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Gender in the ICU

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Women in Critical Care

An overview of gender inequity in critical care medicine, why there is limited progress towards gender equity in this particular specialty, barriers to women's progress and possible solutions.

The United Nations Educational, Scientific and Cultural Organization have delineated the difference between two entities - equality and equity as "Gender equality, does not mean that women and men have to become the same, but that their rights, responsibilities, and opportunities will not depend on whether they were born male or female. Gender equity means fairness of treatment for men and women according to their respective needs. This may include equal treatment or treatment that is different, but which is considered equivalent in terms of **rights, benefits, obligations, and opportunities".**

Progress toward gender equality in the United States has slowed or stalled. Recent research on the gender differences in scientific careers shows that although almost 49% of high school graduates are women, only 11% occupy top academic positions as opposed to 89% of men showing the underrepresentation of women. Despite dramatic progress in moving toward gender equality between 1970 and 2018, in recent decades, change has declined. The slowdown on some indicators and stall on others suggests that further progress requires substantial institutional and cultural change. Progress may require increases in men's participation in household and care work, governmental provision of childcare, and adoption by employers of policies that reduce gender discrimination and help both men and women combine jobs with family care responsibilities.

Why Aren't We Making More Progress Towards Gender Equity?

Research shows that one reason may be that many leaders acknowledge that the bias exists in general but fail to recognise it in their daily workplace interactions. This "gender fatigue" means that people aren't motivated to make a change in their organisations. Through ethnographic studies and interviews across industries, the author identified several rationalisations leaders use to deny gender inequality. "First, they assume it happens elsewhere, at a competitor, for example, but not in their organisation. Second, they believe that gender inequality existed in the past but is no longer an issue. Third, they point to the initiatives to support women as evidence that inequality has been addressed. Last, when they do see incidents of discrimination, they reason that the situation had nothing to do with gender. *Until we stop denying inequality exists in our organisations, it will be impossible to make progress".*

While the number of women entering medical school now equals or surpasses the number of men, gender equity in medicine has not been achieved. Women continue to be underrepresented in leadership roles (e.g., deans, medical chairs) and senior faculty positions. In addition, women do not enter medical specialties as often as men, which can have important implications for the work environment, reimbursement, and the delivery of patient care. Compared with other medical specialties (e.g., anaesthesiology, dermatology, etc), critical care medicine (CCM) is a medical specialty with some of the lowest representation of women. While strategies to improve gender equity in critical care medicine exist in the published literature, efforts to comprehensively synthesise, prioritise and implement solutions have been limited.

CCM is not "gender-friendly" by design. This will have a major impact on the discipline given the increase in the number of female doctors. While there is an increase in females in critical care medicine, women continue to be underrepresented in roles such as full professors in academic critical care medicine (Mehta et al. 2018; Mehta et al. 2017; Parsons et al. 2019; Metaxa 2013), authors of scientific literature (Mehta et al. 2018; Metaxa 2013), speakers at international conferences (Mehta et al. 2018), editors in journals (Mehta et al. 2017; Parsons et al. 2019), members of scientific boards (Mehta et al. 2017; Metaxa 2013), entrepreneurs and CEO of start-ups (Kanze et al. 2017; Malmstrom et al. 2017), engineers and designers for medical devices (Kanze et al. 2017; Malmstrom et al. 2017), authors of guidelines (Metaxa 2013; Merman et al. 2018), and members task force panels (Mehta et al. 2018; Mehta et al. 2017; Parsons et al. 2019; Janssen et al. 2019). Participants unanimously described critical care medicine as a specialty practiced predominantly by men. Most women described experiences of being personally or professionally impacted by gender inequity in their group. Postulated drivers of the gender gap included institutional and interpersonal factors.

Barriers to Women's Progress

Female physicians continue to face myriad challenges in medicine ranging from implicit bias to gaps in payment and promotion to sexual harassment. Therefore, it is not surprising that although equal numbers of men and women now graduate from medical school, only a small fraction of female physicians become medical leaders. Currently, in the U.S., only 3% of healthcare CEOs are women, 6% are department chairs, 9% are division chiefs, and 3% are serving as chief medical officers. This is despite women comprising 80% of the healthcare workforce and evidence that having women in upper management and on corporate

boards is associated with improved financial performance and enhanced accountability.

The gender pay gap also varies from 34% to 50% among physicians. In a study by Chadwick et al. (2020), women's most important workplace concerns included work-life balance (64%), compensation (43%), combining parenthood and work (30%), gender equity (19%), career development (16%), relationships with colleagues and staff (16%), age discrimination (6%) and sexual harassment (1%).

Women are persistently underrepresented and the study of women's leadership is neglected or treated in a different way in leadership. "Women leaders' decision-making capacity and consequently their effectiveness as leaders, are judged based on conceptions about their motherly role, them being emotional and their physical attributes unrelated to their leadership capacity" (Sjoberg 2016). 'Gendered leadership' based on assumed group characteristics, spreads the weightage of "male and masculine characteristics, such as strength, power, autonomy, independence, and rationality, typically, while devaluing female and feminine characteristics, such as emotionality, passivity, dependence, marginalisation, and weakness". However, individual women (and men) experience 'gendering' and the processes by which gendering operate differently based on their diversity. Furthermore, men are associated with the public sphere (work politics and public life) and women are associated with the private sphere (motherhood, household, and the bedroom). These (mis)conceptions of gendered leadership associating good leadership with male characteristics and weak leadership with female characteristics are further reinforced through 'gender tropes' which signifies "gender norms and stereotypes which reinforce existing gendered leadership".

> **"critical care medicine is a specialty practiced predominantly by men .... women describe experiences of being personally or professionally impacted by gender inequity in their group"**

A Recent Survey on Women in CCM

A recent study by Siddiqui et al. (2021 - unpublished) reveals some important insights into the practice of critical care by anaesthesiologists, especially during the pandemic showing a high degree of stress and anxiety among anaesthesia trained intensivists. However, when these data were analysed by gender and age, it was found that women and younger respondents felt more anxiety symptoms. Also, there was strong evidence to suggest that women and younger physicians felt emphatical that bias and lack of diversity were present in CCM. This study provides new and telling information about the disparity of perception of anxiety, diversity, and bias within CCM by different demographics. This information can be used to address these issues of systemic bias and provide personalised avenues of burnout mitigation.

A Way Out

If programmes acknowledge gender fatigue and modify their behaviour, this opens the possibility of wider change within organisations. The goal is to create a culture where gender equality can be openly discussed without assigning blame or guilt, and instead, people at all levels of the organisation can be proactive about modifying their daily behaviours. According to Mehta et al. (2018), "critical care societies can establish diversity policies. Journals can publish the principles and methods of panel composition for professional document development. There should be publicly available metrics of women's representation on panels for definition documents, consensus statements, and practice guidelines. Gender parity policies can be incorporated into relevant bylaws within all areas of academic critical care. Training must be offered on diversity and unconscious bias for all critical care academics, particularly those in leadership positions". Until we stop denying inequality exists in our organisations and specialties, it will be impossible to make progress.

Conflict of Interest

None. ■

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