Spring General Assembly 2015

Policy Statement on Gender Equity within the Healthcare Profession

Proposed by: UCL

Summary
Medsin is committed to supporting the equal opportunity for all people, regardless of gender, to achieve their full professional and personal potential. The Universal Declaration of Human Rights articulates that everyone be entitled to human rights "without distinction of any kind, such as race, colour, [or] sex." Medsin recognises that gender inequity remains a significant obstacle worldwide: women not only face violence and discrimination as a result of their gender, but also remain under-represented in leadership roles and many specialties within medicine. Therefore, Medsin reaffirms its call for a greater drive towards gender equity through the empowerment of women and ensuring that structures within and outside of medicine support, not inhibit, women's ability to be equals in our society and in their health.

Introduction
The UNHCR defines gender equality or equality between women and men as the equal enjoyment by females and males of all ages and regardless of sexual orientation, of rights, socially valued goods, opportunities, resources and rewards.[1] Equality does not mean that women and men are the same but that their enjoyment of rights, opportunities and life chances are not governed or limited by whether they were born female or male.[1]

Background Information
Sex and gender discrimination have greatly impacted health, social development and prosperity. Globally, women are poorer, less educated, experience higher levels of violence, and are underrepresented in senior and government position.[2] Gender equity is a basic human right, and gender inequity is a major impediment against societal advancement, particularly in reducing poverty[2]. Women play a diverse range of roles within societies around the world. Therefore, efforts to promote female empowerment and gender equality in leadership within health and participation in government, business and the community must maintain a culturally sensitive approach, whilst advocating strongly for women's rights. Domestic and sexual violence remain endemic in many parts of the world and adversely affect women's health, with more than one third of women worldwide reporting sexual and/or physical violence.[3,4] Furthermore, women's rights are often impinged upon where they are unable to access healthcare or healthcare services, especially around contraception and termination of pregnancy.[5]

We acknowledge that individuals who are transsexual or gender-diverse face discrimination and the aforementioned challenges, in many cases to an even greater extent, as is discussed in the Medsin's LGBTI Health Policy (2013). In all of Medsin's beliefs and calls to action below, we have endeavoured to include gender-diverse individuals by advocating for equity for those of 'all genders'.
The ongoing exclusion of sex differences within study design and analysis has reduced the accuracy and applicability of much of the body of evidence-based medical research.[6] Although gender-differences are well recognised in many frequent disease states, treatment and management guidelines are often not gender-specific.[7] Where research lacks sufficient female data, any treatment recommendations should – but in the past, often has not – state that evidence has primarily been obtained from male subjects and may not have equal effects on females.

Significant changes in the gender composition of medical students and subsequently medical practitioners have been recognised over the past 30 years in a wide range of countries, not just the United Kingdom, but also the Netherlands, Norway, Sweden, Finland, Russia, Australia, Canada and the United States[8,9]. However, in countries such as Japan, medicine remains a male-dominated

profession both in clinical and academic settings[10].

Despite medicine traditionally being a male-dominated profession[11], in recent years, women have had an increasing presence in the medical field, bridging the gender divide in terms of numbers of medical students in most countries. The Royal College of Physicians reported that by 2017 the majority of the medical workforce in the UK will be female[12]. Although this is the case, there remain countries in which significant barriers prevent girls from completing their secondary, or even primary, education[2], and where ongoing support and advocacy will be necessary to ensure parity is reached. Yet, despite this influx of women into the medical field, there is still a significant gender disparity in pay rates, and women in leadership positions.[13] It has been shown that a gender-balanced workforce is beneficial to both students[14-15] and patients[16], providing a more effective health care system that parallels societal evolution. Several international studies[13, 17-18] have demonstrated that although there is an extensive pool of women academics from which future leaders can be drawn, this is not reflected in the number of female applicants or appointed professors. This is due to a number of reasons such as gender-biased expectations and recruitment methods, inflexible working environments.[19]

The issue in the UK, is not so much the access to medical school, but the fulfilment of women's potential once they have entered the profession, for example in the UK, only 25% of consultants are women, despite 45% of Specialty Registrars (SpRs) being female.[19] This need to increase the representation of women at senior level has been acknowledged by the General Medical Council.[20] Moreover, gender bias, whether unconscious or implicit, persists in the appointment, evaluation and promotion of females for medical school faculty positions,[21] as women's intellects are given significantly less repute than their male counterparts'. Improvements in women's health are intrinsically linked to women in academic medicine, with many recent advances in women's health being made by female doctors and scientists. Thus, it is critical to the advancement of women's health that women's leadership in academic and clinical medicine is encouraged and supported.[23]

Gender inequity is also present in medical schools across the world. A recent article in the African Journal of Health Professions Education found that 51% of female South African medical students felt they were professionally viewed differently to their male counterparts.[23] Furthermore, female medical students experience less attention and support than their male peers, in addition to experiencing sexual harassment, sexist jokes[24] and direct gender discrimination.[25] The British Medical Association's report on Equality and Diversity within Medical Schools also notes the problem of sexism, both among students but also between teaching staff and students.[19] Women in cultural minorities are also more likely to expect gender discrimination within medical school than men.[26] Combined, these gender-specific barriers can impact women's medical school experiences and their persistence into a career as a doctor. There is also gender bias in perceptions of certain specialties, for example, female medical students in Egypt report preferring so-called "feminine" specialties including dermatology, clinical pathology and radiology, while "men's club" specialties such as neurosurgery, urology and orthopaedic surgery remain taboo.[27] This is not only a problem in other countries but also in the UK. The concept of the 'hidden curriculum' is that certain specialties are only deemed acceptable for certain genders for a number of reasons, through the reinforcing of stereotypes such as these 'mens clubs', but also the lack of part-time flexibility within some specialties.[19]

Although women represent almost half (in much of Europe and other Western countries) or the majority (Russia and post-Soviet nations) of physicians in many countries, there remains a pattern of gender segregation within many medical specialties, primarily as the result of historical gender stereotypes.[28] Many female medical students and doctors feel that family demands limit medical career paths, yet males do not demonstrate the same concerns.[29-31] Women also feel greater pressure to conform to normative gender expectations.[29]

Aspects of some medical training programs including gender discrimination and sexual harassment from nurses, patients, and colleagues, have been shown to influence specialty choice for many women.[32] In the UK, there is evidence to suggest that women are not taking up specific roles as a result of perceived gender-based barriers.[33] Furthermore, women report less confidence in their clinical abilities than their male colleagues, although often perform better.[39-40] Lower confidence results in less career satisfaction and also influences women's decision-making with regards to continuation as a doctor.[10]

Within the medical profession, many specialties have a strong gender-skew. For example, surgery remains a significantly male-dominated field, while paediatrics, psychiatry, general practice, obstetrics and gynaecology tend to have a greater proportion of females.[34] Underrepresentation of females in the field of surgery has been well documented around the world, for example in the USA [35], the UK [36] , Malawi [37] and Israel [38]. Subsequently, there has been a paradoxical shortage of orthopaedic surgeons due to the increased proportion of female medical students, very few of whom become surgeons.[37] Moreover, in countries such as Pakistan, although female medical students outnumber male students, only approximately half of them actually work as doctors[41] primarily due to family commitments. This lack of female practitioners has resulted in disproportionately high rates of female-specific cancers and subsequent mortality, particularly in rural areas of Pakistan[41]. In England, in dermatology for example, 76% of SpRs are women, but only 26% of SpRs are female and only 8% are women among consultants in general surgery.[19]
In many, if not all, countries, male physicians have higher earnings than female physicians, even after adjustment for medical specialty, practice setting and number of hours worked.[42-45] In the United States, male doctors earn 20% more than their female counterparts.[45] Although much progress has been made in the past 30 years in narrowing the gender pay gap, there remains significant work to do.[46]

Main Text

Medsin believes that:

1. Gender equity is a basic human right, as articulated by the Universal Declaration on Human Rights, and much work remains to be done to ensure that this human right is upheld;

2. Gender inequity and discrimination both within and outside of the medical field contribute to poorer health outcomes;

3. Hospitals and medical workplaces should actively promote gender equity and a discrimination-free work environment to ensure those of all genders feel safe and equally-respected;

4. Medical professionals in the same specialty and working context, irrespective of gender, should be remunerated at an equal level;

5. Sustained, proactive and immediate action is required to reach a stage of equal representation of all genders in leadership positions and equal opportunity in all medical specialties;

6. Hospitals and medical workplaces are required to frequently assess changing workforce demographics and implement flexible working arrangements for doctors at all levels of training;

7. Post-graduate training should cater for all doctors who wish to have a family while training;

8. Medical education should be gender-aware and every subject should include, where appropriate, sex- and gender-specific symptoms and treatments.

The Spring General Assembly of Medsin calls for:

1. Voting Members to:
   a. Promote awareness regarding the health impacts of gender inequity at an individual and population level;
   b. Implement policies that actively promote educational and leadership opportunities for all medical students, irrespective of gender;
   c. Ensure that students receive support for, and are not disadvantaged by, prioritizing family commitments and that flexible study options are provided where possible;
   d. Develop and implement (or support implementation of) a medical curriculum that takes into account and emphasises gender-specific presentations and treatment options;
   e. Recognise the complexities of gender identity, and promote an inclusive and sensitive atmosphere;
   f. Promote awareness of the consequences of gender inequity and disadvantage experienced by women and those of minority gender groups in the medical profession.

2. Hospitals and other medical workplaces to:
   a. Implement policies that actively promote educational and leadership opportunities within medical workplaces and recognise and remove barriers that prevent this from being achieved for those of all genders;
   b. Ensure that medical professionals receive equal remuneration for equal work, irrespective of gender;
   c. Develop policy that promotes and encourages equitable gender representation in all medical specialties and leadership positions;
   d. Create an environment that is supportive of employees and trainees having a family, with measures such as flexible working arrangements, retraining opportunities and childcare services, ensuring that those with families are not discriminated against;
   e. Develop policy to recognise and actively prevent sexual harassment, sexist attitudes and sexist or inappropriately gendered language for both patients and staff;
   f. Monitor the medical workforce to ensure graduates, trainees and specialists of all genders have the opportunity to highlight any issues or barriers within the system.

3. Medical colleges, professions and specialties to:
   a. Facilitate and support the varied needs of medical graduates and doctors as they complete specialist training;
   b. Encourage flexible training hours across all specialties;
   c. Encourage the creation of support and mentoring networks between junior medical practitioners of all genders and senior medical practitioners who can relate to their particular needs and difficulties;
   d. Engage with all populations when writing policies to ensure that the needs and perspectives of the entire medical workforce are taken into account.

4. Medical practitioners to:
   a. Be aware of the growing body of evidence regarding gender and sex difference in disease and treatment response, and ensure their practice is current;
   b. Be aware of the effect of gender-based violence on health and advocate for primary and secondary preventative measures to decrease the health impact of gender-based

violence.

5. Researchers to:
   a. Consider proportional gender representation in their study design and report on gender-specific results;
   b. Ensure guidelines reflect current understanding of differences in disease and treatment between genders.

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