

Addressing leadership competency gaps and gender disparities in India's medical workforce: a call to action



Kamal Gulati,^{a,*} Julie Davies,^b and Ángel González de la Fuente^b

^aDepartment of Centralized Core Research Facility, All India Institute of Medical Sciences, New Delhi, India

^bGlobal Business School for Health, University College London, United Kingdom



Introduction

India's National Health Policy (2017)¹ and *Vision 2035* seek to “[e]stablish a governance framework that is inclusive of political, policy, technical, and managerial leadership at the national and state level.”² Yet doctors in India typically become executives based on seniority without formal management training. Moreover, according to February 2022 data, women in India occupied only 18% of healthcare leadership positions.³ WHO National Health Workforce Account data showed that during 2020 of 1,014,538 medical doctors in India only 14.2% were women. While there are several positive examples in states like Kerala where there are women who are directors of higher institutes, Karan et al.⁴ found that 31% of women with technical education in medicine were out of the labor force. Amongst medically trained 30- to 40-year-old women, 20% were not working and most of them were engaged in household work instead. At a senior level, there has only been one woman out of 16 directors of the All India Institute of Medical Sciences (AIIMS), New Delhi.⁵ There are only three women executive directors of the 18 new AIIMS which the Ministry of Health and Family Welfare is establishing across India.

Medical leadership development

Evidence⁶ suggests that leadership development programmes can significantly enhance medical leadership competency gaps in India. Additionally, diversity, equality, and inclusion improve the standards of care, quality of working lives, community relations, and ability to address health system challenges.⁷ We argue that a better understanding of leadership development and gender inequality regimes can inform systems-led policy reforms in the country.

Gender inequality regimes

Acker^{8,9} defines workplace inequality regimes as systemic disparities between employees in power who control goals, resources, and outcomes; workplace

decisions such as how work is organized; opportunities for interesting work and promotion; employment security and benefits; pay and other financial rewards; respect; and the capacity to enjoy work and a sense of belonging.

In India, there are persistent societal expectations that women should prioritize marriage and family life rather than their careers. In the field of medicine, demanding rotas, long working hours on shifts, and beliefs that women are the primary family carers tend to overburden women doctors. Acker's⁸ work on inequality at the individual level helps us to understand Indian women doctors' predicaments in systems where the ideal doctor conforms with “the image of the unencumbered worker”. Acker⁹ notes an ideal worker stereotype “who is totally dedicated to the work and who has no responsibilities for children and family demands other than earning a living”. Acker¹⁰ contends that job demands “are structured on the assumption that the ordinary worker is a man, an abstract person who has few obligations outside work that could distract him from the centrality of work”. Moreover, Acker¹⁰ lamented “the non-responsibility of organizations for human survival and reproduction” which results in workplace disadvantages, especially for women who have caring responsibilities. This is particularly acute in India where married women usually live with and care for their in-laws.

In India, intersecting and overlapping processes create entrenched systemic inequalities based on gender, class, and race in society generally as well as in the medical field. This scenario requires national and institutional policies to mandate and ensure the implementation of major reforms to address gender discrimination.¹¹ The consequences of suboptimal talent management in medical leadership in India and the dismal underrepresentation of women in medical leadership positions are serious for individual's careers and patient care as well as for health and economic systems regionally and nationally.

Conclusion

We call for effective policies and practices, which address normative and structural gender inequality and the dearth of leadership development at national, regional, and institutional levels in the medical workforce in India. Key priorities should include first

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*Corresponding author. Department of Centralized Core Research Facility, All India Institute of Medical Sciences, New Delhi 110029, India.
 E-mail address: kamalgulati.09@gmail.com (K. Gulati).

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ensuring that medical school admissions criteria and curricula, decisions on hiring, promoting, and rotating doctors emphasize practical leadership potential for all doctors in India. Second, we recommend mandating continuous leadership development for doctors at all levels using evidence-based medical leadership models drawing on multispecialty research collaborations and in partnership internationally with medical leadership providers. Third, to shatter glass ceilings and glass fences, systems need to be adapted to encourage women doctors and medical leaders with dedicated resources and flexible working arrangements that promote work-life balance. Finally, better implementation of equality, diversity, and inclusion policies with anonymous systems for reporting misconduct and unprofessional behaviors will make healthcare organizations decent workplaces for all doctors.

To achieve the leadership development objective in India's National Health Policy¹ (2017) and *Vision 2035*,² we must urgently advance gender equality in healthcare¹¹ and address current inequality regimes⁸ which marginalize women doctors.

Contributors

Kamal Gulati, All India Institute of Medical Sciences, New Delhi, India; Julie Davies and Ángel González de la Fuente, Global Business School for Health, University College London, UK.

Declaration of interests

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