Final Report: Climate Review of Department of Anesthesiology

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Introduction

This report begins with an overview of the purpose of this review, the methods employed, and certain conditioning considerations, together with select reflections on the Department of Anesthesiology. A series of findings is presented next, organized into 5 topical categories. The substantive entries in each category are noted because they appear to be influencing workplace conditions - - how individuals throughout the Department experience their jobs, including perceptions of fairness and professionalism. They all tie into one another, often in subtle and complex ways, and not all are co-equal in significance. No single element or concern mentioned should be considered to exist in isolation. The report concludes with a short summary and a series of recommendations.

Purpose, Methods and Conditioning Considerations

The purpose of this review is not investigatory, focused on any specific issue or person. Rather, the objective is to assess the workplace environment in the Department globally, to find out what if any concerns members of the Department might have, or that might be independently identified. The review is not designed to make any formal determinations of possible violations of law, regulatory rules or policy, but is informed generally by institutional, professional and legal indicia of commonly accepted workplace standards.

Over 130 interviews have been taken, including almost all members of the M.D. faculty and extending to Certified Registered Nurse Anesthetists (CRNAs), Certified Anesthesiology Assistants (AAs), Residents and Administrative Staff. Extensive documentary information also was reviewed. Departmental personnel have been cooperative throughout the process.

Each finding is supported by direct evidence (personal testimonials or documentary information), and additionally has been corroborated by multiple additional sources. No finding represents the narrative or perception of only one or two individuals, and care has been taken to ensure that corroboration comes from men and women both, across all categories of employment status (e.g., faculty of all tracks and ranks, CRNAs, AAs and administrative staff).

In addition to the foregoing considerations, certain conditioning features almost always are present in a review of this nature, and have been intrinsic to the process followed here:

- On almost any subject, a wide variance in perspective (and belief) may exist, especially in a department divided so extensively by specialization, geography and professional experience. This makes corroboration all the more important.
- *Proof* of specific findings is not always the operative consideration. To the extent one person or a group of persons believes something to be 'true,' it potentially has the same influence on workplace politics and experiences as whatever objective 'truth' might exist. It is both necessary and possible, however, to gauge the relative legitimacy and/or responsibility of different beliefs given how they resonate with the experiences of others and objective indicia of commonly accepted workplace standards. This analysis has been performed.

- There often will be a temptation to compartmentalize different events, to disassociate them from one another as a means of suggesting they're 'one-offs' and therefore don't represent a continuing trend, practice or attitude. This can be true, but when the elements of apparent 'one-off's appear congruent with the essential features of others, they can and should be examined in association to determine the presence or absence of patterns. That is an essential feature of corroboration, and has been a component of the analysis performed.

Finally, many different perceptions have been shared regarding how things are going in the Department, from 'it's all good' to the exact opposite and pretty much everything in between. The findings do not attempt to reconcile or balance this all out, only to report on conditions as they appear to exist - - or are perceived to exist - - irrespective of who believes in them or not.[1]

Select Reflections on the Department

The Department of Anesthesiology has a long and distinguished history. Despite myriad challenges, a good number of which are addressed in this report, the Department consistently has managed to provide high quality medical care, resulting not only in departmental growth and diversification, but proving foundational to the evolution of care at the UW Hospital and the greater Madison area. In addition, it has maintained an exceptional program in medical training and education, and under Dr. Pearce's leadership has taken steps to enhance the Department's research profile.

But as much as these commitments reflect an admirable measure of passion and commitment - - qualities that came through repeatedly through the interview process - - a significant and increasing number of departmental personnel are dissatisfied with how things are going. Many are frustrated, angry and disillusioned, not always for the same reasons but certainly with overlap. Conversely, others profess to like things just the way they are, although to varying extents they acknowledge the presence of these other views.

This open contradiction provides an apt starting point for a deeper assessment of factors affecting the Department's workplace environment. Notably, there appear to be multiple sources of division throughout the Department, which in combination with significant and often unremitting workload stresses are encouraging a range of objectionable behaviors. In addition, there are historical and operational factors contributing to very different work life experiences for some sectors of the faculty and staff, and these, too, are proving additionally divisive and corrosive.

Findings

As noted earlier, the key findings in this review are organized into 5 categories, with specific sub-topics as noted:

A. <u>Structural and Operational Factors</u>

1. Growth and Expansion
2. Clinical Care in an Academic Environment

[1] The range of perceptions is graphically depicted in a series of word clouds, prepared on the basis of the following question posed to each person interviewed: 'Share with me three words that you feel best characterize the Department.' The word clouds appear as Attachment A, and are referenced later in association with specific aspects of this report.

3. CRNAs and AAs
4. Leadership Opportunities
5. Faculty Mentoring
6. OR Management Team, i.e., the Board Runners (focus is main hospital ORs)
7. Insularity
8. Professorial Appointments
9. Full-time vs Part-time Schedules
10. Transparency and Communication
    a. Leadership Perspective
    b. Other Perspectives

B. Recent Developments and Additional Stressors

1. Change in Residency Program Leadership
2. Faculty and Staff Turnover

C. Areas of Acute Concern

1. Lack of Respect/Collegiality Among Sub-Specialties and Clinical Locations
2. Gender
    a. Residency
    b. Pregnancy and Nursing
    c. 'Positioning'
    d. Recognizing Achievement
    e. Advancement (tenure)
3. Bullying and Intimidation

D. Compensation

E. Call

The findings are reviewed in the order presented immediately above.

A. Structural and Operational Factors

The Department of Anesthesiology is large and relatively complex, comprising approximately 80 faculty, 30-something CRNAs and 30-something AAs, 50-plus administrative staff, and practice sites at 3 hospitals and 4 regional treatment centers. Much of this growth has transpired over the last 10 years, generating a variety of complexities that are both significant and escalating, compounded by emerging challenges such as the recent merger with Meriter and the unpredictable, changing landscape of health care locally and nationally. Before turning to discussion of specific areas of concern, a few preliminary observations regarding departmental operations are warranted.

Whenever workplace issues become prominent, there is a natural tendency to try to place blame. Some attribution will be fair, some will not, but it happens. The effort to assign responsibility, however warranted, can tend to obscure other efforts that deserve credit. As Chair of the Department for the last 10 years (only recently announcing his resignation), Dr. Pearce ultimately is the person primarily accountable for conditions in the Department, but that responsibility should not erase the effort he expended on behalf of the Department for over a decade. Leadership is hard, and he shouldered the

burden for a significant period of time, confronting near-constant growth and expansion of clinical demands among other challenges.

1. Growth and Expansion

   The rapid geographic and clinical diversification of the Department has had a marked impact on relationships. People still profess to like working with each other, and to value their colleagues, but this sentiment increasingly appears restricted by individual spheres of sub-specialty group practice and/or physical location (especially the more physically distant locations, such as The American Center in Sun Prairies, or TAC). Members of the Department don't know each other as well as they did prior to expansion and diversification, and correspondingly know less intimately what goes on routinely in other colleagues' spheres of practice and/or work. To an appreciable extent, there appears to be a tendency to 'fill in the blanks' about the particulars of other sub-specialties and practice locations, usually through negative comparisons involving one's own workplace experiences against what is assumed about the others. This tendency runs somewhat counter to the professed appreciation of one's colleagues overall, which was typified by positive descriptors such as camaraderie, collegiality, friendly, kind, nice and pleasant.[2]

   The disaggregated character of the Department - - and the sense of internal division - - was a subject of frequent reference, through descriptors that included siloed, disconnected, fractured, fractionalized, fragmented, insular, compartmentalized, divided and discombobulated.[3] Worse, the abridgement of relationships and mutual understandings between different clinical environments and practices appears to be contributing to a culture in which open disrespect is commonly expressed regarding other groups or specialty units, supported by inferences such as who works harder, or longer hours, or more complicated cases, or has some of what they do unfairly valued under the Compensation Plan.

   Whatever the underlying merit of these perceptions, the consequences are becoming progressively corrosive, contributing to a range of negative perceptions of the overall environment, described variously as distrustful, arrogant, bullying, discriminatory, disunity, hostile, suspicious, individualistic, disrespectful, toxic, selfish, provincial, feudal, deteriorating, and non-cohesive.[4]

   While these descriptions are not solely a consequence of growth and diversification, and in fact implicate more broadly a range of concerns about the departmental environment, they undoubtedly have been encouraged by it. Exacerbated by stress, they seem to be fueling other attitudes and behaviors that are problematic. Moreover, there are limited efforts underway to attempt to counter the centrifugal impulses affecting departmental cohesion: monthly faculty meetings, weekly grand rounds and informational emails appear to be the most inclusive present practices other than an annual holiday party, and most of these do not really cater to all

[2] Extracted from the word clouds, Attachment A.
[3] Attachment A.
[4] Attachment A.

or even most personnel in the Department. Modest efforts on a smaller, more local or unit-type scale do occasionally take place, but their impacts overall seem limited.

2. Clinical Care in an Academic Environment

Anesthesiolgy is a clinically-oriented department operating in an academic environment, with clinical faculty outnumbering tenure-track (basic) research faculty by greater than 10-1. Little substantive exchange appears to take place between clinical and basic research faculty, such as research seminars, and collaborative research activities are very limited. Overall, clinical and research faculty seem to operate in largely separate spheres, and the lack of interaction - - and thus mutual awareness of daily activities - - has contributed to a sense of segregation and distrust over departmental priorities, allocation of resources and perceived parity of contribution. In particular, many clinical faculty question the degree to which resources and/or financial support generated by clinical revenues is being directed toward basic research faculty.

A related concern exists in relation to the perceived infrastructure available to support clinical (non-basic science) research. Among the faculty, and to a lesser extent the CRNAs, there is interest in clinical research (research is a component of career advancement on the CHS faculty track, which is the dominant track in the Department). Not among all, but certainly many. There is frustration over the scarcity of time available to pursue these interests, of course, including the variable predictability of 'academic call,'[5] but more problematic is the sense that there is no clear infrastructure or support for such efforts, that they are not taken as seriously or valued as much as basic research, and that when support is made available it is done not programmatically but more on an individual basis and not according to any clear or objective guidelines. The perception is that this results in unequal access and opportunity, and preferential variance in how achievements are celebrated, publicized or rewarded.

3. CRNAs and AAs

CRNAs and AAs are vital members of the Department. While most report positive working relationships, they do not feel especially respected or valued. 'Just bodies in the room' was a frequent characterization, and together they report often being made to feel marginalized and uninvolved in departmental affairs. There are national political factors affecting both groups, and differences in training and education that in some ways are incongruent with how they all are asked to perform similar job functions. There is evident friction and/or unease between CRNAs and AAs, and a sense of discomfort reported by several CRNAs relative to clinical faculty, and the manner in which these concerns are being managed does not seem to be helping to abate them, contributing to additional examples of segregation and division detracting from a commonality of mission and community.[6]

[5] CHS faculty receive a certain allocation of 'academic' days each month, when they are at liberty to work or research or other non-clinical activities. 'Academic call' exists to help meet clinical coverage demands, and entails the person to be on 'call' for clinical service even while on their academic day.

[6] CRNAs are Registered Nurses with additional training in anesthesiology, and while licensed to provide primary anesthesiology care in Wisconsin, they are not permitted to provide such services as part of their clinical

The friction between CRNAs and AAs derives from multiple sources, some of which contribute also to the at-times discordant relations between CRNAs and faculty anesthesiologists. When legislative hearings were held in Wisconsin regarding licensure for AAs, some faculty testified in favor of licensure while some CRNAs testified against it (the legislation was passed). CRNAs reportedly felt disrespected and devalued by the process (as did some AAs, resenting the opposition to their efforts to obtain professional licensure). CRNAs also complain of a series of actions they see as designed to further devalue their professional credentials, such as not allowing them to practice outside of their UW employment, titling CRNAs and AAs under the common title of 'anesthetist,' and declining to allow a training program for CRNAs while hosting one for AAs. Several CRNAs also reported instances of being belittled by attending anesthesiologists, screamed at, even physically touched and intimidated. AAs, on the other hand, feel aggrieved by the attitude of the CRNAs when both groups essentially are asked to perform the same functions, but otherwise share the sense of marginalization and depersonalization noted earlier. Both groups also feel there is no real opportunity for career growth (there is a 'senior' title available after 5 years), in that extracurricular achievements such as advanced training or degrees receive no consideration.

4. Leadership Opportunities

Among the faculty, men outnumber women by an approximate 2:1 ratio. Historically, and even today, the representation of women in more prominent leadership positions seems to have been well below this ratio. Only in the last 2 years, for instance, have women been appointed to roles that include them in the Chair's weekly leadership meeting (one just late year). Appointments are made by the Chair, and do not appear to be open to application, nomination or vote.

Early in his tenure as Chair, Dr. Pearce reportedly instituted a policy against considering part-time faculty for leadership roles. To an extent, this makes sense - - it can be difficult to lead if one is not present. But there is more to consider. Many of the part-time faculty actually are present and working well beyond the percentage of their appointments, just as is true of full-time faculty. The mere fact of a part-time appointment - - in any percentage - - does not necessarily equate to a lack of availability, and painting all situations with the same brush only serves to explain the prohibition against part-time faculty eligibility for leadership roles, not legitimize it. More problematic, most of the part-time faculty are women, and this practice effectively has reduced for years the eligibility of women generally to be considered for leadership roles (only very recently, a few part-time faculty were appointed to leadership roles). Finally, there are several instances of individuals - - men - - being left in significant leadership positions for extended periods of time despite well-documented practices disrespectful to women and others.

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appointments in the Department. This reportedly has led to conflict at times with the primary attending faculty anesthesiologists in the Department, i.e., disagreements over primary anesthetic care, but insufficient information was elicited to evaluate this issue more fully.

This combination of leadership factors, of tolerated disrespect, a lack of open eligibility for advancement and persistent underrepresentation of women unquestionably has contributed to - - and helps to illustrate - - an undercurrent of male centrism that actively influences workplace conditions throughout the Department. This aspect of departmental culture is addressed at several points in this report, but it also generated specific descriptions from various interviewees, who in addition to descriptors already noted, such as disrespect, discriminatory and toxic, used words like inequality, misogynistic, sexist and patriarchal to describe the Department. Some male faculty offered additional perspective, describing the departmental culture as a *boy's club,* or a *frat-boy environment,* or a *good-old boy* network.

This is not to suggest that every moment of every day is actively uncomfortable or imbalanced by gender - - that is undoubtedly not the case. Most women reported very positive relationships with their male colleagues, both as mentors and friends, even those they described as sometimes engaging in offensive behaviors. But the cumulative impacts are undeniable.

5. Faculty Mentoring

There is a formal mentoring program for faculty in the Department, but most interviewees indicated it does not operate with regularity or according to any kind of designed format, or in a way that ensures equal access and opportunity to junior faculty. In particular, it was fairly universally acknowledged that junior faculty have to seek out their own mentors, and that assigned mentorships do not typically result in much interaction. While it also appears that many senior faculty take seriously the responsibility to mentor, the knowledge and expanded opportunities associated with such relationships unquestionably are being made available unevenly, or at least not in reference to any stabilizing baseline.

The results are predictable: some junior faculty feel they have received terrific mentoring and support, while others feel they have been left largely to navigate issues of career development and progression on their own. While the unpredictability and relative quality of mentoring affects both men and women, there are additional implications relating specifically to gender.

Just as individual junior faculty have to seek out mentors, senior faculty have the prerogative of choosing to get engaged when approached, which introduces a variety of subjective criteria - - again contributing to variability of access. Two considerations make this especially troublesome. First, a large percentage of the faculty have been hired directly out of the Residency Program, giving them a head start in establishing the kinds of rapport and/or relationships with senior faculty that can evolve into 1:1 mentoring. Since the Residency Program historically has attracted significantly fewer women than men, the implications are obvious: more men than women have benefited from this advantage (some see this possibility as correlating with a perception that former male residents tend to advance earlier into leadership roles[7]).

[7] The prohibition on part-time faculty serving in leadership roles has to be taken into account here as well, as part-time female faculty currently outnumber male part-time faculty in a 3:1 ratio, and historically the ratio was even higher.

Second, as women significantly outnumber men in part-time appointments, the frequency with which senior faculty openly expressed reservations about the perceived commitment and/or dedication of part-time faculty to the medical profession certainly suggests a possible negative impact on mentoring for part-time women. This possibility seems even more realistic given how commonly part-time female faculty expressed the sense they were taken less seriously by their colleagues.

On a final note, many of the anesthetists interviewed lamented a general lack of mentorship within their specific sector in the Department, which they linked with the perception that there are no real advancement opportunities (beyond 'senior' status eligibility after 5 years of service).

6. OR Management Team, i.e., The Board Runners[8]

The role of the Board Runner is powerful, largely thankless and absolutely vital, typified by a relentless pressure to ensure that all ORs are adequately and appropriately staffed, taking into account both clinical and educational factors.[9] It is a big job, and requires a certain firmness of tone - - not every assignment can devolve into a negotiation, there simply is not time or adequacy of staff to accommodate preferences (although, as will be noted, there is a perception that some faculty routinely are accorded more favorable assignments and/or colleague assignments).

A broad spectrum of views was expressed regarding the perceived fairness, attitude and professionalism of many of the Board Runners, all of whom were appointed by Dr. Pearce and, until very recently, all of whom were men. There is no rotation involved in the appointments, or process for open application, nomination or election. Some individuals have been allowed to remain as Board Runners for extended periods of time despite extensive evidence of highly unprofessional behaviors, often - - but not exclusively - - involving interactions with female faculty and anesthetists.

Many faculty and anesthetists expressed no concerns about their interactions with the Board Runners, and felt at liberty to raise concerns about assignments if patient care is implicated. A significant percentage of faculty and anesthetists described their experiences very differently, however, noting a commonality of sexual innuendo or crude personal comments, a tendency to openly belittle or denigrate those who raise concerns about assignments, and an inclination to punish with less favorable assignments those considered to be 'complainers.' Favoritism in

[8] This discussion pertains primarily to the operating rooms at the main UW hospital. Relatively autonomous (and arguably less stressed) locations such as the Children's Hospital and The American Center (TAC) in Sun Prairie for the most part appear to be avoiding some of the more serious behaviors noted.

[9] In effect, the Board Runner assigns personnel to all of the operating rooms, ideally taking into account the complexities of the cases involved, the individual clinician/anesthetist's other duty demands and recent work schedule, pregnancy where appropriate (i.e., avoiding assignments to rooms using x-ray equipment), and other factors.

assignments also was a subject of frequent complaint, mostly perceived to advantage senior male faculty.

The Board Runners challenged the accuracy of these representations, but the reported behaviors were corroborated substantially by interviewees not directly impacted by them. Many of those affected say they no longer feel comfortable raising issues of patient care because of the hostility of the anticipated reactions, although they uniformly felt they had satisfactorily addressed any areas of concern by seeking out the assistance of colleagues.

7. Insularity

As noted earlier (in part), a significant percentage of the faculty attended Wisconsin for some combination of Medical School, Residency and/or Fellowship. Entering the Department with a sense of 'how things work,' and an awareness of how authority is represented and exercised throughout the Department (recalling the predominant presence of men in leadership roles, including the Board), certainly can inhibit an inclination to upset the status quo. For women, the discouragement has been even more overt: numerous accounts were shared of being warned during residency to 'just keep your head down,' and 'don't rock the boat and you'll be okay' - - in effect being told just to endure behaviors directed at them because of their gender because it was the best way to 'get by.' Not only would these behaviors directly condition the behaviors/experiences of female residents, but they undoubtedly would influence the 'peer' relationships of young female residents brought into the Department as physicians.

These contributors and/or indictors of a male centrism in the Department will not be noted as such each time it is relevant, as could have been done in reference to the discussions on leadership opportunities and mentoring, but the issue manifests in a number of contexts. Moreover, it is abundantly clear that the issue profoundly influences the workplace experiences of many female faculty and anesthetists: if they lack (or perceive a lack of) equal opportunities for leadership, mentoring or other career enhancers, and/or they are subjected to differential treatment that often is demeaning and pointedly directed to their status as women,[10] they are not having the same experience as their male colleagues. This, too, contributes to a profound sense of division in the Department, and it is not only women who perceive this to be happening.[11]

8. Professional Appointments

There are 10 different faculty tracks in the Department, most prominently Clinical, CHS and Tenure. Most clinical faculty are CHS, which includes research as a component of advancement. Only 7 faculty are on tenure-track appointments, which carry reduced clinical responsibilities. Clinical and CHS faculty characterized their status as 'second-class' in a hierarchy that clearly appears to place tenure-track faculty at the apex, noting that only tenure-track faculty can serve

[10] This specific issue is addressed later in this report.

[11] See Attachment A, in particular noting the variance between the male and female faculty word clouds describing the Department.

as chair or sit on the departmental Executive Committee. While this is a university requirement and not a matter of departmental prerogative, it does represent an additional source of structural conflict and division.

There also appears to be a sense of division between the CHS and Clinical tracks, with CHS being considered more respected - - it involves research, it entails the possibility of progression in rank and it pays more. Many faculty appreciate the options that are available, i.e., being able to select a track that is compatible with individual preferences for a work-life balance, but these perceptions of status differences in the Department are clearly present.

9. Full-time vs Part-time Appointments

The Department generally has been supportive of part-time status for clinicians, but the attitudes of some in the Department regarding part-time work have become openly critical (overall, there is a 2:1 ratio of full-time to part-time faculty[12]). Some frustrations appear to reflect legitimate differences of opinion, e.g., part-time availability can complicate scheduling, and some part-time practitioners are more willing than others to surrender 'off' days to clinical or departmental needs, which can further complicate clinical coverage or calendaring of departmental activities. But there appears to be some conflation of these concerns with the fact most part-time faculty are female (3:1 ratio to men, but historically higher), such that criticisms have taken on a gendered character that in combination with other departmental attitudes and practices risk further relegating women to a secondary status. Notably in this regard, part-time male faculty did not report being subjected to critical comments regarding their status, and certainly none that seemed to emphasize their gender as a part of the criticism.

Many women - - mostly junior faculty but not exclusively - - recounted numerous comments from male colleagues (and senior leaders) suggesting they lack a full measure of commitment to medicine because of family priorities, that they 'cost' the department more, and that their interests in maintaining a 'work-life balance' are selfish in view of departmental needs and patient care. Many also feel they routinely have been targeted for less savory assignments on account of this kind of prejudice, been overlooked (or rejected) for career-enhancing opportunities in leadership, research or other service activities, and been singled out for belittling or disrespectful comments regarding family priorities.[13]

Notwithstanding the above, there does not appear to be any systematic, intentional policy in the Department actively seeking to subordinate women. In fact, many interviewees - - including a number of senior women faculty - - denied seeing or experiencing any disparate treatment on the basis of gender. This perception does not account, however, for some of the structural and practical subtleties that very possibly have worked to this effect, and which have been described very well in the medical literature as well as noted earlier in these findings. It also does nothing

[12] The CRNAs and AAs interviewed indicated that part-time status is not typically a consideration in their jobs, although there may be some exceptions.

[13] In the perception of some, including several senior women, these complaints have more to do with part-time status and disagreements about it than they do with gender. While this may in part be legitimate, the abundant evidence of a disrespectful attitude toward women generally suggests that at least for many in the department the issue cannot be attributed exclusively to attitudes toward part-time status.

to account for the kind of personal, day-to-day exchanges in which women report having been made to feel 'lesser,' or subjected to comments, attitudes and behaviors dissimilar in kind from anything their male colleagues might experience.

In any pressurized workplace, there have to be ways of blowing off steam, or releasing pent-up frustrations, and crude exchanges or exasperated commentaries are understandable. To a point. When they persistently denigrate a sector of the workforce, or evidence attitudes of hostility or limited acceptance of belonging, they are no longer excusable.

10. Transparency and Communication

    a. Leadership Perspective

    Departmental information largely is disseminated through monthly faculty meetings and informational emails, and to a lesser extent through Section Heads and similar unit-focused leaders. Most senior leaders interviewed, and a significant percentage of the more senior faculty, expressed general satisfaction with the amount of information that is shared regarding departmental affairs, noting that all matters of importance are subjected to inclusive debate during faculty meetings. A small number of persons in leadership positions expressed the view that too much information is shared at times, producing a retardant effect on the decision-making process. These views are consistent overall with a perception among longer-serving faculty - - mostly men - - that departmental operations are proceeding acceptably, and that the needs and interests of this more established constituency are being met. These views also appear markedly incongruent with those held by a clear majority of faculty, anesthetists and administrative staff.

    b. Other Perspectives

    Without exception, the complaint (and corresponding plea for change) most often expressed concerned a duality of limited transparency and ineffectual communication. Important news regarding departmental developments was frequently described as 'trickling out,' not shared in any systemic sense or subjected to meaningful discussion, or 'dropping out of the sky,' devoid of explanation or context and impossible to align with any sense of departmental direction. Faculty meetings were described as largely pro forma, where discussion of topics either is not encouraged or often is actively discouraged through the dominant voices/demeanor of a small number of senior faculty and/or senior leaders. Many interviewees indicated they no longer regularly seek to attend (and a large number 'attend' only by phone in any event, given the dispersal of the faculty through so many geographic locations).

    The last strategic planning exercise took place at least 8 years ago, antedating many of the changes that have come to the Department. There appears to be no unified sense of direction - - at least in the perception of most persons outside of the leadership - - and a view that the Department constantly is in a reactive mode to changes dictated by

UWHC, the UWMF or other external agencies. Given that many in the Department feel that there is an absence of regular, reliable updates on departmental developments, and few opportunities for meaningful discussion and alignment with understood strategic priorities, dissatisfaction and skepticism is almost inevitable. So, too, is a sense of disconnect with the leadership and more established sector of the faculty, which together seem less bothered by such concerns.

It might be fair to suggest that senior leadership knows full well what it is doing, and how best to balance the needs and interests of the Department, and that there is a clear plan to achieve desired goals. Even assuming this to be true, it is readily apparent that there is a general lack of confidence that this is the case. Throughout the Department, people want to know more, they want access to information earlier and more regularly, and they want to have more meaningful opportunities to discuss important topics.

B. Recent Developments and Additional Stressors

1. Change in Residency Program Leadership

The Residency Program recently experienced a change in leadership. Significant unease was expressed over the timing and manner of the removal of the former long-time Director, and the lack of explanation that was provided. It was cited as further illustration of a perceived lack of transparency regarding important departmental matters, and judgments about departmental direction which people don't understand. There also is concern about the impact of the change on the Residency Program, coupled more recently with the departure of the Coordinator, although people generally seem supportive of the new leadership. More generally, there is unease regarding the overall problem of transition in the Department, with Dr. Pearce announcing his intention to step down as Chair and a number of other personnel departures.

2. Faculty and Staff Turnover

While hiring to meet clinical and other demands has been a subject of on-going negotiation with authorities outside the Department, and efforts inside the Department, the faculty and administrative staff also have seen a number of critical departures. While the reasons for individual decisions to leave employment vary widely, the pattern here is something of concern -- not helped by the time it takes to successfully recruit replacement personnel. Especially troubling to many of those interviewed was the departure of several key members of the ICU team due, attributed generally to failed efforts to get the Department to do something to abate terribly excessive workloads (as an example, one of the departed physicians reportedly worked 55 full-time shifts above a normal full-time schedule in the course of a year).

Illustrative of the difficulty of recruiting replacement faculty, reportedly 9 offers have been made to ICU-trained anesthesiologists, and only one has accepted. Additionally, the Department recently lost its Administrator, CFO, Research Program Manager and others, and there have been other departures from the faculty. This is not normal attrition, and the reasons people cite most often are represented at least in part in these findings.

With specific reference to administrative staff, people generally seem to like the work, and to not directly experience many of the issues described elsewhere in these findings. However, they share a sense of isolation, noting the absence of regular staff meetings or established communication loops that apprise them of departmental developments. Internal frictions also appear to be increasing, perhaps contributing along with the sense of isolation to the observed frequency of turnover.

C. Areas of Acute Concern

1. Lack of Respect and Collegiality Among Sub-Specialties and Clinical Locations

Almost everyone interviewed acknowledged an increased level of friction and disrespect among the different sub-specialties and geographic locations. Among the complaints cited most often were: they don't work as hard; they don't take call; they ask for special dispensation regarding the patients they care for; they get out earlier; they aren't as specialized; they don't work the harder cases; they complain too much.[14] These sentiments tied directly to perceptions of a steady erosion of departmental collegiality and shared mission, which in turn highlighted the paucity of opportunities available to interact as a community.

One troubling example of this internecine conflict is the Pediatric Section, because it illustrates how one source of discord can take on additional destructive attributes. While opinions varied regarding which sub-specialties and/or geographic service locations appear to attract more commentary or disrespect, the Pediatric Section far and away was the most often cited. Contributing factors appeared to include it's geographical separation (located at the Children's Hospital), the insistence of member physicians on serving fewer OR's simultaneously given their sense of the relative complexity of the cases, a reluctance to engage junior residents (again attributed to their perceptions of the relative complexity of the cases), a perception that their call responsibilities are less onerous, and that when called to assist in the adult ORs there at times appears to be some reluctance based on a professed lack of recent experience with specific kinds of cases.

Whatever the relative merits of these factors, the resulting acrimony appears to have taken a turn that implicates other concerns noted in this review. In particular, irritations appear to have taken on an open patina of gender dismissiveness or irritation, almost certainly encouraged by the fact a majority of the pediatrics faculty are women, and many of them are part-time. Numerous interviewees - - men and women - - commented on the commonality of references to pediatrics as "the crying hospital," or "candyland," or pediatrics faculty as "candy-stripers."

It might be possible, in the abstract, to look at such demeaning references as reflecting only a linkage of irritation with location, i.e., it's the Children's Hospital - - kids cry, they like allusions to

[14] As noted earlier, and as acknowledged in a number of interviews, these criticisms often emerge from assumptions, not actual familiarity with what happens in spheres of practice other than one's own. The impulse to make such assumptions undoubtedly is encouraged by the reduced familiarity that people in the Department have with one another (and what clinical duties they perform), as well as the virtual absence of opportunities to engage personally - - outside of the workplace. This, too, was acknowledged by a number of interviewees.

Candyland, etc. But there are simply too many other ways in which gender appears to have been inserted into the work space to overlook the implications here, or to fail to appreciate the measure of disrespect communicated through terms of reference that infantilize professional clinical judgments.

2. Gender

There is disagreement over whether gender is an issue in the Department. There is even resentment at the very suggestion. Several people, including some in important leadership roles, suggested in interviews that it is only a matter of misperception. Others - - including some women - - simply did not see it as a concern, suggesting in part that it has been unfairly confused with issues involving part-time status. With due respect to these perspectives, gender is an issue in the Department.[15]

a. Residency

For many years, obviously almost exclusively under the leadership of the former Residency Program Director, the Residency Program chronically has enrolled substantially fewer women than men - - reportedly at times as imbalanced as 14:1. Throughout the interview process, no real explanation was proffered for this phenomenon, other than to suggest that the program was attempting to attract the best candidates available, and even when efforts were redoubled to attract more women, one year the ratio might be near equal and the next year revert to a serious imbalance. The assumption, then, was that factors extraneous to the Program were responsible.

Several factors undermine the integrity (and convenience) of this assumption. First, by all accounts, the Residency Program has long been considered a premier option nationally - - there is no reason to consider it to be more attractive to men than women in this regard. Second, there is no reason to believe that women generally are any less qualified or appealing as candidates for the program. Third, numerous interviewees referenced comments suggesting that pregnancy among residents was considered disruptive, and while it appears that pregnancy has been accommodated in fact, the possibility of bias in admission to the program certainly is suggested by comments of this nature. Fourth, former residents and faculty of both sexes recall different incidents in which female residents unquestionably were treated differently than men, including episodes where multiple women were referred to by the same name on the pretext they were indistinguishable, or, similarly, asked to put name tags on their foreheads. Fifth, multiple residents and former residents recounted being advised by senior female faculty to 'keep their head down' and simply tolerate practices they might find directed to them because they were women because that was just things worked. Finally, other than select years in which efforts appear to have been redoubled to attract more women (a relatively recent development), it appears that the typical experience of potential enrollees was heavily dominated by

[15] Attachment A again provides a useful illustration of this point, if the word clouds of male and female faculty are compared.

meetings with men - - faculty and current residents. More than a few persons interviewed recalled potential enrollees asking repeatedly 'where are the women?'

Fortunately, most former female residents reported generally positive experiences, despite having to tolerate conditions as described. That does not excuse, however, the extent to which obvious factors ineluctably associated with gender have been ignored, tolerated or overlooked by the Department in relation to the Residency Program, or passed off as attributable to circumstances beyond local control.

b. Pregnancy and Nursing

Staffing all of the OR needs is a constant challenge for the Department, and this obviously becomes more complicated as clinicians or anesthetists take maternity/paternity leave, become less available to ORs where X-ray procedures are required, or, in the instance of nursing mothers, require the flexibility and the facilities to breast pump. Fair enough. But it is the Department's responsibility to accommodate these challenges, not the obligation of individual women to apologize for being pregnant or for needing to nurse their infants. Unfortunately, and at times outrageously, the experience of pregnant women in the Department too often has been openly humiliating.

Until the relatively recent intervention of a new Department Administrator (who now has left the Department), there appears to have been little or no effort to supply facilities for nursing mothers to pump. While some facilities now have been established, they are spread out and apparently often fully occupied, resulting in a persistence of nursing women 'hunting' for a spot to pump while also enduring criticisms and/or negative comments of colleagues about being away from their assigned responsibilities. While the simple complexities of medical care undoubtedly will produce occasional circumstances where pumping cannot occur exactly as necessary or desired, it never should be the case that a woman feels victimized or defensive about meeting her responsibilities as a mother. While the allocation of facilities for this purpose is not simply a matter of departmental prerogative, requiring the collaboration of the Medical School and the UWHC, more effort in this regard could and should have been made. The negative commentaries and pressures associated with breast pumping, however, do represent a departmental responsibility, and one that has not been addressed adequately. At least one nursing mother reportedly stopped pumping - - and therefore nursing - - simply because of the negativity she was forced to endure. If true, this is an abomination.

The Department apparently maintains a 'list' of pregnant women so that Board Runners know to avoid assigning them to rooms involving X-ray procedures. While this generally appears to work satisfactorily, there were a number of instances reported that contribute to a general unease among women faculty and anesthetists about even volunteering the fact of their pregnancies. In one instance, several people overheard a Board Runner say "I don't give a shit about that" when considering where to assign a pregnant physician, and several women reported being assigned to X-ray rooms on occasion irrespective of their inclusion on the list - - and then having to endure negative reactions when they objected. Moreover, while inclusion on the list naturally abridges individual privacy regarding pregnancy, there

were several reported instances when Board Runners openly expressed frustration with scheduling complications they clearly attributed to pregnancies, e.g., one Board Runner calling out openly words to the effect of "who here isn't pregnant!" While the exasperation is perhaps understandable, it represents one more instance of blaming - - and shaming - - pregnant women for being pregnant. This simply should never happen.

c. 'Positioning'

Although not ubiquitous by any means, there appear to be repeated instances of men differentially positioning female faculty and anesthetists simply by the manner of their introduction and/or treatment, and the effect is unquestionably cumulative. One illustrative example was shared by several interviewees, of being introduced not as a physician but as "this young lady," or words to similar effect. While perhaps well-intentioned, or even prompted by fondness, this kind of differential introduction tends to devalue women in relation to their professional male colleagues, and makes a point not of the individual's status as a physician or anesthetist, but her status as a woman. There are other, less kind examples. "Don't tell me you're knocked up too." "If he dies, I'm sure he'd rather yours be the last face he sees." And references to stretch marks, and bloating, and other references to pregnancy that again demean the individual's status as a peer and a professional.

d. Recognizing achievement

Numerous interviewees referenced instances in which the research or service achievements of men were publicized far more expansively than was the experience of women. Taken along with everything else that has been mentioned, it appears as another example of a differential playing field based on gender.

On a separate note regarding achievement, several people shared examples of individuals providing relatively long periods of service on behalf of the Department only to be informed by email they were being replaced (colleagues being informed similarly by email, usually without explanation). This kind of curt dismissal from service not only is unlikely to encourage any sense of voluntarism, but it further illustrates the frustration expressed by many that important departmental decisions are made without explanation or justification, and often barely with any notice at all.

e. Advancement (tenure)

A number of interviewees expressed concerns about equity in career advancement, pointing out that until perhaps a month ago, male full professors outnumbered females by a ratio of 4:1. And it was more than just the numbers, it was the records of the individuals involved. Moreover, it seems notable that every person with a tenure-track appointment - - the 'apex' in the perceived departmental status hierarchy - - is male.

3. Bullying and Intimidation

Almost every person interviewed acknowledged that bullying behaviors are commonplace, and that status, voice, language and body language all are used in ways to intimidate others. While some of these interactions center on the Board, it's clear they are more ubiquitous and that they are not merely an expression of male-female interactions (although that certainly occurs). Numerous examples were shared of both men and women contributing by their behaviors to a caustic environment in which apprehension and even fear are commonly experienced. Coincidentally, there also is general apprehension about retaliation against those who resist, or speak against such conduct, because it is seen as a form of unacceptable defiance. This affects not only those who are directly victimized by uncollegial behavior, but discourages observers from intervening, broadening the sweep of overall discomfort.

As noted earlier, people still like each other, and appear to genuinely collaborate well in support of clinical care. But many do so against a backdrop of personal vulnerability that colors their everyday experiences.

An important distinction requires mention in this respect. Clinical faculty and anesthetists work long hours in intrinsically stressful situations, with lives literally at stake. Emotions and stress build up, and outbursts or charged exchanges take place (maybe an apology afterward would be in order). Everyone understands this. What is at issue is something different, reflecting crude dominance behavior, and it has no place in an equitable working environment. It also filters into other aspects of Department life, touching everything from mentoring to compensation. As should be obvious, routinely treating an individual - - or individuals in a group - - in a disrespectful or demeaning fashion almost certainly influences later interactions with that person or group, leading to an entrenchment of attitude and demeanor than can be cumulatively dispiriting and oppressive.

D. Compensation

It is beyond the scope of this review to conduct a thorough analysis of pay equity, as the Compensation Plan is extremely detailed and highly nuanced, and a proper evaluation would require annualization of many data streams. It is readily apparent, however, that a compelling majority of faculty consider the plan to be opaque at best, administered with little or no transparency, out-of-date with respect to many of the changes that have occurred throughout the Department's steady period of growth, and manipulated subtly and secretly in ways that increase compensation for select individuals.

Consistent with these impressions, irrespective of their relative merit and/or accuracy, the Department reportedly has registered the lowest satisfaction ratings for several years now in the annual UWMF compensation survey. For many faculty, it simply is a fact that there is little to no confidence that compensation and issues of relative merit are being adjudicated fairly and objectively. Notably, while almost all interviewees expressed a desire for greater transparency in Departmental decision-making, the insistence on greater transparency in compensation was virtually unanimous and certainly attracted the strongest sentiments.

E. Call

Taking call is an indelible feature of professional life for most faculty anesthesiologists in the Department, and under almost any formulation likely would lead to complaints about fairness, equitable distribution of responsibility, and adequate recognition and compensation, particularly among different geographic locations and varieties of sub-specialty practice. For physicians already confronted by heavy and persistent clinical demands, it is an additional burden and tends to generate strong feelings among many of the faculty on exactly these points. In addition, it represents an additional point of friction on the full-time versus part-time continuum, with part-time faculty at times taking call in greater proportion than their appointment would seem to warrant, but also representing different attitudes about availability on 'off' days, with some adopting a flexible attitude toward work responsibilities and others remaining insistent that a day off is a day off.

The Department has instituted several measures designed to generate confidence in the overall fairness and compensation of call scheduling, but the success of these measures appears to be limited in part by the factors noted above, as well as the general lack of confidence/trust in departmental processes noted elsewhere.

Summary Observations

As noted at the outset of this report, there are real strengths to the Department: an unflagging commitment to patient care, a dedication to teaching, an evolving research profile, a sense of camaraderie - - at least among one's most immediate colleagues - - and, frankly, the sheer will to persevere against a range of aggravations, not all of which are experienced similarly. There is widely shared pride, and history, and a desire to be better.

Change is hard. It takes time and energy that in the Department of Anesthesiology already is in short supply. The recommendations that follow, however - - whether adopted as is or modified/augmented for greater effect - - will require more effort on the part of individuals in the Department. Not all will support the need for some or all of the recommended actions, and to some extent that is an individual prerogative. But some aspects of the departmental culture need to change or there may well be serious legal consequences.

There are aspects of the workplace that can and should be improved, irrespective of legal considerations. Strategic planning. Transparency. Communication. Mentoring. Call equity. Compensation, at least in ways that engender confidence in objectively applied criteria. Inclusivity, not just among the faculty, but the Department as a whole. CRNAs and AAs - - working through the issues and dealing openly with the frustrations. Staffing - - and while the Department cannot act alone in this regard, if too much is being asked and the necessary external support is lacking, then reasonable limits on clinical commitments should be considered. People are burning out.

There are aspects of the workplace that have to change. Legally and ethically. The structure of power and authority is a place to start, so that leaders are held accountable for behaviors that diminish or denigrate others. Equality in resource support and opportunities for advancement has to be secured, including consideration for leadership roles. Women are going to be treated as peers and professionals, and the Department is going to take responsibility for ensuring that appropriate accommodations such as adequate numbers of nursing stations are made available , and that the blaming and shaming directed at those who take advantage of them ends. The status quo has to change.

Recommendations

The recommendations that follow are a starting point. The Department has to take ownership of corrective actions, but in view of all the information that has been elicited through interviews and document review, there are some measures that warrant specific consideration. As recommendations, what follows should be considered and discussed throughout the Department, and adopted, amended or augmented as necessary. Doing nothing with regard to areas of concern warranting specific recommendations, however, would be entirely unacceptable.

1. **Engage More as a Community**

   The Department is operating more and more like a confederation than a unified whole. Ways to engage with each other both personally and professionally should be explored, particularly involving more clearly segregated sectors like TAC, MSC, etc.

2. **Consider Occasional Rotations**

   Lack of mutual awareness between the sub-specialties and clinical locations continues to create friction over who is doing how much, etc. Consistent with patient safety and scheduling demands, consideration might be given to rotations that allow more direct exposure to what is happening outside of one's primary sphere of practice.

3. **Retreats and Strategic Planning**

   A comprehensive, inclusive strategic planning process should be instituted to address not just some of the operational challenges identified through this review, but to plan for the future. Semi-annual or annual retreats could augment this process, as would smaller working groups comprising representatives of all major sectors of the Department. A conversation on departmental values should be included, together with an updated sense of common mission and vision.

4. **Transparency and Communication**

   A clear majority of the Department desires greater transparency and efficient, inclusive communication about departmental affairs. Given the complexities involved, precise recommendations for what might be done likely would not be helpful. A retreat specifically focused on this critical issue - - which touches directly on so many issues noted in these findings (such as the Compensation Plan, resource support and leadership appointments) - - would be prudent.

5. **Leadership Accountability**

   Access to leadership appointments must become more generalized, and leaders have to become more accountable for their actions - - not only as they personally conduct themselves, but as they ensure others act professionally as well. Among the options that should be considered are the following:

      a. Leadership roles at a certain level of responsibility could be posted for application, and a mechanism introduced to gauge departmental support for each candidate,

e.g., ballots. Among the roles that should be included are Section Heads, Medical Directors and the Board Runners.

b. An Appointments Committee could be convened to screen candidates and consult with the Chair on possible appointments. Such a Committee ideally would include representatives from all major sectors of the Department, conceivably subject to election.
c. At least annually if not bi-annually, departmental personnel should be surveyed for feedback regarding the performance of persons in leadership positions. The results could be shared with the Appointments Committee and/or the Chair, to be taken into account in renewal or designation for other leadership roles.
d. Leadership roles at a certain level of responsibility could be subjected to established terms.
e. Eligibility for leadership roles should be closely examined for criteria clearly material to the role, e.g., is part-time status truly incongruous with the anticipated demands of the role.

6. Compensation Plan

There is a pronounced lack of confidence in the current administration of the Compensation Plan, with corresponding demands for greater transparency and documented consistency. There are lingering concerns about gender equity. In consultation with UWMF and the Hospital, a thorough reassessment of how the Plan is administered appears essential. A working group tasked with this project, culminating in a department-wide review, might be one option - - but action is required.

7. CRNAs and AAs

The complex issues surrounding these members of the Department require specific, continuing engagement, as does the broader question of how CRNAs and AAs are perceived and treated. Some type of formal liaison could be established, or a working group convened, to identify key issues and formulate appropriate remedial strategies.

8. Research and Resource Support

This is another area where a clear majority of the Department is clamoring for greater transparency and documented consistency. A working group could be convened to establish clear guidelines as well as measures designed to ensure accountability. Annual publication of all distributions might be helpful.

9. Residency Recruitment

Recruitment practices should be carefully re-examined, perhaps in consultation with other programs in which women have been recruited more successfully, to ensure progression toward a more appropriate balance of men and women, as well as diversity more generally.

10. Call Scheduling and Valuation

This is already a work in progress, but a lot of frustration remains. As the issues are broader than just call scheduling, it might be necessary to have a retreat-type conversation over how to value different kinds of call, account for variations in call participation and scheduling, and address other nuances that are perceived as inequitable.

11. Recognition and Achievement

The Department does not appear to recognize service or achievement well, and, according to many, not equitably. Consideration should be given to appointing a committee or an office to take responsibility for regularizing this type of activity.

12. Equity Issues

At least for now, there is no clear resource person in the Department to whom people feel comfortable going with concerns. Some thought might be given to creating such a role, with assurances of confidentiality when requested, such that there is better communication about potential issues before they worsen through inaction.

13. Leadership Orientation and Mentoring

Many persons in leadership roles indicated they received no orientation or assistance in the nuances of 'how' to lead, but were left to 'sink or swim' upon appointment. There are many options available to enhance leadership awareness and proficiency, and consideration should be given to institutionalizing this kind of training.

Mentoring should become much more standardized, with measures instituted to ensure equality of access, well-understood guidelines for progression in rank and regular, substantive engagement with mentees. As with leadership, there are numerous options and resources available to improve mentoring practices, and consideration should be given to exploring and adopting best practices in this regard.

14. Professional Advancement and Promotion

Given the concerns that exist generally over fairness and equity, it might be helpful to retain an external reviewer to objectively examine the progression and promotion practices of the Department.