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EDITORIAL

Feminism, equity and the family-centred workplace

Women are significantly less likely than men to be appointed to senior management roles; those women who do succeed are paid substantially less than their male counterparts.[1] Recognising both that women in health care are under-represented in positions of power and leadership and that this gender inequality is harmful to science, medicine and global health, The Lancet decided to publish a theme issue on feminism. Their call for papers yielded over 300 submissions from over 40 countries; the theme issue was published in February 2019.[2] A leading article entitled 'Feminism is for everybody' quoted African American feminist bell hooks (no capitals) who wrote a book of the same name in 1952.[2] Although there is no single agreed definition of feminism, hooks said that to be feminist meant 'to want for all people, male and female, liberation from sexist role patterns, domination, and oppression'. Men can be feminists. An important theme that emerged in the Lancet issue was that systemic, often implicit, bias against women in health has persisted and results in women being disadvantaged in being promoted and in being rewarded financially compared with men.[2] In academia, women are less likely to obtain grant funding, be published and obtain promotion.[2] Women face unique, often unmet challenges in the workplace.

Why does gender bias matter? It matters to science. More gender-diverse and inclusive teams improve outcomes in science and medicine.[2–4] It matters to patients. A Florida study found female patients with acute myocardial infarction were more likely to survive if they were treated by female than by male doctors.[5] Male and female patients treated by female doctors had similar outcomes, suggesting a unique problem for male doctors treating female patients. The outcome difference was attenuated for male doctors who had more exposure to female patients and female physicians.[5] Studies showed patients had better outcomes when treated by female surgeons in Canada and women internists in Japan.[4] The postulated explanation is that gender is a marker of behaviours that lead to better outcomes: female doctors spend more time with patients, follow guidelines more closely and have better communication skills than their male counterparts.[4]

Gaps in gender equality are narrowing globally, but significant challenges persist in all countries. Approaches to improve gender equality need to be made by individuals and at the organisational level. Egalitarian men can do their utmost to promote opportunities for women in medicine and science. But to quote feminist Mary Beard, 'you cannot easily fit women into a structure that is already coded male; you have to change the structure'. Implicit gender bias in academia results in men being consistently judged to be superior to women in terms of skills, productivity, work and leadership on the basis of gender alone. We need to dispel the 'myth of meritocracy' perpetuated by those within the hierarchy who have a vested interest in excluding people on the basis of gender or race. The change must be real: many institutions put forth blithe statements about equity, belied by persisting inequity. Often, the best way to improve the lot of women trainees affected unfairly by excessive work hours or work demands is to improve the lot of all trainees. This way ensures that excess work burden does not fall on less represented groups, such as women or people of colour, the so-called 'minority tax'. We need to make systematic changes in medical education, in the way we treat men and women in the workplace, in the way we promote men and women in academia and in equality of remuneration.

Paediatrics focuses on children and their families, yet too often we neglect the needs of our young paediatricians with young families.[6] Women's usually temporary exit from the workplace to bear and care for children is a major factor in their career trajectory: they fall behind and never catch up. Women who leave surgical training report not only long working hours but also sleep deprivation, bullying, discrimination, sexism and sexual harassment.[7] They lack sufficient supports and suitable role models. They are also disproportionately affected by the impact of pregnancy and childbirth and child rearing.[7] Society has competing demands: productivity and family. We need to challenge hierarchical medical specialist models that fail to promote specialist training for women of reproductive age due to patriarchal beliefs that to do so would take a training opportunity away from a 'more diligent and career-minded' male who will not suspend their training or ask for time off to bear and rear children. Change will require increased flexibility for reproductive choice, family/life balance and child care opportunities (funding support and places) in medical institutions. A colleague who worked in the Netherlands was impressed by the recognition of the importance of having at least one parent at home caring for the baby reflected in generous provision of job-sharing opportunities to accommodate two working parents. Paediatricians should struggle for a truly family-centred workplace, one in which all staff with families feel supported to rear their own children. Such a workplace would be equitable and would respect feminist principles.

All those of us who cherish equity should strive to be better feminists.

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