better future whatever that is and to help bring everybody along towards it. (M11)

Dr Marshall spoke about the importance of not only having a vision but also helping people see their role in the organization’s vision. The deans agreed to be successful in their role “fundamentally, you have to be vision-driven and principle-driven” (C15) and thus knowing what your vision for the future of the organization was essential. Dr Carlson recalled that she learned this important concept when she was department chair and had extrapolated this concept to her decanal leadership career as well as her work mentoring other leaders. She was asked by a dean:

> What’s your vision for your department and I said, well, I’ve got this 5-year vision. Oh, he said, I don’t mean 5 years. I mean your view for your department, where do you expect to be in 20 years…we should be thinking about long after we’re going to be the leader, what’s it going to look like, have that long view and planning. (C6)

Having clarity of vision and creating goals to move in the direction of that desired vision was described by the participants as “very critical to these roles” (D14) and a salient feature of their experience as dean.

Although the dean's role requites setting goals for the organization and themselves, some of the women said they did not set personal goals until they were prompted by mentors or the ELAM course. Dr Stewart said, "I think setting goals. I mean women, I don't think—I think it's probably changed more now, but in my era, as I said, I didn't have any goals of being dean. Men, of course, they often have those goals" (S12). She went on to say that women must be strategic in setting goals. Most of the deans said that they developed their goals over the duration of their career as dean. Dr Stewart said that her mentor Dr Carlson told her "to think big" (S5). Between her mentor and ELAM, she was encouraged to create personal goals of "what did you want to do in 5 years and what did you want to do in 10 years" (S5). She aimed to be chair of her department or associate dean and then dean someday and then she set out to achieve these goals. Dr Stewart, along with the other deans, said that they developed personal career goals as described above although, at points during the interview said, "I never planned my career, I never set goals" (S5) until they attended ELAM or were encouraged by their mentors as mentioned above.

Beyond personal goals, the deans said that their overall goal as deans "was certainly to learn what needed to be done and then do it, but I certainly wanted to ensure that medical education was actually training people to be the doctors that we needed for the community, as trite as that may sound" (C13). Another dean shared a similar sentiment: "I have the large overarching goal in terms of using your position to make the world healthier as sort of a life overarching goal" (J5).

*Imposter Syndrome*

One final feature of being a successful dean meant overcoming the imposter syndrome. Imposter syndrome presented itself in the form of women believing that others were more deserving of their decanal leadership positions, or that they were not true academics, or that they were "pseudo-researchers" (D5). They overcame their imposter syndrome by taking courses, learning from others, seeing their successes, and via the efforts of their support team as previously described. Dr Dawson shared that "my own default personality as well in terms of wanting to be 101% confident that I can do a job before I [can] get rid of that imposter syndrome" (D8). Dr Marshall said that she had a severe case of imposter syndrome and so she found the ELMA course boosted her confidence and "taught me about things I didn't know I needed to know or didn't know right, so there's a whole thing on finances and budgets and financial planning for an institution" (M13).

This final major theme of success on the job was characterized by the deans learning on the job, preparing for meetings, gaining trust and galvanize enthusiasm, setting goals, and overcoming the imposter syndrome.

**Summary of Findings**

In summary, the six major themes elucidated from the data that describe the lived experience of women deans within the Canadian academic medicine context included: authentic self, building a support team, sexism and the culture of academic medicine, woman dean as agent of change, becoming a dean and getting the job, and success on the job. Being a woman in the upper ranks of academic medicine required the participants to present their authentic self in all contexts which they felt enabled their success. The women built a team of supportive individuals

including mentors, role models, sponsors, and other supportive relationships that they identified as helping them navigate some of the challenges within the context of medicine. Academic medicine was described as rife with sexism and all of the participants, at one point or another, had experienced the negative consequences of sexism both on a personal and professional level, yet they were able to mitigate these challenges via their supports and being their authentic selves. The participants identified themselves as agents of change with the goal of improving the climate of academic medicine for learners and physician educators with the overarching goal of improving care for patients and the health of society as a whole. With their impressive credentials, advanced degrees, and other means they were able to acquire their decanal positions and have strived to make positive changes at the medical school level and beyond. It was evident from their description of their sponsors and supportive relationships that this further enabled their professional success. They were also incredibly successful in their roles as dean because they learned on the job, gained the trust and galvanized enthusiasm among the people that they worked with. Beyond that, they also set and achieved their goals while overcoming episodes of imposter syndrome and mitigating the other challenges that presented themselves on the job.

# Chapter 5 – Discussion

The purpose of this phenomenological investigation was to identify and describe the essence of the lived experience of women deans in the leadership of academic medicine in Canada. This research also aimed to explore, via the participants' lived experience of the phenomenon under investigation, who they were and how they had navigated their successful path, to and through, decanal leadership. The women were hardworking, dedicated, and outstanding at their craft of medicine but what set them apart from their physician peers was their ability to scale the hierarchy of academic medicine where so many others have been unable to do so. This study gleaned knowledge from the few women who have been successful at becoming dean rather than simply restating the challenges of the complex career disadvantages that are well documented in the literature. It was evident that the women deans were able to walk the fine gendered line of socially sanctioned behaviours for women leaders with their carefully cultivated team of social and professional supports which was described in this research as their support team. These novel findings are two factors that enabled the participants to carve a path to and through decanal leadership in the Canadian academic medicine context. The participants saw themselves as having carved a unique path, often unplanned, to a decanal leadership position. One woman called her path "the carpé diem approach." Interestingly, all eight of the women traversed a very similar path to their position as dean; this feeling of being unique or unusual was likely because they seemed to compare their experience to the status quo, that being, male deans (N. Brown, 2020; Isaac et al., 2009). This was a key finding that populated the women's lived experience on the journey to being dean. A specifically unique finding in this research is that the successful few women deans have cultivated a support team around themselves which assisted them in mitigating the complex career disadvantages that have limited so many women before

them while supported them walking the fine gender line as described below. This study is also unique in that it was conducted by a female physician who employed a phenomenological methodology to gain a deep understanding of the lived experiences of women deans in academic medicine in Canada. At the time of conducting this research no such study had been performed by a female physician using this methodology with this participant population in Canada.

Despite medical school matriculants being overwhelmingly female for decades now, this has not translated to an equal number of women deans in academic medicine; thus, the current situation continues to be men holding the majority of senior leadership positions (Monteiro et al., 2022). Women continue to be outsiders in the deanery of academic medicine (Jacobson et al., 2021; Larson et al., 2019) and the participants found this to be their experience as well. This dissertation research identified six major themes as outlined in the results section above which defined the lived experience of being a woman dean in academic medicine. This research fills the gap in the literature and has provided some insight, via the lived experience of the participants, into the factors that have enabled the success of these women deans through the proverbial minefield of complex career disadvantages. This discussion chapter will weave what has been identified from the lived experience of the participants into the existing scholarly literature via three major categories: women deans and their support teams, walking the fine gender line, and carving a unique path. These are novel findings and are supported by a foundation of prior academic literature.

There are very few studies that have investigated women deans (Isaac et al., 2009; Larson et al., 2019) and none, to the author's knowledge, have focused on the lived experiences of women deans in the Canadian context. There has been research investigating the career trajectories for deans but their participants have been mostly male (Jacobson et al., 2021) and of

those studies, some have identified a lack of women participants and attempted to describe some contributing factors for this dearth of women (Jacobson et al., 2021; Monteiro et al., 2022). Those studies have not provided novel solutions to remedy this persistent lack of women in decanal leadership. More commonly, studies looking at leadership career trajectories have not recognized the gender imbalance in their participants nor offered a gendered analysis. There are a plethora of studies that have identified that previous attempts to bolster the proportion of women in the senior levels of leadership of academic medicine have been insufficient, ineffective, and failed miserably to make any meaningful change (Monteiro et al., 2022). Glacial progress and disabling factors have been a consistent feature in the literature for decades (Richman et al., 2001). This dissertation research is novel and fills the gap within the literature wherein it has brought new insight from the successful few women deans within the Canadian context. This research provides phenomenological insight into the career trajectories for women aspiring to be dean, what it means and how it is navigated and experienced. This research can inform future generations of women leadership aspirants while also contributing to the body of scholarly literature on women in medicine more broadly and women in decanal leadership more specifically.

**Women Deans and Their Support Teams**

The literature documents a longstanding history of complex career disadvantages that stifle women's ascent to leadership (Bismark et al., 2015). The participants in this study were able to negotiate these challenges by cultivating a team of supports. From participant to participant, the story was clear that they needed and benefitted from supports such as friends, family, and deans. The factors that disable career advancement for women seem to be heightened in the realm of academic medicine leadership which serves as a microcosm of the greater society.

The women's lived experience demonstrated that their team of supports was protective against the barrage of complex career disadvantages. Some of these included: sexism (Balmer et al., 2020), gendered assumptions of leadership, the leaky pipeline theory (Beeler et al., 2019), the Matilda effect, the imposter syndrome, and the lack of role models, mentors, and sponsors (Monteiro et al., 2022). There are many disabling factors that have been described as limiting women's career advancement both within, and outside of medicine (Mousa et al., 2021) and in-depth knowledge of how these are experienced and then successfully mitigated has been elusive. Some suggested remedies including affirmative action, mentorship programs, and encouraging women to "lean in" et cetera, have failed to create sustainable, measurable, and acceptable change over the decades that women have been involved in medicine (Bismark et al., 2015; Monteiro et al., 2022; Mousa et al., 2021). Possibly, these measures have not considered the strength of the patriarchal culture and other systemic issues that support those behaviours and continue to plague medicine. Medicine and the academic medical environment, like many areas of society, are impacted by societal expectations, social class, gender stereotypes, sexism, and the Old Boys' Club, as well as the continuing male heir (Balmer et al., 2020). The current dissertation research has identified that the women deans viewed themselves as competent and successful, and that they became deans in part by cultivating a team of supports that have endured over the long term of their career development. Their team of supportive people have helped showcase their ability to lead and have helped them believe in themselves and their ability. This support team included mentors, sponsors, peers, family and friends, as well as other people outside of medicine. The literature has, for decades, described the positive impact that a mentor and the impact that sponsorship (Grass & Latal, 2022) can have on career advancement and success; however, it appears that the new finding in this dissertation research is that, rather

than only having one mentor or a single sponsor, women who have been successful have had a team of supports to help them navigate the minefield of complex career disadvantages in medicine. Mentorship can be defined by someone actively providing advice for career and skill development whereas a sponsor advocates and endorses a sponsee (Grass & Latal, 2022).

This research supports the assumption that sponsorship and mentorship positively impacts career advancement (Han et al., 2022; Hansman, 2016). This dissertation goes further to demonstrate that all of the participants had a team that included mentors, sponsors, peers, family and friends, and people outside of medicine, not just one mentor or sponsor. Additionally, some members of the participants' support teams were identified as long-term relationships spanning from childhood through to the participants' professional role as dean. Trusson and Rowley's (2022) qualitative study investigated barriers and facilitators for career advancement for women professors in clinical academics and found that barriers exist at the individual, interpersonal, institutional, and societal levels. They also found that, as expected, societal views on gender roles also impacted career advancement for women. These are not novel findings but rather support what has been documented in the literature; further to this, Trusson and Rowley (2022) reported that increasing the number of women leaders and having a culture that supports work-life balance would be a facilitator to career advancement. The current study's novel finding of the strength of a team of supports does provide evidenced via the participant's lived experience that this can be helpful for successful career advancement. This also raises the question of how one builds these social supports without strong cultural and societal networks to begin with.

The participants identified that women are expected to perform more administrative, teaching, and other "invisible work" (Beeler et al., 2019, p. 1508) while also having fewer mentorship, sponsorship, and networking opportunities than their male peers. They were also

aware of the additional disabling factors such as the gender pay gap, gendered assumptions of leadership, and implicit bias which have resulted in few women being able to scale the hierarchy in academic medicine. Beeler et al. explain based on the current rate of professional advancement for women it could take more than 50 years to reach gender parity in the leadership of academic medicine. Beeler et al.'s article suggests term limits on leadership positions as one factor that may improve this timeline; yet, just because there is a vacant position this does not guarantee that a woman will get hired nor remain in that position. Not only do prospective women leaders, like the deans in this study, need training in activities such as leadership, finance, accreditation, and human resources (Lang & Keenan, 2022) but more so, they will require support when in those leadership roles due to the gendered assumptions of leadership. White et al. (2012) found that women had less robust networks to assist with their transition into decanal positions; thus the women deans in the current study mitigated this by creating a team.

A novel finding in this dissertation demonstrated in the participants' lived experiences was that their support teams appeared to be somewhat protective against attrition from the leaky pipeline and appeared to have enhanced their career trajectories while also mitigating some of the gendered assumptions of leadership. My study participants were able to avoid what White et al. (2012) called "glass cliff jobs" (p.6) which are jobs that women are offered with a high chance of leading to failure. Women were able to navigate those challenges while also being their authentic selves, which they reported as important for their success in acquiring their decanal position as well as functioning successfully in that role. The participants navigated a path through the well-documented gender gap in promotions by having a team of mentors, sponsors, and supports who helped showcase their talents, skills, and credentials while assisting with networking opportunities, support through challenges, and celebrating the successes when

they occurred. Having these supports also assisted the participants in building and maintaining their self-esteem and self-efficacy while also managing failures when they occurred. Given their long acculturation in higher education and workplace challenges, the women were better able than some to manage.

Dr Isaac described a number of mentors, sponsors, and supportive relationships throughout her lifetime. One quotation that highlighted both her experience and that of the other participants was that her sponsor took an active role in her career advancement, she “not only opened the door for me, she pushed me through it.” Once Dr Isaac was in her decanal leadership position, she felt competent and well supported and free to ask her for advice. This continuing support affected her own sense of self and helped her develop confidence and increase self-esteem which was important for success on the journey to decanal leadership. The participants had demonstrated success in areas of clinical work, research, and education which is expected of dean aspirants (Isaac et al., 2009; Larson et al., 2019; Sagraves et al., 2022). They had advanced degrees, leadership courses, and excellent credentials (Lang & Keenan, 2022; Trusson & Rowley, 2022). They were dedicated, hardworking, and had excellent interpersonal skills which is again, is an expectation for leaders in academic medicine; but what was unique about the lived experience of the women is that they cultivated a team of mentors, sponsors, role models, and supportive relationships that helped them propel their excellence forward through the hierarchy of academic medicine. The participants in my study needed and valued their support team. This team was akin to an advisory board, sounding board, social and emotional support, and at times a shoulder to cry on when needed. This need for support challenges studies such as Mousa et al. (2021) which looked at interventions aimed at improving the underrepresentation of women in healthcare leadership. None of the 91 studies reviewed by Mousa et al. (2021) discussed having a

multidisciplinary team of supports such as the one that the participants cultivated on their leadership journey.

The women deans in my study were expected to be hard working, dedicated, and demonstrate excellence in the tripartite mission of academic medicine (clinical work, research, and education), they were also expected to have a command of finance, human resources, and other administrative duties. While the participants outperformed their peers in all of these venues, the significant finding within their lived experience is that they developed a team of supports who helped showcase their excellence while mitigating the complex career disadvantages that eradicated so many other women on the same leadership path.

### Walking the Fine Gendered Line

The women deans I interviewed knew that there were a multitude of gendered assumptions for women in leadership and those aspiring to leadership, yet they were often able to navigate the fine line between what is, and is not deemed, socially acceptable behavior for women leaders (Manzoor & Redelmeier, 2020; Monteiro et al., 2022). This finding speaks to the call by Mousa et al. (2021) who identified a need for further research in the context of healthcare leadership where "traditionally masculine perspectives of leadership and hierarchal cultures still prevail" (p. 7). This dissertation research is situated in this documented gap in the literature. According to Monteiro et al. (2022), women experience doubt, criticism, and are deemed to "not look like leaders" (p.6), while also being held to different standards than males in leadership. The participants identified periods on their leadership journey where they were aware of these double standards and gendered assumptions of leaders. Monteiro et al. explained that women are expected to have better interpersonal, surgical, and clinical skills than their male peers. Women

are also judged more harshly when they make an error or display more “masculine leadership styles” (p.6) rather than emphasizing their femininity. This constitutes the fine gender line that the participants seemed to navigate while being their authentic selves. It must be remembered, however, that this study was limited to how the women perceived themselves and their journey.

The participants reported the importance of being their authentic selves at all times, despite the sexist culture of medicine. These outstanding women were able to do this while also being an agent of change and finding success in their role as dean. They are what Cameron et al. (2019) called “superwomen” (p.2); indeed, one of the participants used this very term to refer to herself. One participant summed this up succinctly as one must “know who you are and what you’re capable of” (C19) while also “model[ling] appropriate behaviour at all times” (S6) because there is a certain “leadership phenotype” (S6). The participants noted that they had career setbacks when they did not present their authentic selves but rather tried to fit into a gendered mold of what they thought was a specific “leadership phenotype.” One woman even reported missing out on a decanal job opportunity because she tried to “play it too cool” when being interviewed for the job. She learned from that experience that it was okay to be herself and not play into what might be a specific female or male “leadership phenotype.” She now shares this story and teaches other women leaders who she mentors that they must be themselves. This tension between societally sanctioned gender roles and decanal candidate behaviour was echoed in the experiences of the other participants.

The women remarked that one must be able to showcase their desire for the job while also portraying self-confidence, emotional intelligence, excellence in interpersonal skills, among many other important leadership qualities while also being their true selves rather than trying to fit into a specific mold. The participants identified feeling like an outsider in the upper ranks

where there was a dearth of diversity compounded by the sense that “leadership looks different on men than on women.” Jefferson et al. (2015) noted that since the beginning of women being allowed to attend medical school they have been relegated to being outsiders by the male status quo. This experience of being an outsider and feeling isolated continues to be present especially in the leadership of academic medicine, up to and including the deanery, according to the participants. This finding is supported by prior literature such as Mousa et al. (2021), Onumah et al. (2021) and White et al. (2012). Yet, from an outside perspective they are already part of a very select group of professionals which raises the question of how difficult this must be for women generally.

The experiences of the participants echoes Cameron et al. (2023) which highlighted that the lack of gender diversity in academic medicine leadership persists and continues to be a challenge for a multitude of reasons. Women and minoritized groups are accosted by the “norms and expectations shaped around white, male, cis-gendered, and able-bodied default on which the profession of medical practice and scholarship is based” (p. 2). Specifically, there are gendered assumptions of appropriate behaviours for women and men and those individuals who defy these socially sanctioned roles and behaviours experience negative consequences thus stifling career advancement. My study confirmed Bismark et al.’s (2015) finding that having women in senior leadership positions is associated with better organizational performance and a decrease in the cultural and ideological divides that exist. Certainly, the women in this study saw themselves as being very effective, despite the gender challenges. The study participants identified sexism as an issue and subsequently perceived themselves as agents of change in their role as dean. They remarked that in their role as dean they wanted to lead that change. It was their desire to improve the culture of academic medicine and consequently improve the experiences for trainees,

physicians, and subsequently patient care. Some may question of whether they have highlighted their altruism as an expectation of their role, or whether a further study might find a more complicated pattern. As a physician, the author identifies with the participants that altruism is often a core driving factor for practicing medicine and pushing through the struggles that exist within the system but further exploration of this concept within the realm of academic medicine may provide further insights. Yet, Onumah et al. (2021) found that gender bias and sexism are strong reasons for women leaving academic medicine whereas institutional factors such as women leaders and women role models and mentors have a positive impact on women's intent to remain in academic medicine. The findings of the current dissertation research support these findings and are evidenced by the lived experience of the participants.

The eight women in this study observed that the upper ranks of academic medicine were populated mostly by men as they were one of very few women at the decision-making tables. Similarly, Cameron et al. (2019) stated that women are less likely to advance in comparison to men in academic medicine and the critical mass theory has not been effective. Beeler et al. (2019) highlighted that the decades old laissez-faire approach to facilitating equity in medicine via a critical mass of women has not effectively translated into more women in the leadership of medicine despite a majority of medical student graduates being women. In medicine, women are required to work harder and be superior to their male peers this is also true in their efforts to gain access to leadership (Brunton, 1992; Cameron et al., 2019). This was echoed in the lived experience of the female participants in this dissertation research. The women did, however, identify some strategies, as outlined below, that enabled their success in navigating the fine gender line to achieve their positions as dean and be successful in that role.

The participants described having to use humor, picking their battles, and engaging in "the meeting before the meeting" as methods to navigate the sexist culture of academic medicine. They also stated that once they were in a position of power, they would lead change and help others speak up, thereby, changing the culture of their organization. Cameron et al. (2019) aptly stated that "women's leadership within academic medicine unfolds within complex layers of highly gendered assumptions about success, knowledge, authority, and expertise" (p. 3). Leadership has been socially ascribed as a male role and when women act in a leadership role, especially in a male dominated domain such as academic medicine, they may experience tensions where these behaviours are deemed incongruent with female gender roles. For example, when the participants were strategic, assertive, and authoritative, they were sometimes demonized such that they may be called aggressive. The participants had to pick their battles so that they could be effective in their leadership roles. They also employed emotional intelligence and were often able to read when and where these approaches and strategic actions should be used to get a point across or move on a certain action item. Depending on the circumstance some of the participants employed humor while others were direct when pointing out sexist behaviour and this resulted in change within their organization. Although Isaac et al. (2009) found that one participant in their study reported using humor to navigate tensions, this was not documented elsewhere in the literature surrounding women deans. Picking their battles meant sometimes, to get certain things done, they would tackle one issue and then return to others at another time because it may be counterproductive to their whole goal of impacting change to attack all the issues at once. The concept of picking one's battles is a significant feature of the women's experiences navigating their role as dean.

The participants prided themselves on being hard workers. They recognized that it was important to network and prepare for meetings, prior to the meetings so that they could create effective change and action. This was what they called "the meeting before the meeting." Being well versed on the meeting's agenda, garnering support and identifying where people stood on certain issues before the meeting was essential in allowing the participants to facilitate change and lead effectively. Being prepared and having the "meeting before the meeting" was just one of the many approaches that the women deans employed to enact change and action. In some ways, they have adapted the typical male approaches to leadership, begging the question of how leadership and organizations might be configured differently.

In an effort to make change and improve the culture within academic medicine, the women believed that they must speak up, and out, against discrimination and unfair practices while helping others have their voices heard. They identified the importance of visibility and leading by example such that they made conscious changes to improve the culture around them. The participants identified that those sitting closest to the chair of a meeting, for example, were able to have their voices heard more easily and thus they would situate their boardroom tables strategically to help bring up voices who may otherwise be excluded, missed, or silenced. The women also supported others who might not otherwise have their voices heard nor be included. In fact, they performed for others the same services that were integral in their own success. They did this as a means to facilitate change and improve the sexist culture of medicine while also challenging the status quo. These activities are well supported in the literature such as the cross sectional study by Onumah et al. (2021) which found significant association between women's intentions to stay at an institution and remain in academic medicine was tied to peer mentorship, role models who were women, and institutions who helped recognize gender bias. Mousa et al.

(2021) also support that organizational changes that propel more women into leadership positions would increase organizational productivity. Their systematic review supported an approach of organisational change that focuses on organizational and systemic level changes rather than a "focus on fixing the individual" (p. 2). The participants of this dissertation research felt that they were agents of change. They would strive to make change beyond the level of the individual and have an impact at a systemic level that being, at the level of a medical school with subsequent effects on medicine in general and consequently patient care.

The participants of this study were able to be their authentic selves, straddle the fine gender line, while also being agents of change. They often felt like outsiders because there were one of very few women in the leadership of academic medicine, but, they appreciated that, as Cameron et al. (2019) pointed out, they must "perform exceptionally in order to be considered deserving of inclusion" (p.2) To be included into an elite club such as academic medicine would move them from one elite area to another, may further strengthen professional hierarches yet allowing the women to be agents of change.

**Carving a Unique Path**

On numerous occasions, the women stated that their journey was unique and that they did not reach their decanal position in the same manner as others. Yet, from a distance, their lived experiences were markedly similar to one another, although what it felt like was unique. The participants' experience of their journey being unique is aligned with, the hermeneutic phenomenological methodology that was employed for this study, as stated by van Manen (1990), it is "in a broad sense, a philosophy or theory of the unique; it is interested in what is essentially not replaceable" (p.7). Their experience was one of a kind and an essential meaning elucidated about their decanal journey. Van Manen goes on to say that phenomenology is

concerned with gaining a deep understanding of "the nature or meaning of our everyday experiences" (p. 9). For these women, their path was indeed unique because it was their own, and yet it appeared on the outside to be markedly similar to other women deans. The women appreciated that in comparison to their male peers, they did indeed have a markedly different experience both on their path to leadership as well as their experience holding their position as dean. The literature supports this finding where men and women do experience leadership differently (Bismark et al., 2015). Women are more likely to populate lower level decanal positions (Schor, 2018). The participants differentiated those positions as being a "baby dean" versus a "big dean or dean dean." To reach the top tier of the academic hierarchy they had to be superwomen (Cameron et al., 2019) in addition to the usual credentials and benchmarks expected of decanal candidates (Detsky, 2011; Hromas et al., 2018; Lang & Keenan, 2022). Being one of very few women in those top tier positions was a contributing factor to their sense of traversing an unusual path. Likely women in other professions have similar trajectories but the streamlining of work and education made their worlds smaller and more intense for them.

Jacobson et al.'s (2021) prospective cross sectional study reviewed CVs and online databases to identify common pathways to becoming a dean of medicine in the USA. Their study looked at both male and female deans, of which only 16% were women. They found that on average deans had 30 years of experience, advanced degrees, an H-index of 40 or greater, and had held department chair positions as well as assistant/associate dean positions prior to becoming dean. The participants of the current dissertation research had all of these credentials as well. Women are often measured against "male-associated leadership ideals" (Cameron et al., 2019, p. 2) while also being judged on their compliance to gender norms which they often defy when striving for leadership. The essence of the participants' lived experience candidly describes

a successful path to decanal leadership for women in the Canadian context at this point in time. The reason that the women all described their path as unique is because they were comparing their path to that of men who aspire to and become dean. To the author's knowledge there are no other studies that describe, from a phenomenological approach, the lived experience of women deans in the Canadian context; therefore, it is likely the participants had very little evidence-based information to compare their experiences with.

Jacobson et al. (2021) depicts a common pathway to dean but, as with many other studies, it neglects women's specific experiences and does not provide a deep understanding of that pathway for women. This dissertation research fills this gap within the literature while also providing some information that might ameliorate the career trajectories for women aspiring to become dean in the realm of academic medicine. All of the participants had the above-mentioned credentials, practice and academic experience, advanced degrees, and specialized training. They engaged in research activities and held sequentially more distinguished leadership positions such as residency program director, department chair, and then some were assistant/associate dean prior to becoming dean. Those findings are supported by the scholarly literature (Jacobson et al., 2021). Neither of the two studies that looked at career paths for deans spoke about leadership courses such as the Executive Leadership in Academic Medicine program nor a team of supports, as described above, which were two significant factors that were specific to the women deans' experience (Isaac et al., 2009; Jacobson et al., 2021).

The deans appreciated and excelled at all features of the tripartite mission of academic medicine, those being education, research, and clinical care. They found that taking leadership courses, and specifically the ELAM program had a career boosting effect. This was one unique feature of their path to decanal leadership. Dannels et al. (2008) and Richman et al. (2001) were

two studies that investigated the efficacy of the ELAM course and identified that it had a beneficial impact on both leadership behaviours and career advancement. These findings are supported by the lived experience of the women deans in the current study. Richman et al. reported there were only four women deans among 125 US medical schools in 2001. It was not until 1999 that the first woman became a dean of medicine in Canada (Robb, 1999). The ELAM course began in 1995 and subsequently Dannels et al. (2008) found via their cohort study that 69.8% of participants over the duration of the study had achieved the rank of full professors and 63.5% had career advancement to senior leadership positions such as department chair or greater. The women deans found attending this course to be helpful on their journey to decanal leadership because it provided them with a venue for mentorship, sponsorship, networking, and learning the skills required to be a successful senior medical leader. Some of those skills included: human resource management, accreditation, research, governance, finance, along with many other skills that they described as essential to being a successful dean. The purpose of the course was to provide women with executive leadership training (Dannels et al., 2008) through a one year fellowship with the goal to further expand the number of women in the upper ranks of academic medicine leadership. This has proven effective in the experience of the women deans of this study. And, more importantly it affected how they felt about their own potential as they were further inducted into the hierarchy of their profession. The Royal College of Physicians and Surgeons of Canada identifies the “leader role” and leadership education as important in meeting the health care needs of patients and have incorporated this in the CanMEDS physician competency framework (*Royal College CPD*, 2025). This component within medical education curriculum occurred well after the participants acquire their medical education thus the participants sought out their own courses such as ELAM.

The deans acquired a plethora of credentials, leadership skills, and appropriate experience while avoiding the so-called "glass cliff jobs" (White et al., 2012, p. 6) to acquire their decanal positions. They often described that they had not initially planned to be dean but then in the same breath it clearly took a great deal of foresight and effort to acquire the criteria to be a decanal candidate. They also had to be superwomen who functioned above the average that would be expected for a male candidate. This concept of being a superwoman has been a strong hold feature in the experiences of women in medicine in general since women were granted the permission to enter medical school and has persisted further feeding into the sense that the women traversed a unique path to decanal leadership.

**Study Limitations and Delimitations**

Delimitations are boundaries that are set by the researcher whereas limitations are potential methodological weaknesses (Peoples, 2021). Some common limitations of this methodology which are present in the current dissertation includes the small sample size, limited time with this specific busy participant population, and generalizability to a greater population. Generalizability was not the goal of this investigation but importantly one must appreciate that the researcher provides an interpretation of the data and then subsequently constructs "a possible interpretation of the nature of a certain human experience" (van Manen, 1990, p. 41). A delimitation in this study included the researcher's inability to share participant profiles which is a common feature of phenomenological research because the participants would be easily identifiable. This phenomenological study investigated the lived experiences of eight women deans, some of whom were assistant, vice, and associate deans while some were "dean deans" as the women would say. Phenomenology attempts to, in part, identify the essence of the lived experience of a phenomenon under investigation (Peoples, 2021) yet, this may not be entirely

representative of “all women.” By virtue of the limited number of women deans in Canada, a delimitation of this investigation is that it was not possible to share specific details about the participants personally as they would be easily identifiable. This includes their speciality, decanal title, academic rank, cultural background, race, sexual orientation, family of origin, or socioeconomic status. The lack of in-depth family history information meant that investigations of social class links was not possible.

As a PhD student in the realm of education and a physician- I straddle the world of medicine and the world of academia in education. This dissertation employed hermeneutic phenomenology that was neither a feminist phenomenology nor a critical phenomenology; therefore, it was not designed to necessarily employ nor overlay a theory to unearth specific issues related to power dynamics, socioeconomic status, culture, class, race, gender, nor other features yet as academics we are charged to question and critique. Criticality is a term that describes a process whereby a researcher reflects on ideology, and this is impacted by the researcher’s identity and social location. Ideologies are the beliefs, values, justifications, and explanations that appear “self-evidently true and morally desirable” (Brookfield, 2000, p. 38). Criticality is an attempt to challenge dominant ideologies and the power relations that support those ideologies. This research was not designed to specifically question nor challenge dominant cultural values nor the social system within academic medicine. Yet, as a researcher I acknowledge that “at the basis of criticality is the attempt to unearth and challenge dominant ideology and power relations” (p.38) and speculation could be offered in certain circumstances. As a physician, I have acquired a certain privilege and as outlined on page 14 of this dissertation my multifaceted identity anoints me with certain privileges and a lens with which I bring to my research and everyday life which has impacted my interpretation of the data and appreciation of

the dominant culture within medicine. Future research should consider this important concept of power as it has ubiquitous reverberations, thus a lens specifically on this feature would be fruitful.

Another limitation of this study, which is exacerbated by the small number of women deans, was the lack of perspective from a wider diversity of Canadian deans. It would be important to focus future study in this area with a potential commentary on minoritized populations. One must keep in mind though, the burden of the "minority tax" (Rodríguez et al., 2015), which is defined as "the tax of extra responsibilities placed on minority faculty in the name of efforts to achieve diversity" (2015, p. 1). This likely impacted the diversity of women who were able to participate in my study.

It would be interesting to consider future research that employs case study methodology focusing on one dean-dean's experience versus a comparative case study of two or more deans. Case study would focus on the individual woman being studied, rather than the lived experience of a group of women deans with the goal of identifying common universal essence and experience (Patton, 2002). Case study could also employ multiple sources of data (Merriam & Tisdell, 2016) for analysis including the participants CVs, scholarly research, in addition to interviews.

The study participants focused on sharing their own experiences of success on the journey to decanal leadership thus they did not delve into stories of those who were not successful as this was not the focus of the study. A concept that was not addressed in this dissertation included the Queen Bee Syndrome (Goff et al., 2024). Queen bee syndrome or phenomenon occurs when women who achieve success in a male dominated realms are then more critical of women subordinates limiting their upward mobility. The participants were most

concerned with creating a positive environment and challenging sexism, gender biases, and discriminatory practices; therefore, they did not want to perpetuate them. Additionally, the Old Boy's Club and gender binaries were ever-present in the participants' experiences, and as such, perhaps employing a specific feminist phenomenological methodology (Käll & Zeiler, 2014) would have further delved into and examined these concepts.

Finally, phenomenological interviews can be lengthy, and time is at a premium for deans; thus, I tried to use the time I had available to my best advantage. I realize this may have limited the depth of information provided; however, the women deans were candid about their experiences and efficient in their responses. One could also consider whether professional boundaries prevented some of the researcher-participant intimacy that is usually associated with this form of qualitative work; however, I felt that we developed good rapport, and the participants were candid, as stated above, in their responses and divulged sensitive information about their lived experiences.

## Conclusion

At the outset of this dissertation research, there had only been eight women deans of medicine in Canada in over 175 years of the history of medical schools in Canada (Beeler et al., 2019). This provided evidence of the staggering lack of women in the senior leadership of academic medicine. Multiple studies had documented the complex career disadvantages limiting women's access to those leadership positions, yet none had described the experiences of the successful few women deans. The purpose of this hermeneutic phenomenological investigation was to identify and describe the lived experience of women deans in academic medicine in Canada. The eight deans interviewed were superwomen who excelled as physicians, educators, and leaders. Their lived experience of being a woman dean is one where they had cultivated a

support team while navigating the fine gender line and subsequently carved a unique path to and through decanal leadership.

The women in this study successfully navigated their path to decanal leadership while avoiding “glass cliff jobs” (White et al., 2012, p. 6) and impeccably negotiated the ubiquitous complex career disadvantages that have stifled so many women before them. It was through their lived experience a deep understanding of the powerful, meaningful, and seemingly protective nature that their support team had on them. Those teams were comprised of role models, mentors, sponsors, and other supportive people who they had a longitudinal relationship with. They learned from, and succeeded with, this team. This was a novel finding where the women required a team of supports rather than just one or two individuals. The women expressed that their path was unique, yet their paths were very similar to one another, thus lending itself well to this phenomenological methodology. This was another novel finding, where their path was unique in comparison to their males decanal peers but similar to other women deans. This is the first study to employ a phenomenological methodology to document Canadian women deans’ experiences in academic medicine and it is the researcher’s hope that this will provide a starting point and factor in ameliorating the career trajectory for other women who aspire to be dean.

**Recommendations for Future Study**

This investigation is a steppingstone to a better understanding of women dean’s experiences in the Canadian academic medicine setting. One could consider expanding this study to include deans from STEM and other humanities. This would allow for research to compare and contrast these domains to provide a broader perspective on the lived experience of women deans in academia. Another consideration might be to engage in a study utilizing a different methodology as described above in the limitation section, such as comparative case study; thus,

multiple forms of data could be collected to provide further depth to our understanding of women deans. As alluded to in the limitations section of this dissertation, future study should consider of utilizing a critical phenomenological methodology or other methodology that might provide further a critical lens to this research topic area and assist in uncovering "submerged power dynamics" beyond gender which were central in the current dissertation research as experienced by the participants. Paradis et al.(2020) explains a component and assumption of critical theory is that a person's reality is shaped by social, political, economic, cultural, ethnic and other constructs and these, among many other social structures determine a person's thinking and behaviour which often occurs unconsciously. Who can be a leader, who can speak, who can hold power and be considered an authority would be further evaluated via the application of a critical lens. Therefore, one of many remaining questions from this research is about the privileged world of academic medicine and medicine in general. These participants were considered, by some, from a privileged class of people who are being further inducted into the privileged world of academic medicine. In many ways, they saw themselves as being hardworking and fully deserving of their privilege, whereas the participants identified male leaders as having untold privilege. The researcher had this perspective too. The women did not share any thoughts about their own privilege nor how it was built, maintained and strengthened by factors apart from industry and good will. Hegemony is a concept that was not explicitly explored in this research. It is essential though, in future study, to consider the power structures, processes, interactions, and importantly the practices that sustain hegemonic assumptions that are embedded in the lived experiences of the participants. Critical phenomenology or another critical methodology would assist future research in considering power and untangle these important

issues as this may further result in ways to remedy the dearth of women in the upper ranks of academic medicine.

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