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The Future of Gender Equity in Healthcare – The ANZ experience

Shailja Chaturvedi FRANZP

Psychiatrist, Sydney, New South Wales, Australia

Abstract
Globally there is an increasing participation of women in the general workforce, but the healthcare workforce has always had a higher proportion of women. It is estimated that the majority of the 75% of women who constitute the global health workforce mostly occupy the lower ranks. Among doctors, women are under-represented in positions of power and influence.

This article aims to increase awareness of factors that impede the potential of women doctors, and considers initiatives that could be implemented in the healthcare sector to address the gender inequality, including a fair representation in positions of leadership and influence. Although this article will focus primarily on issues related to gender equality, the author recognises the impact of intersectionality of the factors that contribute to differential attainment.

Diverse workforces tend to perform better in productivity, innovation, balanced decision-making and job satisfaction. There is research suggesting that women doctors have better communication skills, spend more time with patients, adhere better to guidelines and may even have better outcomes in healthcare decision-making. Women tend to anchor their leadership in purpose and impact rather than personal ambitions or power; demonstrate emotional intelligence in inspiring their teams, and promote collaborative working in the interest of the organisations they lead.

There is an opportunity to learn from initiatives that promote women in leadership roles, as well as published reviews that encourage organisations to address gender disparity in pay and positions of influence. Now is the time to add the multiple dimensions of diversity and intersectionality to this initiative for gender equality and justice in the medical workforce.

Keywords: Equity, leadership, woman doctor

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Introduction

Equity and equality are not interchangeable. Equity is fairness in treating individuals according to their needs. Equality on the other hand, is being equal, individuals being treated the same, irrespective of their differences. So equity is a deliberate action to give the disadvantaged, an opportunity to compensate for their lack of privilege.

The Pathfinders

Although denied the privilege to study medicine initially, the passion, drive and determination of women to become doctors has prevailed. The first ever registered female doctor was Dorothea Erxleben, in Germany. She was born in Quedlinburg, Prussia, in 1715 and was instructed initially by her father. The idea of a woman studying medicine was shocking at the time, but she was given special permission to study medicine in the University of Halle, yet not allowed to practice until 1754.[1]

Almost a century later, British-born Elizabeth Blackwell graduated in 1850 from the Geneva Medical College in New York, defying all odds after receiving unanimous support for her admission by the young men of the College.[2] While from the antipodes, Constance Stone joined the Women's Medical College in Pennsylvania, graduating in 1887, as the first Australian born female doctor.[3]

Stone realised that women doctors needed to support each other to make headway against the wall of societal resistance. The Victorian Medical Women's Society was formed under her leadership, in March 1895.[4]

The first Indian female doctor, Anandi Bai Joshi, qualified from the Women's Medical College, Pennsylvania in 1888.

Leadership Style

Gender equity remains a complex issue, and it is one of the important determinants of health and economic development. Although the proportion of females working in the global health workforce has increased to 75%, with a rising participation in science and the general workforce, women are mostly limited to the lower ranks.[5] Despite attaining gender parity in medical schools, the underrepresentation of women in senior positions persists worldwide, according to the 'Women in Workplace Report, 2022'.[6]

Leadership is often defined around traditionally deemed masculine characteristics, which undermines women's confidence in their capabilities, leading to their lower likelihood of self-promotion for career opportunities and award nominations. The assessment that a woman's leadership style is less effective than a man's is not based on any robust evidence but rather driven by societal norms or misperceptions. However, effective leadership is not the exclusive domain of any gender.[7] Women leaders have been shown to exhibit traits such as thinking systematically, taking a holistic view, managing complexity, and adopting an inclusive approach to leadership.[8]

Glass ceilings

Despite gains overall, women are still under-represented in leadership positions in science, technology, engineering, and mathematics (STEM). Part of this problem of under-representation stems from lack of role models, unconscious biases,

discrimination, and unwelcoming climates.[9] Gender bias contributes to the glass-ceilings in the race for top positions and is a barrier to career progression for women. Organisational culture in relation gender related issues is a factor (in addition to situational and interpersonal issues) contributing to the persistence of glass ceilings. [10]

Female surgeons in particular are known to face unfair assessments of their credibility by patients and colleagues, as they face stereotyped expectations that they will carry out more of caring functions (soft skills), such as meeting the emotional needs of patients. Furthermore, they are more likely to face objectification, [11] and sexual harassment. [12] There is also woman's tendency toward understatement which poses barriers to career development- or reaching 'up' for growth opportunities, sometimes described as the imposter syndrome.[13]

Parental or Caring Responsibilities

The age at which women generally become mothers coincides with critical stages in their careers. This requires juggling long hours of work and family responsibilities, compounded by inadequate implementation of parental leave and childcare policies. Mothers now devote even more time to primary childcare per week than they did in earlier generations, despite the fact that fathers, too, put in a more hours than they used to. Pressures for intensive parenting and the increasing demands of most high-level careers have left women with very little time to socialise with colleagues and build professional networks. [14]

Intersectionality

The experience of women from minority backgrounds is different than their majority counterparts,[15] across all areas and this is also applicable to women in leadership. Understanding multiple and simultaneous dimensions of social inequality—most commonly gender, race, class, and sexuality—intersectionality reveals the unique experiences of individuals who occupy multiple marginalised social categories. [16]

Improving cross-cultural communication and providing patients with access to a diverse group of physicians may lead to more patient involvement in care, higher levels of patient satisfaction, and better health outcomes.[17] However, there is significant variation across dimensions of inclusion, where women from racially underrepresented groups are less likely to view their workplace as fair, open, or supportive.[18] Minority women leaders tend to be evaluated more negatively than minority men and women from majoritarian groups, both under conditions of organisational success or failure.[19] Intersectionality of gender, ethnicity and religion may clash specifically, with organisational expectations of being male, of being white, and of work-related socialising, which may adversely affect career progression.[20]

Gender Diverse Leadership

Gender diverse leadership leads to significant social and economic gain, with improved productivity, innovation, decision-making, employee retention and satisfaction.

Interventions from ANZ

The Australian Medical Association (AMA) has committed to advance equity, inclusion and diversity, focusing on gender equity in its 2020-2022 plan. [21] The AMA plan envisages that the medical workforce should reflect the diversity of the patients it cares for and be underpinned by the values of professional integrity, respect and collegiality within the medical workplace and training environment.[22] The AMA has lobbied state and federal governments for leave entitlement, interstate portability of working conditions or accumulated privileges, and equitable access to flexible work arrangements. The AMA has set a target of 40% male, 40% female and 20% flexibility for all AMA Councils, Committees and Boards, in addition to encouraging and supporting potential female candidates to participate in leadership and representative roles and be speakers at the conferences.

The Australian & New Zealand College of Psychiatrists has also been at the forefront, where their female colleagues outnumbered male psychiatric trainees for the first time in 2020.[23] It is attributed to College's flexible training program and modular credentialing to address breaks in the training program.

Australian NZ College of Anaesthetists and Faculty of Pain Management (ANZCA FPM) has publicly acknowledged the benefits of gender equity to its fellows and society. It has made inroads with the representation of gender equity on committees, where women hold 51% of positions compared to 37% in 2018 and from 28% in 2018 to 46% in 2019 for FPM.[24] It is addressing unconscious bias by providing an interview tool kit, promoting gender-neutral language in its documents, and ensuring that childcare and breast-feeding facilities are available at its venues. Initiatives include the generous provision of parental leave, flexible hours, leave conditions, and part-time rostering.

Australian NZ College of Obstetrics and Gynaecology (RANZCOG) recognises that an organisation composed of differing skills, experience, perspectives, age, gender and culture leads to improved leadership, more robust decision making and a better outcome for the patient. However there is still work to be done, as although it has the highest percentage of female members compared to other Australian NZ Colleges, it also has the lowest number in the top-level leadership roles held by women. [25]

Australian College of Surgeons (RACS), following reports of bullying and harassment by its members, is proactively targeting female representation in training, on its Board and committees, and enacting its Diversity and Inclusion Plan 2016.[4]

Discussion

The United Nations Population Fund defines gender equity as a process of being fair to both women and men. To ensure fairness, strategies and measures must be available to compensate for women's historical and social disadvantages and systems that prevent women and men from operating on a level playing field. [26] Gender equity involves supporting a fundamental human right for an individual to reach their potential

without bias and discrimination. Understanding and improving gender equity and diversity will benefit the patients and is associated with the safety, quality and economic prosperity of the whole community.

Women make up a disproportionately lower number of senior leadership positions in industry, healthcare organisations and academic institutions. Over the last five decades there have been changes to the disproportionate composition of leadership positions and there is a healthy move to a position of equality in societal partnership. However disparity still exists.

Culturally women tend to lack self-promotion and networking for professional gain, which dedicated mentors and career advisors should address. The increasing recognition of women's role in mitigating the gender barrier can only be achieved, by promoting the policy of female empowerment, when an average person changes their view of women's traditional role, to be restricted to being a carer and a homemaker. Gender balance must be aimed at all levels, like selection committees, editorial boards, medical councils, and other decision-making bodies.

More than four decades since the United Nation's Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was adopted, a review of the evidence demonstrated that majority of research has focused on interventions addressing gender inequalities; very few reviews explicitly included human rights based interventions. However, studies have weak design and use of intermediate outcome measures limit the quality of evidence. Further, there is limited evidence on interventions that addressed marginalised groups. [27]

Improved gender inclusion was the most frequently reported change, particularly for education and media interventions. Much of the interventions measuring social change in gender equality did not achieve beneficial effects or had only partial beneficial effects on outcomes, calling into question their efficacy in practice. Education and awareness-raising strategies, also predominantly had only partial beneficial effects.[28] The Economic and Social Council (ECOSOC 1997/2), defined gender mainstreaming as "a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally, and inequality is not perpetrated.

Interventions that help improve gender equity include implementing governance framework; ensuring commitment from top management, bottom-up participation; framing synergies with other initiatives, strategies for tackling resistance; allocation of resources; ensuring sustainability of actions; training staff for gender competence, rewarding experience and knowledge and offering transparency. Data which provides regular updates on declared targets, expected standards and monitoring; contributes to the successful implementation of the interventions.[29]

Such initiatives include the introduction of Athena SWAN; the

Expert Group Review; the Gender Equality Taskforce; the Senior Academic Leadership Initiative; research funding agency initiatives and tackling challenges around sexual harassment. The best possibility of leveraging change arises when it is driven at the state (macro); the institution (meso) and the situational (micro) level simultaneously, by gender competent leaders willing to tackle the historically male dominated, masculinist criteria, procedures, processes and micropolitical practices that are "normalized".[30]

The Athena SWAN Award Scheme for Gender Equality has a complex contextually embedded system of action planning within the context of universities. It depends on a multitude of contextual variables that relate in complex, non-linear ways and dynamically adapt to constantly moving targets and new emergent conditions.. [31]

Conclusion

This paper discusses the issues surrounding gender equity in the medical profession, particularly in leadership roles. It highlights the historical achievements of women in medicine, while acknowledging the barriers they have faced. The author highlights the difference between equity and equality and argues for gender diverse leadership. The barriers to gender equity include societal norms, bias, discrimination, and the intersectionality of race, class, and sexuality.

The paper emphasises the need for organisational change and a complex suite of interventions that include multiple actions and areas of intervention with a focus on the complex system being embedded in local dynamics; accepts the non-linearity of interventions and adapts to emerging conditions, and highlights the impact in terms of contribution to change, improved conditions to foster change and the increased probability that change can occur. Transparency and commitment at the highest level are key.

Future research should include the dimensions of ethnicity, socio-cultural background and multiple deprivations in addition to gender.

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