

# When a panel discussion on women’s leadership became a case study in its challenges

Ashifa Trivedi<sup>12</sup>, Renée McCulloch<sup>3</sup>, Heather Caudle<sup>4</sup>, Nuthana Prathivadi Bhayankaram<sup>5</sup>, Nisha Thakrar<sup>6</sup>, Cicely Marston<sup>7</sup>

<sup>1</sup> NHS London Procurement Partnership, London, UK

<sup>2</sup> Evelina London Children’s Hospital, London, UK

<sup>3</sup> Great Ormond Street Hospital for Children NHS Foundation Trust, London, UK

<sup>4</sup> Northern Care Alliance NHS Foundation Trust, Salford, UK

<sup>5</sup> Medical Women’s Federation, London, UK

<sup>6</sup> NHS England, London, UK

<sup>7</sup> Nuffield Department of Primary Care Health Sciences, University of Oxford

Correspondence to Ashifa Trivedi: ashifa.trivedi@nhs.net

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## BACKGROUND

A panel discussion at the Faculty of Medical Leadership and Management (FMLM) 2024 Annual Conference illustrated both the power and fragility of authentic dialogue. Entitled “Women in Leadership, a Celebration and Call for Enhancement: Time to Reflect on Progress and Get Radically Honest,” the session created space for celebration, challenge and truth-telling — offering a live demonstration of both progress made and the persistent barriers women face in healthcare leadership.

The FMLM, as the UK’s professional home for medical leadership, convenes healthcare leaders across disciplines to share practice and drive improvement. This session was co-designed and delivered by women in senior leadership roles with the intent of fostering an open, inclusive conversation. What followed made clear that the session did more than showcase leadership: it surfaced the subtle, systemic dynamics that often remain unspoken — particularly around gender, power and allyship.

This commentary provides a reflective narrative of the session from the authors’ perspectives as panellists (HC, RM, CM) and attendees (AT, NT). The agenda focused on celebrating achievements, reflecting on progress and discussing future directions for enhancing women’s leadership in healthcare.

## CASE EVALUATION

From the midwives of ancient times to recent Nobel Prize winners, women have always played a pivotal role in advancing medicine, despite being undermined and excluded from many roles because of gender. Trailblazers like Dr Elizabeth Garrett Anderson, who in 1865 became the first woman in Britain to qualify as a physician and surgeon,<sup>1</sup> and individuals such as Isabella Skinner Clarke and Rose Coombes Minshull, who became the first women elected as full members of the Pharmaceutical Society of Great Britain in 1879,<sup>2</sup> exemplify how women have shaped healthcare in the face of powerful opposition. Reflecting on the remarkable journey of women in healthcare leadership, the panel noted that despite enduring challenges relating to sex discrimination, racism and inadequate accommodations for caregiving responsibilities within our healthcare systems,<sup>3</sup> there is an undeniable sense of progress and evolution, marked by increasing representation and a diminishing occurrence of ‘firsts’.

The process of the panel discussion itself provided an instructive illustration of key dynamics. Two chairs next to the panellists were purposefully reserved for the audience to dynamically step up and participate in the discussion. One of the three men in the room immediately took a seat and remained there for half the session, limiting contributions from the remaining 80 participants — 95% of whom were women. Research has shown that men generally talk for longer and make more frequent contributions than women in formal contexts such as seminars and TV discussions.<sup>4</sup> While the panel actively welcomed men into the conversation, it was striking how this space was occupied in a way that left little room for women. We had assumed participation would be shared fairly and had asked contributors to return to their seats once they had finished speaking. However, our inclusive design — intended to create space for broader dialogue by yielding discursive space that would otherwise be taken up by panel members — ended up reproducing the very gender dynamics we were there to challenge.

The male contributor dominated the space, used a derogatory term (referring to women’s supposed “bitchiness”) and incorrectly claimed a panellist had made an error. His tone and failure to yield the space to others jarred with the spirit of the event — celebrating women’s leadership and envisioning a gender-equitable future. The audience was visibly unsettled, murmuring in response. Whether intended or not, the effect was disruptive and discomforting — a reminder that individual behaviours, even within inclusive spaces, can replicate systemic patterns that marginalise women.

After several audience interventions — women taking turns to occupy the remaining chair and actively yielding the space to one another — the rhythm was restored. The man eventually left the chair, prompted by the panel and audience’s gentle but firm reassertion of the event’s intent. The way the dialogue had been subverted without officially ‘breaking the rules’ of the space appeared to have unnerved some

participants. Recognising this, Professor Caudle reflected on how similar these dynamics were to harmful dynamics experienced by many outside the room. She commented that the incident highlighted the need to be explicit about the purpose of the space. This transformed the conversation by allowing the group to openly acknowledge what had happened and reflect on it, finding unity in a shared experience and an affirmation — witnessed by the group — that these experiences can happen anywhere, including in spaces intended to highlight women's achievements and voices. The incident demonstrated that even well-intentioned spaces must be actively protected to ensure they remain inclusive.

During the session, women who were physically prevented from speaking adapted by sharing the second chair in rapid succession. They spoke out, listened actively and maintained a robust discussion, seeking genuine understanding. Holmes suggests women tend to contribute more talk in less formal contexts and that their contributions often facilitate exploratory talk — talk which assists a more extensive exploration of issues — something we saw clearly as the audience supported each other and collectively corrected the course of events.<sup>4</sup>

### **POTENTIAL SOLUTIONS**

Inclusive leadership holds promise in addressing gender and power dynamics. This leadership style promotes awareness of and actively seeks to reduce structural inequalities that exist in professional environments. Inclusive leadership training can equip leaders with the tools to recognise when certain voices are dominating and to take proactive steps to ensure that all participants have equal opportunities to contribute. For instance, the panel chair was aware of the need to create space for diverse voices and aimed to address this by adding extra chairs for contributors from the audience. However, when one chair was taken up for an extended period, this gesture inadvertently highlighted how power imbalances in leadership spaces — often linked to gender, race or other factors — can impede the contributions of others.

In clinical leadership, such situations can be mirrored in decision-making meetings or clinical discussions where certain individuals, potentially those in more senior or traditionally male-dominated roles, may unintentionally overpower others. This can silence valuable perspectives, particularly from underrepresented groups, and inhibit authentic contributions from diverse voices.

One study that illustrates the consequences of ignoring power imbalances examined exclusion of Black women from research datasets. The 1994 US-based Study of Women's Health Across the Nation (SWAN) aimed to analyse the health of middle-aged and older women; however, many Black women were excluded after experiencing menopause earlier, in line with the hypothesis that Black women age earlier due to biological weathering.<sup>56</sup> This exclusion, rooted in assumptions about biological differences, is not only an example of marginalisation in research but also reflects

broader structural barriers that individuals from racially minoritised groups face in both healthcare and leadership. The study's findings, while addressing health issues in middle-aged women, failed to account for the unique experiences of Black women, resulting in research that was less generalisable to a significant portion of the population.

The importance of inclusive leadership practices becomes clear: leaders must not only encourage participation but actively monitor and adjust for power dynamics in real time. Dr McCulloch's response — giving space for the man to speak and ultimately politely asking him to vacate the chair — demonstrated how authentic leadership can address dominance while preserving the integrity of the space and ensuring it remains open and equitable for all participants. Inclusive leadership involves recognising subtle power dynamics, especially in spaces where people from different backgrounds and genders might feel uncomfortable asserting themselves. It requires clinical leaders to be proactive, not just in making space for diverse opinions, but in creating structures that ensure equality. This can be achieved by actively challenging behaviours that perpetuate inequity, providing feedback when necessary and fostering a culture where everyone feels empowered to participate authentically.

Embedding inclusive leadership within clinical practice can ensure that all professionals, regardless of gender or background, are able to assert their authority and contribute meaningfully to discourse. This approach can transform the culture of healthcare leadership, moving beyond token gestures to create genuine opportunities for everyone to thrive.

During the rest of the discussion, the panel and audience reflected on specific challenges relating to pay, racism and other structural factors, creating inclusive spaces and leading with authenticity. Dr McCulloch reflected on the persistence of the gender pay gap (for example, a 17% gender pay gap among nurses).<sup>7</sup> Recently, NHS England released its Pharmacy Workforce Race Equality Standard report,<sup>8</sup> revealing disparities in higher Agenda for Change bandings among pharmacists, particularly affecting women from racially minoritised communities. Overall, 31.9% of pharmacists are women from racially minoritised communities; yet this proportion decreases dramatically with seniority, declining to 24.2% at band 8a and only 5.9% at band 9.<sup>8</sup> Similarly, among nurses, midwives and health visitors — despite almost a third (29.2%) being from racially minoritised communities — only 3.5% of NHS trusts in England have a Chief Nurse from a racially minoritised group.<sup>9</sup>

In the UK there are high levels of stress, burnout, anxiety and depression among nurses and midwives, particularly in the NHS.<sup>10</sup> Younger and recently qualified female midwives, along with those with disabilities, face heightened risks, which in turn affect the delivery of safe maternity care. Creating inclusive spaces that accommodate diverse needs is therefore paramount. The panel welcomed audience contributions on

strategies to balance motherhood with senior leadership and avenues for women to influence healthcare policy. Balancing these roles requires careful management to avoid burnout and warrants further consideration, including how to manage clashes of childcare availability with work or shift-working hours.

Dr McCulloch also reflected on the ‘authority gap’ — where women are treated as less authoritative — and on how women are often asked to be authentic while experiencing pressure to conform to expectations in roles historically occupied by men.<sup>11</sup> This may require women to depart from what they consider their authentic selves, while their male counterparts in the same role may find more space for authenticity. Caroline Criado Perez, in *Invisible Women*, highlights how systemic gender bias often results in the underestimation of women’s authority, further complicating their ability to assert themselves authentically in leadership roles.<sup>12</sup> This systemic bias aligns with findings from Nakamura et al., who explore the concept of women’s authenticity in leadership; respondents in that study indicated that to be successful in male-dominated workplaces they felt the need to adopt an agentic approach while also wanting to be communal.<sup>13</sup>

The need for flexible working arrangements is increasingly recognised as essential in addressing these challenges. In the UK, all employees now have the legal right to request flexible working from their first day of employment — a change that aims to better accommodate diverse needs, particularly for women balancing leadership roles with caregiving responsibilities.<sup>14</sup> This legal change reflects a growing awareness that traditional working patterns can exacerbate the authority gap by limiting women’s ability to thrive in leadership positions, making flexible work a critical factor in supporting women’s authenticity and success.

## **REFLECTION**

It was notable that our determination to hold space for dialogue by adding two chairs for participants ended up adding considerable challenge for the panel when one chair was occupied for a long time by one person. The panel’s authenticity in leadership — acting on a desire to make space for different voices and to engage in genuine dialogue — meant that any correction also needed to be authentic: a strong pushback would have been antithetical to the genuine desire for everyone to contribute in their own way. Eventually, when the man showed no sign of moving and it was clear he was not joining the discussion but also not yielding the space, the panel Chair, Dr McCulloch, asked him to move while reiterating the purpose of the space.

What was most telling was not the intention behind the behaviour but the unexamined entitlement to space and time that allowed it to go unchallenged for so long. These are often not conscious acts of exclusion but rather unconscious reflections of who feels permitted to lead and speak within particular spaces. Moving forward, fostering inclusive clinical spaces may require subtle shifts: encouraging shared facilitation,

inviting quieter voices first or simply becoming more alert to who dominates space. For men in leadership, this may mean self-monitoring contributions and actively creating room for others, especially those underrepresented in senior roles.

The panel discussion raised a nuanced point about responsibility and unexpected behaviours. A reviewer challenged us to consider whether the panel should have taken more responsibility for how the session unfolded: after all, the dynamics in the room were shaped by the actions and inactions of every participant. Handling unexpected behaviour that deviates from norms is inherently challenging because it catches people off guard, potentially placing too much responsibility for regulating the situation on the panel. In hindsight, none of us will be taken by surprise in a similar situation again, and the overall feedback from the group was that the incident was managed well.

However, this brings forward a larger, more uncomfortable question: should women in leadership roles take on the responsibility of managing the room when a man behaves outside expected norms? There is a risk that this responsibility becomes overly parental. In addition, the intersection of entrenched gender norms and social expectations around courtesy makes it difficult to respond in the moment without being seen as aggressive or confrontational.

Another nuance was that there were subtle restrictions on how the panel could respond. For instance, one participant expressed disappointment that a white man took the first turn. While this sparked valuable discussion, it may have shifted the focus away from the broader point about turn-taking. Calling someone out based on demographic characteristics, as was noted in the room, may deter further participation for fear of appearing to gang up on individuals, even when the intention is simply to ensure equitable dialogue.

The panel's leadership response had to balance authenticity, purpose and diplomacy — particularly in navigating the expectation that women leaders should be accommodating even when undermined. Clinical leadership in such moments becomes an act of systemic resistance: not just about making space, but about safeguarding that space against behaviours that reinforce existing hierarchies. Leadership must therefore be grounded in an understanding of structural inequalities and embedded power dynamics, or it risks simply replicating the very systems it aims to challenge.

For some readers, this reflection may feel uncomfortable or even personal. Yet discomfort can be a catalyst for growth if met with openness and a willingness to examine the systems we operate within. Other men present at the incident told us they were unsure whether to intervene in the moment — feeling a sense of responsibility but aware that by doing so they might further undermine the Chair and the panel. Those

men later approached panel members to acknowledge what had happened, which was a welcome expression of solidarity.

These reflections highlight the complex and often uncomfortable nature of navigating gender norms in real time, especially in a space that aims to encourage open and free-flowing dialogue. The incident underlines that even in spaces designed to highlight women's leadership, long-standing social norms continue to play out, subtly influencing the dynamics of the room. This nuanced understanding should prompt further consideration about how best to maintain the balance between allowing free expression and ensuring that entrenched gender dynamics do not go unchallenged.

## **CONCLUSION**

Our panel discussion provides an instructive case study — both in terms of raising key issues and in creating and maintaining authentic leadership and dialogue. Enabling an honest space for equitable dialogue and change can be challenging and, in this case, unintentionally created a site where uncomfortable gender dynamics appeared to be playing out. However, by remaining authentic in our determination to keep a space for dialogue, reaffirming the purpose of the space, explicitly acknowledging that the unspoken rules of the space had been broken, and by being clear without shaming or unkindness, the panel and participants of all genders — including the male participant who overstayed his occupation of the chair — were able to find solidarity, unity and a sense of collective strength, perhaps because of the learning-by-doing that a regular panel discussion would never have achieved.

Allowing the possibility of disruption and unexpected intervention created a space where we ultimately (and unintentionally) reaffirmed the reality of challenges to gender equity and highlighted the value of honest dialogue, the importance of solidarity and the transformative power of authentic leadership. Embracing an intersectional perspective and finding ways to engage in authentic leadership will continue to transform healthcare to meet the diverse needs of professionals and patients alike. These actions are not only the responsibility of those who experience marginalisation but must be championed by those in positions of power — of all genders — who are committed to creating fairer, more responsive systems.

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