GUIDELINES

ISCCM Position Statement for Improving Gender Balance in Critical Care Medicine

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Abstract

Gender disparity in Critical Care Medicine (CCM) persists globally, with women being underrepresented. Female Intensivists remain a minority, facing challenges in academic and leadership positions at the workplace and within academic societies. The Indian Society of Critical Care Medicine (ISCCM) recognized the need for addressing issues related to gender parity and constituted its first Diversity Equity and Inclusion (DEI) Committee in 2023. Through a Delphi process involving 38 Panelists including 53% women, consensus and stability were achieved for 18 statements (95%). From these 18 consensus statements, 15 position statements were drafted to address gender balance issues in CCM. These statements advocate for equal opportunities in recruitment, workplace inclusivity, prevention of harassment, and improved female representation in leadership roles, nominated positions, and conferences. While the consensus reflects a significant step toward gender equity, further efforts are required to implement, advocate, and evaluate the impact of these measures. The ISCCM position statements offer valuable guidance for promoting gender balance within society and the CCM community.

Keywords: Critical care, Female, Gender equity, Leadership, Workplace.

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Introduction

Medicine has conventionally been a male-dominated profession the world over.[1] Traditionally, the idea that men are superior to women is deeply ingrained in our culture. Therefore, it is considered natural that men go out to work and women tend to families and homes. Over recent years, opportunities and encouragement for female education have increased in India, and this is reflected in the number of female students enrolling in undergraduate medical schools.[2] In Kerala, almost 65% of students enrolling in undergraduate medical courses (MBBS) are females, higher than the national average of 51% female students.[3] However, the ratio at the postgraduate level is about 30% women and drops even further in professional practice. One report states that only 17% of female doctors actively practice medicine.[4]

Critical Care Medicine (CCM) is a highly demanding specialty in terms of work-related stress, number of working hours, and irregularity of shift duties. As a specialty, there is gender disparity not only in the workforce but also in academic and leadership positions.[1,5,6] Women Intensivists make up around 20–40% of work force. However, they are less likely to be the first authors in scientific publications, less likely to get funding for their research, and more likely to have their work published in the lower-impact journals.[1,7,8]

Indian Society of Critical Care Medicine (ISCCM) has approximately 17,000 members, 70% of whom are male (ISCCM 2024 Membership Data). There was a long-felt need to address gender parity issues within our society. In 2023, ISCCM constituted

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its first diversity equity and inclusivity (DEI) committee. As a first step, the DEI committee conducted two surveys to gather baseline information on gender parity issues within our specialty. The first survey (unpublished data) addressed the effect of gender on career progression among our former critical care students. Thirty-nine percent of the respondents were females. Though a majority (39%) were working as consultants, half felt that their careers had yet to progress as expected. Key reasons identified were being from the female gender (17.6%), responsibility for family and kids (21%), and need for maternity breaks (13%). The second survey (unpublished data) explored the barriers to equality in CCM and 33% of respondents were women. Among the women respondents, 46% reported that their career in critical care was compromised due to family commitments, and almost half had taken a career break at some point. Half of the women respondents said that they had no support from their spouse/partner for academic work, and 17% said they were solely responsible for all household chores. Almost 40% of the women feel that they were not substantially represented in ISCCM and lacked opportunities in conferences. Half the women said they did not get maternity leave, flexible working hours, or nursing breaks when they rejoined work after delivery.

The observations made from the surveys highlighted the need for an ISCCM position statement to improve gender balance in CCM. Various societies and bodies including the European Society of Intensive Care Medicine (ESICM), Society for Critical Care Medicine (SCCM), International Women in Intensive Care Medicine Network (IWIN), Australian and New Zealand Intensive Care Society (ANZICS) and the French Intensive Care Society (FICS) have provided guidance to promote and gender equity in CCM.[6,9–11] Though the issue of gender balance in CCM is global, regional and cultural differences may create issues that need to be addressed differently. Since research in this area is sparse, we used the Delphi methodology to generate consensus on issues about gender balance.[12]

Materials and Methods

The Delphi Process

A Steering Committee (SC) was formed, including six members (PS, US, FNK, SR, GC, and SNM) from the ISCCM DEI Committee and a methodologist (PN) who executed the Delphi process. An Expert Panel including members of the DEI Committee, past presidents, and other senior members of ISCCM actively involved with the society in leadership positions was constituted. A concerted effort was made to achieve diversity among the Panelists. Upon acceptance, the Delphi survey questionnaire was e-mailed to the Panelists. After each Delphi round, a consolidated report with anonymized responses to the Delphi questionnaire and feedback was discussed among the SC members to prepare the survey questionnaire for the next Delphi round. The survey report and the new survey questionnaire were shared with the Expert Panel. The SC members did not participate in the Delphi rounds.

The literature on this subject is sparse. Therefore, the scope of the project was developed by the SC through an evidence synthesis from the gender disparity cross-sectional surveys conducted by the DEI committee, among the ISCCM members. Delphi survey statements were drafted based on the gaps identified from the results of the surveys. The statements were presented to Panelists as an open round one Delphi survey questionnaire to include their feedback. The Delphi survey included six domains: (1) Workforce recruitment, (2) Addressing healthcare workers, (3) Representation of

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healthcare workers in conferences, (4) Representation in leadership positions, (5) Representation in ISCCM Committees, and (6) At the workplace. The Panelists subsequently responded anonymously through several iterative rounds. The Delphi process was continued until all statements achieved stable responses. The Panelists were allowed to provide feedback in each round.

Consensus and Stability

The survey questionnaires were drafted as multiple–choice questions or seven-point Likert–scale statements. Consensus was defined as 70% or more of Panelists voting on a particular option in the multiple–choice questions or agreement (score of 5–7), or "disagreement" (score of 1–3) on a Likert—scale statement.[12] The median and interquartile range (IQR) were used for responses of Likert–scale statements to describe the central tendency and dispersion. The stability of responses was assessed from round two onwards, using the non-parametric Chi-square (χ^2) test or Kruskal–Wallis test ($p < 0.05$ was considered as a significant variation or unstable).

ISCCM Position Statements

The ISCCM position statements were drafted from the Delphi statements that achieved consensus and stability. The final results of the Delphi process, the position statements, and the manuscript were circulated among the Panelists for approval before submission for publication.

Results

Of the 40 Panelists invited, 38 (95%) accepted to participate in the Delphi process. Twenty Panelists (53%) were female. All Experts participated in the four rounds of Delphi process between in January 2024. Consensus and stability were achieved in 18 of the 19 (95%) of Delphi statements. One statement did not achieve consensus. The final result of the Delphi process is provided in Table 1. Fifteen ISCCM position statements were drafted from these 18 Delphi statements that achieved consensus. These statements are listed in Figure 1. The report of four Delphi rounds is provided in the Appendix One.

Discussion

The Delphi process generated consensus for 18 out of 19 statements (95%) from which 15 ISCCM Position Statements were drafted. These statements serve as a structured framework providing measures that can be adopted for improving gender balance in CCM and within ISCCM.

At the Workplace

Workforce Recruitment

- The recruitment of female staff in CCM should be independent of their plan for marriage, plan to have children or spouse income. Questions related to these should be avoided.
- Pay parity should exist between male and female staff with equivalent credentials and work profiles.

During recruitment interviews, a prospective woman health care worker (HCW) is more likely to be asked about her plans to get married, with underlying negative connotations anticipating likely absenteeism for various family reasons. This may invariably create a bias at the outset, reducing her chances of getting selected, in comparison to a male candidate. Similarly, possible pregnancy or a plan to have children may serve as a deterrent for recruiting a woman for the position. Panelists agreed that the recruitment of workforce should be independent of their plan for marriage or pregnancy. However, a consensus could not be achieved for not asking about the marital status of a candidate during an interview.

It is well-known that women physicians are often paid lesser than their male colleagues. Some reports mentioned a pay disparity between 24 and 35% between female and male counterparts, irrespective of merit and experience.[13] Our survey revealed that women are often asked about the income of their spouse, or why they would want more salary when their spouse was earning well. There was 87% consensus among the Panelists that asking a woman about the income of her spouse during an interview was inappropriate. A method described to address the pay gap issue is to pay men and women equally and also publish metrics of salaries.[1] Panelist of this study agreed with pay parity and that asking a woman about the income of her spouse during an interview, was inappropriate.

Addressing Healthcare Workers

- To prevent female doctors from being identified as paramedics, they could be introduced as doctors to visitors/family members and wear name badges.
- The female staff should be introduced or addressed as equivalent to their male counterparts in professional organizations or conferences.
- Gender-neutral titles/designations should be used (e.g., Chairperson instead of Chairman).

It is a common occurrence, especially in Indian ICUs, for a female doctor to be mistaken for a nurse or other paramedic and be called "sister" or "nurse" by patients/family members or a female voice heard on a phone call to the ICU, to be misidentified as that of a nurse. While this may be not intentional and likely reflects a societal gender stereotype, women doctors resent being misidentified in this context. Active efforts are needed to prevent such stereotyping and bias, which may negatively impact a woman's actions and overall self-esteem. While it is difficult to have a policy for this, being a social bias, one of the ways of preventing this from occurring in ICU, is for colleagues of either gender, to introduce women as doctor's to the patients and their families. Wearing a name badge with a doctor title may also help overcome this problem, though it leaves the onus on the woman to solve the issue.

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Table 1: ISCCM position statements for improving gender balance in Critical Care Medicine

	Agree (%)	*Neutral (%)*	*Disagree (%)*	*Median (IQR)*	*χ^2 p-value*
Domain 1: Workforce recruitment					
1. Recruitment of female staff in CCM should be independent of their plan for marriage	97.4	0	2.6	7 (0)	0.15
2. Recruitment of female staff in CCM should be independent of their plan to have children.	94.7	5.3	0	7 (0)	0.28
3. The following questions should not be asked to female staff during recruitment?	–	–	–	–	0.95
• Marital status	55.3	–	–	–	–
• Intention to get married	78.9	–	–	–	–
• Whether pregnant	60.5	–	–	–	–
• Plan to have children	78.9	–	–	–	–
• Number of children	57.9	–	–	–	–
• Spouse income	86.8	–	–	–	–
4. Salary/professional fees/remuneration should be equivalent to male counterpart with equivalent credentials and work profile (pay parity)	97.4	2.6	0	7 (0)	0.69
Domain 2: Addressing healthcare workers					
1. It has been observed that female doctors are mistaken to be nurses by visitors/family members. The following methods can be adopted to minimize this:	–	–	–	–	1.0
• Introducing the female doctor as doctor X to visitors/family members	78.9	–	–	–	–
• Wearing name badges (e.g., Dr. X)	92.1	–	–	–	–
2. It has been observed that female speakers/moderators are addressed by their first name, while their male colleagues are introduced by appropriate prefixes during conference/ administrative meetings (e.g., Dr/Prof. X). This can be prevented, by introducing/addressing the female in an equivalent manner as their male counterparts	94.7	0	5.3	7 (0)	0.17
3. Gender neutral titles/designation should be used in professional organizations/societies and conferences (e.g., chairperson instead of chairman)	97.4	2.6	0	7 (0)	0.43
Domain 3: Representation of healthcare workers in conferences					
1. The following considerations/arrangements should be made while planning the ISCCM annual conference:	–	–	–	–	0.94
• In addition to other logistic considerations, the date of annual ISCCM conference should take into consideration of family specific responsibilities of female HCWs (e.g., children's annual/ board school examinations)	60.5	–	–	–	–
• Provision for nursing a baby at the venue	63.2	–	–	–	–
• Provision for baby-sitting facilities at the conference venue	73.7	–	–	–	–
2. Though we assume that academic merit is equivalent among genders, sessions/panels with only male faculty is common. Therefore, conscious efforts should be made to avoid only male faculty in academic sessions/panels	73.7	23.7	2.6	7 (3)	0.86
3. In addition to the academic merit, every session should have proportionate gender representation as per society membership	65.8	18.4	15.8	6 (3)	0.58
4. The following measures should be taken to improve female representation in academic meetings:	–	–	–	–	0.14
• Active effort to identify female speakers for a particular topic	84.2	–	–	–	–
• Women mentorship programs	78.9	–	–	–	–
• Efforts to sensitize members about the existing gender gap in female representation in programs	63.2	–	–	–	–
• Quotas for women	0	–	–	–	–
• Specific targets to be achieved over time (e.g., increase representation to X by next year)	18.4	–	–	–	–

(Contd...)

Table 1: *(Contd...)*

	Agree (%)	*Neutral (%)*	*Disagree (%)*	*Median (IQR)*	*χ^2 p-value*
Domain 4: Representation in leadership positions (National/branch elections and College board elections)					
1. It has been observed that female representation is proportionately less in Executive Committee/College board which involve elections. The following measures should be taken to improve female representation:	–	–	–	–	0.08
• Quota for women	5.3	–	–	–	–
• Active encouragement of women to stand for ISCCM elections	97.4	–	–	–	–
• Concerted efforts from ISCCM to encourage female leadership	81.6	–	–	–	–
Domain 5: Representation in ISCCM Committees					
1. In the ISCCM committees (e.g., guidelines/research/scientific/ organizing committees), female nomination should be proportionate to membership ratio (currently it is around 30%)	73.7	7.9	18.4	7 (3)	0.44
Domain 6: At the workplace					
1. If feasible, irrespective of gender, healthcare workers should be permitted flexibility in working hours. This is for genuine/ reasonable family related issues for a limited period of time	81.6	13.2	5.2	7 (1)	0.87
2. There should be equal work distribution among health care workers in the same position	100	0	0	7 (0)	0.23
3. The following infrastructural arrangements should be available for female health care workers in ICU:	–	–	–	–	0.99
• Availability of separate changing rooms	97.4	–	–	–	–
• Availability of separate toilets	86.8	–	–	–	–
• Availability of separate resting area	81.6	–	–	–	–
• Child-care facility	60.5	–	–	–	–
4. Maternity leave should be provided for female health care workers as per the existing national laws from the Government of India	100	0	0	7 (0)	0.69
5. Equal opportunities in academic activities, research and professional growth (e.g., leave for conferences/workshop/ research) should be provided to staff in the same position, irrespective of the gender	97.4	2.6	0	7 (0)	0.84
6. Though there is a law to protect women at their workplace, i.e., Prevention of Sexual Harassment (PoSH) Act, lack of awareness among employees has made it as good as non-existent. The following measures should be adopted to prevent harassment/bullying at workplace:	–	–	–	–	0.95
• Organizing PoSH training programs in the workplace to improve awareness and foster healthy relationships and equality among employees	92.1	–	–	–	–
• Provision for non-judgmental anonymized reporting and redressal mechanisms	84.2	–	–	–	–
• Separate committee to address/investigate harassment/ bullying cases	89.5	–	–	–	–
• Appropriate and transparent action taken against the offenders	81.6	–	–	–	–

HCWs, Healthcare workers; ICU, Intensive care unit; ISCCM, Indian Society of Critical Care Medicine; IQR, Interquartile range; χ^2, Chi–square. The statement which did not achieve consensus is highlighted in grey

This bias also extends to women speakers in scientific meetings, where male speakers are more often introduced professionally using prefixes like "Doctor" or "Professor". In contrast, women are often addressed by their first names. Several gender stereotype titles and designations are used for various positions, for example, "Chairman" instead of "Chairperson", without considering the fact that women may also occupy these positions. The Panelists agreed that women should be introduced or addressed as equivalent to their male counterparts in professional organizations or conferences, and gender-neutral titles/designations should be used.

Workplace Inclusivity

- Equal work distribution and opportunity in academic activities, research, and professional growth, should be provided to staff in the same position, irrespective of gender
- If feasible, irrespective of gender, healthcare workers should be permitted flexibility in working hours, provided for genuine family-related issues and for a limited period
- The infrastructural arrangements for female staff in the ICU should include the availability of separate changing rooms, toilets, and rest areas

Gender equity at the workplace

Workforce recruitment

- The recruitment of female staff in Critical Care Medicine should be independent of their plan for marriage, plan to have children, or spouse income. Questions related to these should be avoided
- Pay parity should exist between male and female staff with equivalent credentials and work profile

Addressing Healthcare Workers

- To prevent female doctor from being identified as paramedics, they could be introduced as doctors to visitors/family members and could wear name badges
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Workplace inclusivity

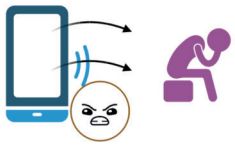
- Equal work distribution and opportunity in academic activities, research and professional growth, should be provided to staff in the same position, irrespective of gender
- If feasible, irrespective of gender, healthcare workers should be permitted flexibility in working hours, provided for genuine family-related issues and for a limited period hours
- The infrastructural arrangements for female staff in the ICU should include the availability of separate changing rooms, toilets, and rest areas
- Maternity leave should be provided for female staff as per the existing national laws

Prevention of harassment and bullying

The measures to prevent harassment/bullying of female employees at the workplace should include:

- Organising Prevention of Sexual Harassment (PoSH) training programs at the workplace
- Provision for non-judgmental anonymized reporting and redressal mechanisms
- Separate committee to address/investigate harassment/bullying cases
- Appropriate and transparent action taken against the offenders

A



Improving female representation in ISCCM

Conferences

- To improve female representation in academic meetings, active efforts should be taken to identify female speakers for a particular topic
- Mentorship programs should be conducted for women
- To improve female participation in the ISCCM annual conference, babysitting facilities should be provided, if requested

Electoral positions

- To improve female representation on the ISCCM executive committee, college board, or as journal editor, women should be actively encouraged to stand for ISCCM elections

Nominated positions

- The female nomination in various ISCCM committees (e.g., guidelines/research/scientific/organising committees/journal or newsletter editorial boards) should be proportionate to the membership ratio

B

Figs 1A and B: ISCCM position statement for improving gender balance in critical care medicine. (A) Gender equity at the workplace; (B) Improving female representation in ISCCM

- Maternity leave should be provided for female staff as per the existing national laws

Though women outnumber male medical trainees in several countries, there are still more men in clinical and academic leadership positions compared to women, across the globe.[5] The Panelists agreed that there should be equal work distribution and opportunities among healthcare workers in the same position for clinical, administrative, leadership, or research responsibilities. Gender equity should be maintained while assigning roles and opportunities in these areas to support professional growth. It is important to recognize and address barriers that promote iniquity in the workplace. Nevertheless, while women should not be denied equal opportunities, they should not step back from taking up such responsibilities. This may be the case in some instances and may be addressed through mentorship programs to support and encourage female staff.[1]

In our surveys women reported a lack of support from family or spouse, leaving them with no choice, but to take career breaks to manage family commitments or childcare responsibilities. Interestingly, the Panelists opined that irrespective of gender, healthcare workers should be permitted flexibility in working hours for genuine reasons. This would further support women, especially with childcare responsibilities, if male healthcare workers are allowed to take breaks for genuine family-related issues. This could help women manage work-life balance, prevent burn-out, and reduce attrition of women workforce from CCM.

Workplace facilities such as separate changing rooms, toilets, and rest areas providing privacy to female healthcare workers are a basic necessity. Almost half of the women in our surveys reported that they did not have these facilities at their workplace. While the Panelists agreed to these basic infrastructural arrangements for the women workforce, there was no consensus for childcare facilities. Although this would be a valuable resource to young mothers working in the ICU, larger logistic and organizational issues may be a reason for the lack of consensus.

The Government of India has laid down regulations for maternity and paternity leave.[14] However, this may not be enforced entirely in all private institutions. The Panelists agreed that these regulations should be followed as per the existing national laws, irrespective of the type of institution.

Prevention of Harassment and Bullying

- The measures to prevent harassment/bullying of female employees at the workplace should include:
  - Organizing prevention of sexual harassment (PoSH) training programs at the workplace
  - Provision for non-judgmental anonymized reporting and redressal mechanisms
  - Separate committee to address/investigate harassment/bullying cases
  - Appropriate and transparent action taken against the offenders

Any form of harassment or bullying at the workplace is unacceptable. Globally women continue to face harassment and discrimination at the workplace from colleagues and even patients or visitors at their workplace. Though some institutions have implemented preventive and supportive measures, this is mostly inadequate.[1] Despite the Prevention of Sexual Harassment (PoSH) Act being enacted by the Government of India in 2013, to address various issues related to sexual harassment in the workplace, many healthcare workers, including women, are unaware of this legislation.[15] The Act aims to create a conducive and safe work environment for women and provide protection against sexual harassment. The PoSH Act mandates that every organization should have a policy for sexual harassment including methods for prevention and service rules for its employees. The Panelists agreed, that at an organizational level, a PoSH policy should be in place, with a clear escalation matrix, provisioning for non-judgmental and anonymous reporting, and a mechanism for appropriate and transparent action taken against the offenders. Women should be encouraged to educate themselves to recognize these issues, and empowered to report them fearlessly if they occur.

Representation in ISCCM

Though ISCCM has 30% of its members as women, their representation in conferences as speakers and in various positions in society remains low. To promote a prosperous and sustainable society, women should be actively included in decision-making to form policies, programs, and strategies of the society.

Conferences

- To improve female representation in academic meetings, active efforts should be taken to identify female speakers for a particular topic
- Mentorship programs should be conducted for women
- To improve female participation in the ISCCM annual conference, babysitting facilities should be provided, if requested

Women's participation in critical care conferences and scientific meetings is not proportionate to the membership across the globe. Chadwick and Baruah reported a female speakership ranging from 1 to 35% in the five most popular critical care conferences, referring to this as a 'disease' we need to recognize and treat. The reasons cited were dates clashing with domestic and family commitments, lack of meritorious women speakers, and invitations to regular male predominant conference circuit speakers.[16]

Some societies and guidelines have proposed quotas for women speakers.[1,6] Representation of women in proportion to society membership, could not achieve consensus in this study. While acknowledging that there was an imbalance in female representation in ISCCM conferences, the Panelists opined against quotas. The argument against quotas compared to merit was a risk of dilution of the quality of scientific deliberations. Instead, Panelists suggested active efforts to identify good female speakers and mentorship programs to support and nurture female members, as measures to increase female representation in ISCCM conferences. Vincent et al., have proposed mentorship programs to support and encourage junior female staff, as a method to address gender imbalance in CCM conferences.[1]

Young mothers are often unable to participate in scientific meetings and conferences because of childcare responsibilities and therefore, miss the opportunity to contribute. The Panelists agreed that to increase female participation, ISCCM should make provision for babysitting facilities at the annual conference if requested.

Electoral Positions

- To improve female representation on the ISCCM Executive Committee, College Board, or as Journal Editor, women should be actively encouraged to stand for ISCCM elections

Over the last 30 years, it has been observed that the proportion of women in leadership positions in ISCCM is low. ISCCM had the first woman president after 30 years of its inception and, prior to which only seven women held vice-president positions. As Catherine DeAngelis, the first woman Editor of the Journal of American Medical Association rightly stated: "We will waste half of our genetic pool of intelligence, creativity, and critical insights and experience. Medicine simply cannot afford that loss".[16] While the Panelists unanimously agreed to encourage women to stand for the elections for various executive committee positions in local and national ISCCM elections, including a concerted effort to encourage them to stand for leadership positions, there was a dissensus for having any quotas for electoral positions. From the feedback received from the Panelists during the Delphi process, it was evident that they believed that this was more a problem of lack of encouragement and motivation, which needed to be addressed and cannot be solved by merely having quotas. Methods have been proposed to improve the proportion of women in leadership positions, including promoting female intensivists as role models and actively encouraging women to apply for leadership positions.[1]

Nominated Positions

- The female nomination in various ISCCM Committees (e.g., guidelines/research/scientific/organizing committees/journal or newsletter editorial boards) should be proportionate to the membership ratio.

Several societies and organizations have made a conscious effort for equal representation of women in various scientific committees.[1,5,7,8,17] Representation of women in ISCCM committees has been consistently low. While the Panelists did not agree to having quotas for women as speakers at conferences or in electoral positions, there was consensus for having female representation in proportion to the society membership (approximately 30%) in various ISCCM Committees. A possible explanation for this is that these positions are nominated by the ISCCM leadership, therefore participation of women cannot be increased unless there is policy for female representation on such committees.

Strengths and Limitations

It is for the first time in the 30 years of existence of ISCCM, that a position statement on gender balance in CCM has been drafted using a Delphi process to generate consensus among experts Panelists, which in itself is a big step forward towards improving gender equity. There are several strengths in the process and the statements drafted. First, the 15 ISCCM position statements not only address gender imbalance within the society but also at the workplace, based on the issues identified in previously conducted cross-sectional surveys by the DEI committee. Second, the consensus statements were drafted by Panelists who were members of the DEI committee, past presidents and other senior members of the society, 53% of whom were women, most of whom have held leadership positions of ISCCM, therefore appreciate the problem and possible workable solutions based on the needs and situation. Third, to avoid any bias from dominance or group pressure, the anonymity of Panelists and their individual responses were preserved until the completion of the Delphi rounds. Fourth, we were able to complete four rounds of the Delphi process in one month, maintaining a tight timeline, participation of the complete expert panel, and no attrition. Finally, we were able to reach a consensus in 95% of the position statements. We believe that these statements provide important guidance to improve gender balance within society and the critical care community.

There are some limitations. Though the expert Panelists included members of the DEI committee and senior members of the society and familiar with the issues of the society, their views may not necessarily be representative of all the society members. Implicit and explicit biases related to the subject were not checked among the Panelists prior to the survey. Therefore, it is possible that the interpretation of statements and the responses received from the Panelists, may have been influenced by their individual biases. However, feedback from the Panelists (during each round) and the stability of the responses should have ensured the fidelity of the responses and minimized individual bias. There are many more aspects on gender balance in CCM, including methods to break biases and barriers which have not been covered in the position statements. Nevertheless, this is a first step in this direction, and over the years these statements are likely to evolve, including other elements, based on the needs and situation of the time.

Regular publication of metrics related to gender inequalities in CCM and dissemination and implementation of these position statement are measures that can help us understand, acknowledge, and work together toward a respectful workplace culture and improve gender balance in CCM.[1]

Conclusion

Using a Delphi process 95% consensus (18 out of 19 statements) was achieved, from which 15 ISCCM position statements on gender balance in CCM were drafted. These statements address gender balance issues related to representation within society and at the workplace. The ISCCM position statements provide important guidance to improve gender balance within the society and the Critical Care Community. Further efforts are required to implement and assess the effects of these statements and address the remaining areas of gender balance in CCM.

Supplementary Materials

The appendix is available on the website of www.ijccm.org.

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