

Gender Equity in the Medical Profession

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Doctors of BC Position

Doctors of BC recognizes gender inequity is a societal issue that shows up in medicine, where female physicians¹ face bias and discrimination that can negatively impact income, career advancement, health and well-being, job satisfaction, and contribute to burnout. While gender inequity in medicine stems from societal gender bias, actions specific to the medical profession can be taken to make it more gender equitable. This statement is a starting point for better understanding the issue of gender inequity in medicine and building on individual and collective physician action to begin addressing it.

Doctors of BC commits to:

- Building on the *Doctors of BC Diversity and Inclusion Barrier Assessment* work to ensure the Association's leadership and governance bodies (committees, the Board of Directors, and the Representative Assembly) reflect the diversity of the Association's membership.
- Using member data to track representation of women and gender diverse physicians in the Association, including those with intersecting identities.
- Using fee data to assist Sections and Societies in measuring the gender pay gap in and between specialties and identifying potential solutions to prevent and/or resolve it.
- Applying Gender Based Analysis Plus (GBA+) in Doctors of BC's decision-making to better understand the impacts on members of decisions and policy based on gender and other identity factors.
- Reviewing physician parental leave benefits administered through Doctors of BC to ensure they are meeting doctors' needs and encouraging people of all genders to use them.
- Helping members access resources like mentorship opportunities and Continuing Medical Education/Joint Collaborative Committee funding available for physicians taking medical-leadership and quality improvement training.
- Helping members advocate at the individual level for fair pay by creating resources to help physicians understand contracts, maximize billing, and negotiate pay, and by directing them to professional contract/legal support services when needed.
- Raising awareness among physicians and in the health care system of gender diversity and gender inequity in medicine and providing ideas for individual and collective action to support positive change.

Doctors of BC recommends that:

- The BC Ministry of Health, health authorities, and other physician employers expand their efforts to identify, resolve, and prevent gender inequity by collaborating with physicians to:

¹ This statement focuses on gender inequity between cisgender women and men: women and men whose gender identity aligns with their sex assigned at birth. Data on gender diverse physicians is extremely scarce but will be covered where data is available, or conclusions can be reasonably be drawn from other studies. Finally, we recognize that sex and gender are not synonymous, however the statement uses "male" and "female" interchangeably with "men" and "women" for purely stylistic reasons.

- remove and/or prevent gender pay gaps in fee codes and alternative payment plans.
 - better accommodate doctors with children or other care-taking responsibilities so that they can participate in leadership, attend training, and avoid loss of income or negative impacts on career advancement.
 - apply a GBA+ or other equity lens when developing policy or making decisions that affect physicians.
 - review hiring and promotion practices to identify and address potential gender bias and track gender representation in leadership and other positions over time.
 - evaluate equity, diversity, and inclusion (EDI) policies and processes, as well as workplace benefit plans, to determine if they are adequately supporting gender equity for physicians, particularly women and gender diverse physicians.
- Medical schools and residency programs build on existing EDI work by collaborating with medical students and physicians to identify and address the impact that gender bias, discrimination, and harassment can have during medical training.

Background

Gender inequity in society leads to unfair treatment and barriers for people based on their gender. Literature, as well as feedback from Doctors of BC's membership, shows that gender inequity in medicine greatly affects female physicians and is a result of both systemic and individual level bias. Like many other professions, medicine was historically dominated by men, established around traditional gender roles, and resistant to the inclusion of women. Today, medicine is much more gender-inclusive – more than half of new medical graduates are women – yet gender inequity persists [1]. It shows up through workplace harassment and discrimination, unequal distribution of domestic labour, and lower income which can contribute to female physicians facing higher rates of burnout, suicidal ideation, depression, and sleep disorders, while experiencing lower rates of job satisfaction [2, 3, 4, 5, 6,7].

Studies indicate that female physicians face higher levels of workplace bullying and are three times more likely than male physicians to report instances of gender-based discrimination [8, 9]. Alarming, 30% of female physicians and medical students have reported experiencing sexual harassment over the course of

their career [6]. [Doctors of BC's 2022 Health Authority Engagement Survey \(HAES\)](#) showed that only 61% of female physicians agree that “people from all backgrounds are treated fairly in our workplace” compared to 71% of male physicians. Discrimination and bias can come from male colleagues, other women, other staff, management, and patients.

The “hidden curriculum” refers to the bias women face in medical school from classmates, educators, and supervisors. Gender bias can lead women to be discouraged from joining higher paying specialties based on gendered assumptions about women's priorities, a lack of existing female representation in certain specialties, and the reported tendency for men to mentor and network with like-minded male colleagues [3, 10]. These barriers mean certain specialties are seen as less gender-inclusive or have greater potential for gender-based harassment or discrimination from colleagues, patients, administrators, and other providers.

For the last 25 years, more women than men have been graduating from medical school; yet they are not equally represented in leadership positions [5]. Across Canada's 17 medical schools, only a handful of women have been appointed as deans. Women are reported

as being underrepresented in academic, medical, and professional leadership roles as well [6]. Gender bias against women as leaders and experiences of harassment or discrimination often discourage women or gender diverse physicians from applying for leadership roles in the first place. Barriers to diverse gender representation in leadership, committees, boards, or sections mean women and gender diverse physicians may not be included in decisions affecting their income or work environment.

Entrenched and unfair societal expectations for women to perform most unpaid domestic labour add to the challenges faced by female physicians. On average, female physicians spend 100.2 minutes more per day to 8.5 hours more per week than male colleagues on such things as household chores, childcare, or other caretaking activities [11]. Unequal domestic expectations affect both women with and without children. For example, female physicians without children still do more caretaking work for dependents such as elderly parents, a sick spouse, or a family member [12]. As a result, female physicians may be forced to work fewer hours, work evenings and/or weekends, or must do part-time and on-call work [13]. The unequal distribution of unpaid labour on women is associated with poorer physical and mental health, which can contribute to decreased capacity for women to become involved in additional leadership positions.

Recent studies show that female physicians have lower income than male physicians, even after controlling for variables such as geography, specialty, and working characteristics. For example, an Ontario study shows that female physicians earn 13.5% less than their male colleagues, while another study showed that women in surgery earned 14% less than men after adjusting for specialty and hours worked [14, 15, 16]. There are several potential contributors. Implicit bias in creating fee codes can lead to lower fees for women-dominated specialties or for procedures more often done by women and/or performed on female patients. Bias can also lead to

fewer referrals for women, fewer high-paying referrals, or over-referral of patients with more time-consuming needs because of assumptions that women are better at providing emotional support [2, 3, 17]. Unconscious bias or underrepresentation of women at negotiation tables can also mean income gaps for women are not discussed and continue to persist.

Gender Equity and Gender Diverse Physicians

There is little data on gender diverse physicians, but a study of transgender, non-binary, and two-spirit Canadians showed that an average of 70% of respondents experienced verbal harassment at school or work in the previous year. 32% reported experiences (real or perceived) of being fired, dismissed, or turned down for a job because of who they are [18, 19]. Similar issues could exist in medicine, however more data is needed to understand the extent of gender inequity faced by gender diverse physicians specifically.

Intersectionality

In online member engagement, physicians described how their experiences of gender bias intersected with bias based on their race, age, and/or ability [2]. Intersectional research on gender equity in medicine is minimal; however, available studies show that racialized women and older women face additional discrimination at all levels of their career [20]. A survey of Indigenous health care providers in BC shows they face disturbing levels of discrimination or bias in the workplace, with 52% of respondents indicating they had personally experienced anti-Indigenous racism at work [21]. Physicians with disabilities also face discrimination, lack of accessible workplaces, and are underrepresented relative to the Canadian population [22].

Gender Equity and Men

Gender equity is often considered a “women’s issue,” but men who challenge the systems that maintain

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gender inequity are needed to make progress. However, gender bias and rigid norms can cause men to be penalized when they act outside gendered expectations or advocate for gender equity. Medicine-specific data is limited, but general workplace studies show that men who: ask for help, advocate for their teams over themselves, ask for parental leave, are agreeable or modest, and who engage in feminist activism are judged to be weak, indecisive, incompetent, and low in agency [23, 24, 25, 26]. As a result, they may get paid less, lose out on promotions, and may be dismissed from their job for poor performance [23, 24, 25, 26]. It is possible that these trends occur in medicine as well; however, more research is needed.

Analysis

As part of a larger societal problem, gender inequity in medicine cannot be solved only through changes in the health care system. However, efforts can and should be made where possible. First, there is a need to better understand and track the issue by collecting data on gender representation (including gender diverse physicians) in leadership, researching factors contributing to or improving gender inequity, identifying potential gender pay gaps within specialties, and collecting more data to enable research on intersectionality and gender equity in medicine.

Doctors of BC remains engaged in ongoing work to improve equity, diversity, and inclusion (EDI), and this work will be beneficial in helping improve gender equity in medicine over time. On the issue of gender equity specifically, the Tariff Committee (the body that considers fee guide changes by Sections) is requesting that when Sections and Societies submit applications to create new fee codes or change existing codes, they must consider gender payment differences. Doctors of BC will support Sections and Societies with data and analysis to meet this requirement.

To build on existing work, Doctors of BC commits to continuing to better understand gender equity

challenges faced by members and applying a gender-based analysis plus (GBA+) lens to inform decision making. We commit to ensuring our governance bodies are inclusive and representative, reviewing member parental leave benefits, raising awareness of gender inequity in medicine, and supporting women and gender diverse physicians in leadership and mentorship.

Improving gender equity also requires the involvement of health authorities, the Ministry of Health, physician employers, and medical schools. We know steps are already being taken. UBC is working to embed EDI considerations in curriculum, policies, and the culture of medical education. The provincial government has committed to applying GBA+ to policy making, and health authorities are including EDI in their policies and processes.

To build on these efforts, medical schools, government, health authorities, and other physician employers should work with physicians to identify local and system-level gender equity issues and develop solutions to address them. Doctors of BC recommends that these groups collect and track data on gender equity in medicine, apply GBA+ to decisions or policy impacting physicians, increase flexibility and support for improving work-life balance, and address bias and discrimination in the workplace and in medical school.

This policy statement is only a start and builds on work being done by physicians individually and collectively. Doctors of BC supports our members in this work and will work collaboratively with our health system partners to create positive change.

References

1. Canadian Medical Association. Quick facts on Canadian physicians. 2019. <https://www.cma.ca/quick-facts-canadas-physicians>.
2. Doctors of BC. What We Heard report: gender equity in BC medicine. Doctors of BC. 2021. <https://www.doctorsofbc.ca/news/what-we-heard-report-gender-equity-bc->

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POLICY STATEMENT



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