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EDITORIAL

WHAT WE TALK ABOUT WHEN WE TALK ABOUT GENDER EQUALITY AND EQUITY IN ANAESTHESIA AND CRITICAL CARE

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The 17 Sustainable Development Goals (SDGs), an urgent call for action by all countries is at the heart of the 2030 Agenda for Sustainable Development, adopted by all United Nations Member States in 2015 (1). Achieving gender equality and empowering all women and girls is placed fifth after ending poverty and hunger, ensuring good education and clean water, addressing climate change, and protecting life on earth (2). Unfortunately, according to the available indicators, the world is not on track to achieve gender equality by 2030. At the current rate of improvement, it will take 285 years to close gaps in legal protection and remove discriminatory laws and 140 years to achieve equal representation of women in leadership at the workplace (2).

In 2019, the World Health Organization published a gender and equity analysis of the global health and social workforce under a very indicative title: ***Delivered by Women, Led by Men*** (3). It has been predicted that by 2030 a shortfall of 18 million healthcare workers will be confronted. At the same time, both horizontal and vertical segregation by gender is present, often driven by stereotypes. Gender discrimination leads to lack of women in leadership positions, who held only 25% of them, despite consisting 70% of the healthcare workforce. A large percentage of women in healthcare encounter bias and harassment, lack of laws and social protection, as well as lower social status and gender pay gap. It has been concluded that gender inequality weakens the healthcare system and delivery of care. However, the most of data comes from high-income countries, with lots of gaps in research and methodology, meaning that no general conclusions can be made or efficacious measures for improvement proposed (3).

Anesthesia and intensive care are no different from other medical fields and mirror broader trends. In a recently published analysis of 30 published studies exploring women's place in anesthesia, their underrepresentation in academia and leadership has been confirmed (4). The increased number of women in medical schools and residency programs does not reflect in an increased number of women leaders. The leaky pipeline, earlier observed in STEM (science, technology, engineering and mathematics) is a metaphorical reference to the decrease in the number of women at every stage of the career progression and is declared in medicine, anesthesia included (4). Again, the research gap is present: the most of studies dealing with

gender equality tend to focus on numbers and structure of women's underrepresentation, and almost none focus on the reasons behind it.

In recently published results of two different surveys including anesthesia professionals, it has been shown that women and men equally aspire to leadership positions and are dealing with the same obstacles, which seem to affect women more (5,6,7). One of the most prominent and most difficult to overcome is childbearing, which places a woman in the position of increased burden of work and challenged work-life balance. At the same time, the most intensive years of residency and training, or academic progression are also at the same age where many consider having children (8). A cross-sectional survey among women physicians, mostly mothers, showed that gender-based discrimination remains common and motherhood is an important reason, whether due to maternity leave (absence from work) or so-called “maternity penalty” (women with families compared to men are seen as “less experienced” and “less qualified”) (8).

Obviously, there are other barriers that are often indirect and difficult to discern. Although macro inequities could be easy to recognize as obvious discrimination, they are rarely seen nowadays. Micro inequities, small events, often ephemeral and hard-to-prove, sometimes unintentionally are not easy to recognize or to address are those that create a culture of gender bias and inequity (9).
For example, in one Swedish study it has been shown that to have a comparable score on grant applications, women researchers need to have three times more first-author publications and to be 2.5 times more productive in a volume of publications or publishing in journals with a higher impact factor (8).
It has been recognized that the system needs changes, but somehow it is always expected that women will lean in, meaning that they should adjust and overcome with their efforts the existing frame of inequity (10).

Additionally, with gender, age, race, ethnicity, class, sexuality, religion, disability, weight and physical appearance, migration not only between different countries but within one, may intersect and create different modes of discrimination or privilege (11). Usually, it is not only gender that creates unfairness and discrimination. Further, unconscious bias is much more common and even incompatible with one's conscious values and because of that, it is difficult to be recognized and addressed. (8)

Aside from personal development and career progression, there is evidence, primarily from business and management sectors, that gender-diverse workplaces have improved productivity, innovation, decision-making, employee satisfaction and retention (8). Similar has been shown in the medical environment: more effective teamwork and higher collective intelligence have been linked with a more inclusive working environment. Also, gender-balanced clinical personnel can affect patients’ outcomes: elderly patients have lower mortality if treated by female physicians

(8). Women patients with acute myocardial infarction have higher mortality when treated by a male physician (12). When male physicians had more women colleagues and patients, this effect attenuated. Yet, not much about outcome and gender medicine is known in anesthesia and intensive care which opens a huge space for further research.

So, what is gender equality? The basic definition says that all individuals are free to develop their abilities and make choices without limitations imposed by gender rules. Equity would go a bit further: all individuals do not have the same starting point and adjustments to the imbalances should be made to fulfill personal abilities and choices. It is all about fairness, justice and basic human rights. In any working environment, the final goal is not to become the same; rights and opportunities should not depend on gender.

How can that be achieved?
Generally, the main focus goes in three directions (8):

- Raising awareness of the gender gap and existing gender bias,
- Identifying the reasons behind the underrepresentation of women and minorities and their challenged opportunity to advance on their career or academic tracks,
- Developing action plans to address these barriers objectively in a gender-neutral/ non-discriminative approach.

In public bodies, research organizations and higher education establishments, starting in 2022, it is required to have a gender equality plan (GEP) in place as a new eligibility criterion to get access to Horizon Europe funding (13). This is one of the strategies to ensure sustainable institutional change.
To meet the eligibility criterion, a GEP must fulfill 4 mandatory process-related requirements:

- Published a formal document on the institutional website,
- Dedicated resources to address the gender equality plan,
- Regular sex/ gender-disaggregated data on personnel and monitoring improvements or change,
- Awareness raising training on gender equality and unconscious bias for employees and decision-makers.

Not all working environments are academic or will apply for funding and grants. However, developing plans for gender equality looks like a good strategy to address gender discrimination. The first step is to make a cross-section of the social environment and to recognize specific problems. Many women, particularly those who are working in predominantly women environments do not recognize problems in equality and equity. Additionally, countries have cultural, religious, social and economic differences, including everyday challenges in politics and disturbing environmental changes. The Corona-19 virus pandemic has just demonstrated the vulnerability of healthcare systems everywhere (8).

Gender equality and equity are not a technical thing, they are a highly political question (14). A high level of social consensus is necessary to move forward.
In anesthesiology and intensive care settings, reaching fairness, well-being and better standards of care is of utmost importance. Everybody can become an upstander and advocate for equal opportunities for all anesthesiologists. Professionals may have a diversity of professional interests and advancement toward education, research, or a variety of subspecialties, but fairness and equal opportunities should be a common goal and interest for all of us.

My professor of histology Vasilije Djordjević Čamba used to say: You can see (recognize) only what you already know.
Let us all learn and see inequality. Both professionals and patients deserve a fair healthcare environment.

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The author is former Chair of the Gender Equity Committee of the European Society of Anesthesiology and Intensive Care.

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