

## Title Page

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Title: **Gender-responsive education and training approaches to improving physician well-being**

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## **Gender-responsive education and training approaches to improving physician well-being**

The findings of the Global Health 50/50 report demonstrate that gender disparity and underspecified gender policies still prevail in the workplaces of influential health institutions despite their commitment to prioritising gender equality in the international health agenda<sup>1</sup>. The report calls for organisations to make the paradigmatic shift from this gender-blindness to gender-responsiveness. Gender-blind approaches ignore or fail to tackle gender disparities and do not transform unequal gender relations<sup>1</sup>. In contrast, gender-responsiveness requires the examination of gender-related experience and evidence to facilitate change and create gender equitable workplaces<sup>1</sup>.

Medical schools and healthcare organisations are not exempt from the responsibility to pursue and ensure gender equality<sup>2</sup>. There is evidence of gender-related disparities in physician well-being outcomes; female physicians have been found to have a 30-60 per cent greater risk of burnout than male physicians<sup>3</sup>. Women physicians die by suicide at greater rates than women in the general population, in comparison with men physicians and their peers in the general population<sup>3</sup>. Female surgeons demonstrate nearly two-fold greater rates of alcohol abuse than male surgeons<sup>4</sup>. High suicide rates have been speculated to relate to gender role stress and occupational gender norms (which extend to men working in women-dominated professions, for example, men nurses)<sup>5</sup>, with signs of gendered encounters occurring during medical school and in training<sup>6</sup>.

Women represent about half of the medical student intake in the USA and EU, but are typically under-represented at higher positions in their fields<sup>2</sup>. In the USA, approximately 16% of medical schools are led by women deans<sup>2</sup>. Beyond statistics on their educational and professional activities, we have very limited understanding of the perspectives of women

underpinning these career trajectories or how gender has impacted on their working lives.

We need to explore the influence of gender roles and expectations on education and training opportunities, career and specialty selection, employment, pay and job security, and the corresponding effect of inequity on individual mental and physical well-being.

The gendered experience of medical school and professional training can serve to limit individuals and affect their career trajectories<sup>6</sup>. Medical students are socialised into medicine, and female medical students develop a professional identity and view of medicine that incorporates the prevailing masculine culture<sup>6</sup>. Medical school teaches men to be doctors and women to be 'women doctors'<sup>6</sup> (p. 1018), with expectations of being approachable, sympathetic and empathetic. Women also describe inappropriate gendered experiences and encounters with patients, colleagues and clinical supervisors, which may not be perceived as sexual harassment and go unreported<sup>6</sup>. The reluctance of co-workers or supervisors to address inappropriate interactions acts as reinforcement that gendered encounters are part of medical education and the culture of medicine.

Ways of coping with gendered experiences in the medical workplace include adopting stereotypical female gender norms, masking or erasing their femininity or sexuality, or adopting masculine behaviour<sup>6</sup>. In establishing a position in the scientific or technological fields, women are being asked more than men; women are asked to "exchange major aspects of their gender identity for a masculine version without prescribing a similar 'degendering' process for men"<sup>7</sup> (p. 2). Progressing in the current culture of medicine can create senior women physicians who may alienate junior women further rather than providing role models, as it "speaks to what women have to go through in order to get to

the positions that they're in"<sup>6</sup> (p.1018). These findings demonstrate how gender norms and expectations manifest in the medical workplace and create structural disadvantage<sup>8</sup>.

Transforming unequal gender relations requires deep change. Individuals need to be educated about how their own worldview contributes to structural inequalities<sup>8</sup>. Medical curricula and professional training programmes should encourage medical educators to examine the role of gender in their teaching, and examine cultural notions of masculinity and femininity encompassed in the system of medicine that they were taught and now practice<sup>6</sup>. Students should reflect on the role of gender on their ideas of medical professionalism and the prestige hierarchy of medical and surgical specialties<sup>9</sup>. Systematic staff training, leadership and mentoring programmes outlined in the 50/50 report can institutionalise space for dialogue and debate about gender equality<sup>1</sup>. Presently, strategies to improve well-being or reduce burnout tend to be gender-blind, not gender-responsive, focusing on general work processes, practice delivery changes, working hours and scheduling<sup>10</sup>, making little or no reference to gender disparities, expectations or norms.

Gender-responsive action requires negotiating and establishing shared values across medical students and physicians, which facilitate a culture and system of medicine that feels fair for individuals of all genders and gender identities. The task is expansive, important, and overdue, but there are key areas for educational and training interventions. Medical students can be taught about variations in patients' and colleagues' expectations of physicians and care delivery based on gender-related assumptions, in order to acknowledge this inequality and better prepare students for future interactions. Medical curricula and professional training programmes can be developed to encourage medical educators to examine the role of gender in their teaching<sup>6</sup>, as well as simultaneously requiring students

to reflect on the role of gender on their ideas of medical professionalism and the prestige hierarchy in medicine<sup>9</sup>. Positive change can be elicited from within medical schools and organisations, by basing interventions on appreciative inquiry into individuals' positive accounts and experience in order to improve behaviours, as opposed to only investigating and managing negative behaviours. Organisational leaders need to be aware that harassment and abuse does not account for all hostile or inappropriate gendered workplace behaviours, and that medical students and trainees may be discouraged from reporting gender discrimination<sup>6</sup>. Medical schools and healthcare organisations should be required to develop and communicate clear gender-related policies and processes<sup>1</sup> for identifying and dealing with gender-related harassment, as well as mitigating against inappropriate gendered experiences which may not constitute harassment but can be harmful or impactful on career trajectories<sup>6</sup>. Finally, we can encourage medical students, trainees and physicians working in challenging environments to build personally relevant action plans for identifying, responding and coping with stress and distress that allow for them to build happiness from stressful experiences by increasing their empowerment and autonomy.

### **Pull-out quotes**

1. Gender-responsiveness requires the examination of gender-related experience and evidence to facilitate change and create gender equitable workplaces.

2. Medical students are socialised into medicine, and female medical students develop a professional identity and view of medicine that incorporates the prevailing masculine culture.

3. The reluctance of coworkers or supervisors to address inappropriate interactions acts as reinforcement that gendered encounters are part of medical education and the culture of medicine.

4. Students should reflect on the role of gender on their ideas of medical professionalism and the prestige hierarchy of medical and surgical specialties.

5. Medical schools and healthcare organisations should be required to develop and communicate clear gender-related policies and processes for identifying and dealing with gender-related harassment.

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