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Editorial

A Prevention Approach to Reducing Gender-Based Harassment and Discrimination in Cardiovascular Medicine

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Gender harassment (physical or verbal behaviour, such as bullying) and discrimination (being treated differently on the basis of gender) are rampant in healthcare. Gender discrimination in the workplace has 4 key manifestations: creation of a hostile work environment, a gender pay gap, inequalities in career advancement, and imbalanced representation in leadership. Half of the women in healthcare training or academic healthcare witness or experience unprofessional behaviour.[1] One in 2 female medical students (compared to 1 in 5 male medical students),[2] and 1 in 3 female physicians (compared to 4% of male physicians)[3] experience sexual harassment. Women in healthcare are less likely to be promoted than their male colleagues, despite having similar seniority and productivity,[4] and women in academic medicine are paid less than men for the same job.[5] Women continue to be underrepresented in upper faculty ranks, with no evident improvement since 1980.[6]

Gender-based disparities in healthcare are particularly prominent in cardiovascular medicine. In Canada, where more than 50% of medical students are women, only 30% of trainees in cardiology and cardiovascular surgery residency programs are women.[7] Only 22% of cardiologists and 9% of cardiac surgeons are women,[7] and there are no women who are heads of departments or residency program directors in cardiac surgery at present. Surveys of female trainees suggest that the underrepresentation of women in cardiovascular residency training programs is influenced by observations of a culture that favour male stereotypes and agentic personality types, and is not welcoming for women who plan to have children.[8] Furthermore, the "leaky pipeline"[9] phenomenon, a metaphor which describes the attrition of women from the academic pipeline before they reach senior positions, reflects the inadequacy of current strategies to reduce gender harassment and discrimination.[7]

The most common strategies to address gender discrimination are professionalism policies, internal grievance systems, and implicit bias training. Clinicians are often unaware of the existence of professionalism policies, and those who are aware may not report unprofessional behaviour because they doubt their report will lead to action by hospitals or universities. Internal grievance systems, typically available through human resource departments, are underutilized because people are concerned that lack of anonymity will result in negative repercussions for reputation and career advancement.[10] In turn, underutilization falsely reassures organizations that harassment and discrimination are not happening. Implicit bias training is a short-term educational intervention that may in fact worsen biases and discrimination by activating stereotypes.[11] There is little evidence that implicit bias training brings about institutional change or reduces harassment and discrimination in the workplace.[12] However, organizations have unrealistic confidence in implicit bias training programs, which desensitizes them to persistent or even worsening biases.[13]

When professionalism policies, internal grievance systems, and implicit bias training fail, cases of gender harassment and discrimination result in formal complaints to administrators, regulatory bodies, professional societies, and human rights tribunals.[14] By this time, harassment and discrimination are so advanced that all possible outcomes result in damage to both complainant and institutions, as well as significant collateral damage such as impact on staff and faculty morale. Here, as in the prevention of cardiovascular disease, we believe "an ounce of prevention is worth a pound of cure." Primary prevention of cardiovascular disease is effective, especially in high-risk patients with a strong family history of premature cardiovascular disease or those with risk factors. Analogously, primary prevention strategies should be initiated in high-risk healthcare environments, in which bullying, cronyism, and severe imbalances of gender should be considered risk factors.

Primary prevention of gender harassment and discrimination should focus on the creation of a more diverse and inclusive work environment. Increased representation of women, and diverse gender, ethnicity, and race identities, in the workplace promotes an institutional climate less tolerant of

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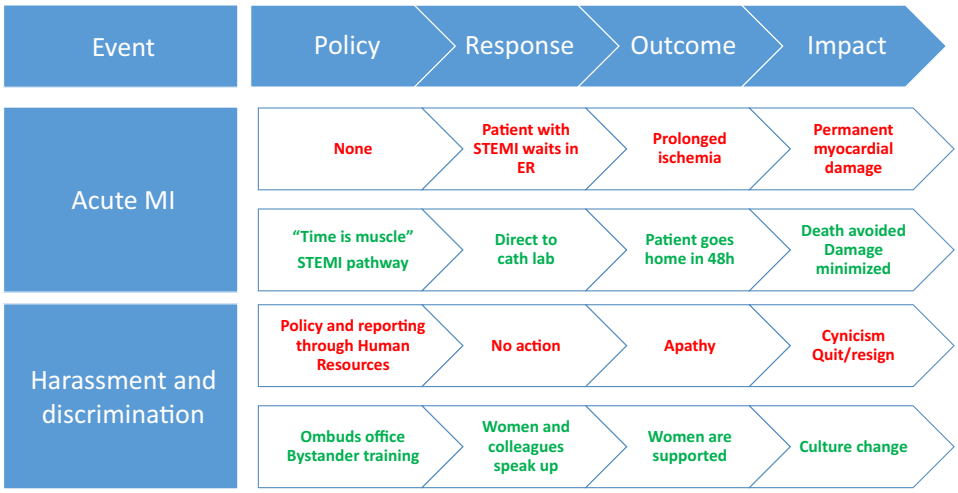

Figure 1. Cardiovascular and discrimination pathways and outcomes. ER, emergency room; MI, myocardial infarction; STEMI, ST-segment elevation myocardial infarction.

traditional decision-making networks such as the "old boys' club." Diversity in the workplace also prevents "group-think" and blind spots, so that issues such as the gender pay gap and unequal career advancement are identified and discussed.[15] Structural changes to create more-inclusive work environments include stronger top-down modelling, discussion of professionalism, and the creation of equitable practices for leadership opportunities and remuneration. A diverse and inclusive work environment is also promoted by informal actions such as the "cup of coffee approach" between the leadership and suggested perpetrators of harassment or discrimination, in order to convey that such behaviour is noticed and is unacceptable.

However, as with the prevention of cardiovascular disease, primary prevention strategies for gender harassment and discrimination are often imperfect, and secondary prevention strategies are required to address persistent symptoms and manifestations. Akin to coordinated ST-segment elevation myocardial infarction (STEMI) pathways, which by reducing ischemic, time minimize myocardial damage and dysfunction, effective secondary prevention pathways to address gender harassment and discrimination are not commonly available in hospital systems and academic medical institutions in Canada. Unreliable secondary prevention pathways, such as professionalism policies that are not enforced and internal grievance systems that cannot maintain confidentiality, instead can result in more damage and disease progression (Fig. 1).

One effective secondary prevention strategy is bystander training, which has been successfully implemented on American college campuses and in the military.[11] Bystander training creates a culture of accountability, where everyone in the workplace assumes responsibility for speaking up against harassment. Bystander training removes the onus from those experiencing harassment and discrimination, and spreads responsibility, agency, and engagement across all members of the workplace.[1]

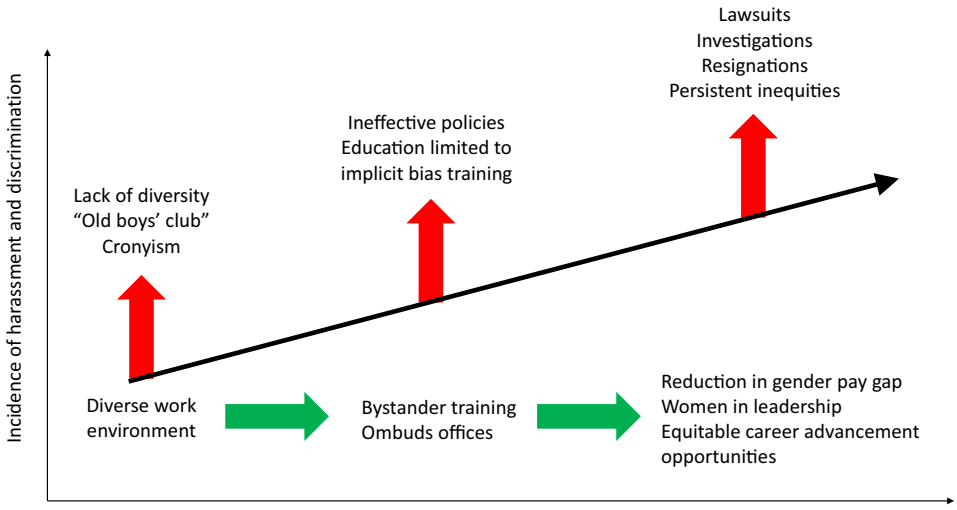

Figure 2. Pathway by which a more gender-balanced and equitable workplace environment can reduce the gender pay gap and increase career advancement and leadership opportunities for women in cardiovascular medicine and surgery.

Those experiencing harassment and discrimination also require a safe and confidential way to speak up. Ombuds offices are independent, confidential, neutral, and informal resources for organizations and their employees. They hear employees' concerns confidentially and help them to think through their options. They also compile anonymous information on hotspots, trends, and systemic issues for organizations to target.[16] Setting up an ombuds office is not as difficult or costly as administrators may think: such offices are even available online through virtual ombuds services, such as tEQuitable, a Silicon Valley startup.[17]

Primary and secondary prevention of gender harassment and discrimination in medicine requires innovative strategies that create cultural and structural change. As with strategies to prevent cardiovascular disease, these prevention strategies should be evidence-based, and their impact must be measured and reported. Only by changing their culture and structure will cardiovascular medicine and surgery departments see significant improvements in the workplace environment for women. Developing and evaluating clear strategies to reduce harassment and discrimination (ie, bystander training and ombuds offices) will shift culture and create a work environment that does not dissuade female trainees from pursuing cardiovascular medicine and surgery. The creation of a more gender-balanced and equitable workplace environment should lead to a reduction in the gender pay gap, and increase career advancement and leadership opportunities for women in cardiovascular medicine and surgery (Fig. 2).

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