Policy Document

Gender Equity in Leadership and the Workforce (2021)

Position Statement

As the peak representative body for medical students in Australia, the Australian Medical Students' Association (AMSA) is responsible for ensuring equitable outcomes for all its members and therefore AMSA:

1. Greatly values diversity and acknowledges that gender equity is an important tenet of diversity, along with other factors including ethnic status, religion, cultural and linguistic background, sexual orientation, and socioeconomic status.
2. Recognises the systematic underrepresentation of people of marginalised genders in medical leadership positions as well as the harassment and gender-based discrimination that function as barriers to achieving equitable outcomes for all medical students.
3. Acknowledges the detrimental effects that implicit bias and stereotyped leadership styles have on gender equity.
4. Commits to achieving gender equity within leadership and training positions- at the medical student level and exceeding beyond.

Glossary

Gender Equity, is defined as a lack of avoidable differences between subgroups of a population, in this case between genders, focusing on equal outcomes rather than equality referring to the equal treatment of the subgroups. [1]

The following terms will be used with respect to their meanings as defined by the Australian Institute of Family Studies [2].

- **Gender:** the socially constructed categories assigned to individuals, usually on the basis of their apparent sex at birth; the inner sense of oneself in reference to these categories.
- **Gender binary**: classification of gender into the two categories of either man or woman based on sex assigned at birth.
- **Gender diverse**: an umbrella term encompassing a range of genders expressed in ways that fall outside of the traditional gender binary, including nonbinary, genderfluid, genderqueer, agender, and gender non-conforming individuals.
- **Cisgender, or cis:** a term used to describe people whose gender is congruent with the one they were assigned at birth.
- **Transgender, or trans**: an umbrella term used to describe people whose gender does not exclusively align with the one they were assigned at birth.
- **Sex:** assigned to a person based on anatomical, chromosomal, and hormonal characteristics. This is classified as either "male" or "female" at birth, but is

AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

Head Office
42 Macquarie Street,
Barton ACT 2600

Postal Address
PO Box 6099
Kingston ACT 2604

ABN 67 079 544 513

Email info@amsa.org.au
Web www.amsa.org.au
Twitter @yourAMSA

made more complex by the existence of intersex variations and potential changes to these characteristics over the lifespan.

It is essential to recognise the distinction between gender and sex, as gender can often be conflated to sex and consequently exclude diverse communities such as the transgender and gender diverse (TGD) community from discussions around gender equity.

Within this policy, "woman" and "female" are used to refer to all those identifying as women, including both trans and cis women. Where this is specifically in reference to trans or cis women, these adjectives will be used.

The term "people of marginalised gender" is used within this policy to refer to women and TGD people. People of marginalised gender are subjected to discrimination on both an institutional and interpersonal level.

Policy

AMSA calls upon:

1. Medical schools, specialist medical colleges, the Australian Medical Association (AMA) and academic institutions to:
    a. Recognise the gender disparity and hostile environments in their leadership and workforce and reflect upon the current gender imbalances within their specific institution by:
        i. Publicly acknowledging that many specialities foster a hostile and inflexible environment that may prevent or discourage people of marginalised genders from entering and settling in a specialty;
        ii. Active identification and rectification of this environment through support and engagement with research and open consultancy on the issue.
    b. In application and selection processes, work to:
        i. Create an inclusive, supportive environment for all applicants of marginalised genders;
        ii. Ensure that the selection criteria used are transparent, fair, equitable and that criteria are applied consistently;
        iii. Implement and respect the 40% men, 40% women, 20% open gender balance in keeping with the internal quota set by the AMA, particularly within leadership places;
        iv. Continuously review and scrutinise procedures and processes to ensure criteria offer equitable access to opportunity and reduce barriers that systematically discriminate based on identity.
    c. Regarding workplace culture and fostering of opportunities, ensuring that:
        i. People of marginalised genders are actively mentored and given opportunities to engage in upskilling and leadership roles in a consistent, transparent and formalised manner;
        ii. Building upon the AMSA Sex and Gender Equity in Medical Research and Teaching Policy (2018), people of marginalised

genders are supported to publish high quality research, sit on peer review panels and share this research with the academic community;

iii. An inclusive training environment where equitable access to flexible work hours, job sharing and parental leave is facilitated;
iv. All medical trainees are educated on workplace rights, including anti-discrimination laws;
v. A culture of gender equity is prioritised and embedded into policy and procedures;
vi. Reporting processes for gender-based discrimination are clearly communicated, transparent and protect individuals who utilise them.

d. Building upon the AMSA Sex and Gender Equity in Medical Research and Teaching Policy (2018), To regularly review curricula through a lens of gender-equity and make changes to ensure safe and equitable care for patients of all genders. This includes review of teaching and assessment of:
    i. Conditions that are specific to women, transgender and gender diverse patients;
    ii. The differences in clinical presentations between genders;
    iii. History taking and examination of diverse body types;
    iv. Gender as a social determinant of health;
    v. Appropriate use of terminology; - covered by other policy
    vi. Gender inequity in medical leadership and workforce;
    vii. Strategies to counteract casual gender discrimination in workplaces
e. In reference to the research disparity:
    i. Provide research and follow-up on gender-based statistics and experiences within the workforce; particularly around the results of the implemented actions.
    ii. Conduct further research into the presence of TGD people in medical leadership and workforce, barriers to their representation, and solutions to address this gap.

2. Hospitals and other healthcare service providers to:
    a. Publicly acknowledge the gender imbalance in leadership and workforce and work to ensure that people of marginalised genders are represented by
        i. Implementing and respecting the 40-40-20 gender balance quota of the AMA, particularly within leadership positions, when appropriate;
        ii. Ensuring equitable opportunities are provided to all employees in the same program or position;
    b. Publicly acknowledge the gender pay gap and work to rectify it by:
        i. Ensuring transparent and consistent methods of performance appraisal are used as a guide for pay increases or promotions;
        ii. Establishing transparent remuneration packages based on consistent criteria;

iii. Providing equal paid parental leave, regardless of gender of parent, and support for employees with children without detrimental impact on employment, including:
    1. Facilitating flexible working hours;
    2. Ensuring equal remuneration based on objective criteria when parents return to work;
    3. Ensuring equitable opportunities and promotions are still given when parents return to work;

c. Prioritise and embed a culture of gender equity into policy and procedures;
d. Establish reporting processes for gender-based discrimination that are clearly communicated, transparent and protect individuals who utilise them.
e. Provide research and follow-up on gender-based statistics and experiences within the workforce; particularly around the consequences of the implemented actions.

3. University Medical Societies to:
    a. Conduct annual reporting into their leadership diversity status;
    b. Deliberate as to why gender-imbalances exist and actively seek to rectify such reasonings. Examples of such actions include:
        i. Implementing positive actions and targets to fast-track participation of people of marginalised genders, by:
            1. Actively encouraging people of marginalised genders to apply for cis-male dominated leadership roles;
            2. Providing training and shadowing opportunities for medical students with the aim to encourage a more diverse applicant pool.
        ii. Establish mentoring and networking opportunities to improve inclusion of TGD individuals in all avenues of medicine;
        iii. Host activities and events that are directed at supporting and encouraging people of marginalised genders in medicine to pursue leadership and workplace opportunities that have suffered from gender imbalances.
    c. Investigate implementation targets across their organisation and recommend them where they see appropriate.

4. AMSA in conjunction with AMSA Gender Equity and AMSA Queer:
    a. To identify organisational gender disparities through:
        i. Conducting annual reports of representation across AMSA volunteers, including, but not limited to, the representation of gender identities, ethnicities and domestic/international status;
        ii. Supporting AMSA members and volunteers to share their diverse lived experiences.
    b. To create safe and equitable application and selection processes by:
        i. Creating an inclusive, supportive environment for all applicants of marginalised genders, such as inclusive language in callouts and interviews, increasing titles collected to include ‘Mx’ or ‘No title’

ii. Ensuring that selection criteria used are transparent, fair, equitable and that criteria are applied consistently;
iii. Investigating and implementing gender targets across AMSA;
iv. Reviewing and scrutinising team demographic data, and recruitment procedures/processes annually to ensure criteria offer equitable access to opportunity and reduce barriers that systematically discriminate based on identity.

c. Regarding organisational culture and fostering of opportunities, ensuring that:
   i. People of marginalised genders are given the opportunity to be actively mentored and engage in upskilling and leadership roles in a consistent, transparent and formalised manner;
   ii. A culture of gender equity is prioritised and embedded into policy and procedures;
   iii. AMSA Gender Equity and AMSA Queer are consulted in National Advocacy endeavours as they pertain to issues of gender equity;
   iv. Reporting processes for gender-based discrimination are clearly communicated, transparent and that individuals who utilise them are protected.
d. Strive to create gender safe events and projects by:
   i. Adopting an intersectional approach to diversity and striving to champion a program that reflects the diversity of the general society.
   ii. Ensuring appropriate use of terminology and content warnings;
   iii. Establishing guidelines around acceptable behaviour related to gender;

5. Individual Medical practitioners to:
   a. Reflect upon and self-assess the potential for gender bias in their own hiring practices, remuneration and selection for training if involved in the recruitment process and change their practice accordingly;
   b. Speak out against gender-biased views and actions that do not meet reporting criteria but impact on the leadership potential of people of marginalised genders amongst their colleagues, in colleges, and in professional work spaces;
   c. Actively provide medical students and doctors of marginalised genders with mentoring and leadership opportunities.

Background

Introduction

Leadership in the Medical Workforce

Leadership in the medical workforce can be defined as motivating, inspiring, organising and aligning strategies to establish direction for individuals and the systems in which they work [3]. Rather than relying on a single leadership figure, medical leadership is a disseminated process whereby medical professionals use their knowledge and training to take initiative to organise and execute strategies to improve patients' outcomes, whilst engaging colleagues to support this [3]. This can be seen within the hospital hierarchy at the levels of senior consultants, registrars, residents, interns, and student doctors. Leadership across each level promotes effective micro-systems that positively impact patient care outcomes [4]. Additionally, leadership in medicine begins before entering the workforce. Within medical school, students can take on leadership roles through their medical student society or AMSA, as well as informally exhibiting leadership through guiding other students and showing initiative within medical student teams.

Diversity within medical leadership is a crucial aspect of ensuring that the workforce sufficiently reflects and serves the interests of patient populations. Gender equity is an indispensable component of diversity, alongside other factors such as culture, socioeconomic background, and disability.

Aim of Policy

This policy will address gender equity in leadership and the workforce at both student and professional levels, ultimately concluding that protracted efforts are required in order to achieve gender equity within leadership and training positions, starting at the medical student level and going beyond. Gender equity amongst medical leaders can be achieved by a culture free of discrimination and harassment [5]. Equity in the medical workforce is also dependent on equity being established at the medical student level.

Gender Equity

The first argument made for Gender Equity in the workforce is an economic argument, and whilst profit is not the ultimate goal for a healthcare system, attaining higher performance and greater system efficiency is, and always remains, a desirable goal within resource-constrained health systems. The majority of evidence supporting the economic argument for gender equity originates from the business and management sector but the principles translate well to a healthcare setting. Published research shows that gender equity in the workforce is essential to productivity, economic output and good health [6]. Described well in the 2015 World Economic Forum, people and their talents are the drivers of economic growth, if half of these talents are underdeveloped and underutilised economic productivity is compromised. [7] Gender Equity not only engages more people in the workforce, but the presence of diverse lived experiences in a team leads to innovative and creative problem solving which increases productivity. [8] Furthermore gender equity allows organisations to attract, engage and retain talented employees. [9] [10]. Similarly, corporate teams that incorporate people of marginalised genders have shown an improved ability to anticipate the demands and challenges of consumers [11].

Gender equity is also essential in leadership as it allows for appropriate representation and elevates a balanced approach in systems and governance. People with diverse lived experiences can facilitate new approaches to leadership, and their position of power can create effective systematic change on multiple levels. Exposure to positive role models in perceived sexist and male-dominated fields can improve medical students' perceptions of that field [12]; therefore, gender equity within senior leadership is important to sustain gender equity into the future. Furthermore, evidence shows that tangible manifestations symbolising a shift in the culture of medicine, such as increasing the visibility of LGBTQI+ and gender diverse health care providers, can help to promote a more welcoming environment for both professionals and patients [13]. This would ultimately lead to a more enriching relationship between medicine and society and reduce barriers of access to care that many communities experience due to discrimination.

Beyond the "business case" for gender equity, ultimately redressing the systemic barriers that prevent people of marginalised genders from fully participating and benefiting from society is important to the wellbeing and health of everyone. Systemic biases including underrepresentation and stereotyped leadership styles must therefore be collectively addressed in order to improve the health outcomes of people of all genders [14].

Gender Inequity

Gendered discrimination exists across the medical profession, where those of marginalised gender identities are under-represented and are subject to institutional (system-related lack of flexibility and limited job prospects) and interpersonal (gender bias against people of marginalised genders) bias.

<u>Representation</u>
Systemic discrepancies exist in numbers and leadership across practising health professionals, medical society committee members and leadership numbers, as well as within academia and research.

The Australian Medical Board collects data on the medical workforce of Australia and the gender identities of those within the workforce. This provides information on the balance of men and women within both the general population and disaggregated specialties. The comments on the data collected by the Australian Medical Board assumes that these categories are inclusive of both trans and cis people. However, it should be noted that this data collection adheres to the gender binary and does not collect information on the TGD community. This makes it difficult to comment on the presence of TGD people within the medical workforce and specialties.

General Workforce
According to this data, the general medical worforce of Australia is comprised of 56.5% men, 43.5% women, and <0.1% people who did not indicate their gender, or were intersex or indeterminate [15].
One study conducted in the United States of America suggested that TGD people comprise <1% of the the medical workforce, despite current estimates of a population prevalence of 5.6% [16,17]. Given this gap between representation of TGD people in

the general population and the medical workforce, it can be inferred that there is a proportional lack of representation within leadership roles. Discrimination and the challenges TGD medical students face in the admission and training process are thought to be significant contributors to this [18-20]. Research has exemplified this; where TGD participants revealed that having to conceal their identities throughout the admission or training process increases stress as they were afraid to be found out [18].

The lack of data for TGD people in the medical workforce in Australia highlights the need for more nuanced investigation that is not limited to a binary divide of gender. The lack of data on TGD people within leadership demonstrates an ongoing and pervasive absence of gender equity within medical leadership.

Specialties

Gender gaps are visible across most specialties. As of 2020, despite half the physician trainees being women, there is significant underrepresentation at the consultant level. [21-22] While there is an equal number of men and women at the general position level, the percentage of women halves at the specialist level [22]. This is particularly apparent in cardiology, where less than 20% of consultant physicians are women [23].

Leadership

The medical workforce and infrastructure go beyond practising physicians alone. Medical and surgical societies govern consulting guidelines, interview doctors and make crucial decisions regarding the delivery of their medical specialty. All general surgery societies across America, Europe and Oceania report under-representation of female members, the highest being only 32.1% [24]. Academic surgery reports a similar pattern, with women being a minority in academic ranks and leadership positions across all major universities. [25] Similarly, only 28% of medical deans and 12.5% of hospital chief executive officers in Australia are women [25], revealing a steep decrease in representation from the largely equal number of men and women as medical students in Australian universities. When people of marginalised genders are excluded from leadership, their diverse lived experience is absent from decision making processes. Although we cannot fully capture the significant and debilitating limitations their absence in leadership creates, it is imperative that we strive to resolve this under-representation.

Academia

Academic research, and events surrounding medical presentations and discussions are an integral part of the profession, and often an essential component to professional progression and attaining leadership roles. Consequently, representation of people of marginalised genders must be prioritised in academia, including but not limited to conference presentations, peer review and committee positions. This position is supported by the Australian Government National Health and Medical Research Council (NHMRC) 2018-2021 Gender Equality strategy. This strategy advises programs such as publication of funding rates by gender, offering part-time research opportunities and video-conferencing in peer review panels. [26]

A study of academic surgeons revealed that cis men had a higher h-index (a metric that measures the citation impact and productivity of a publisher/scientist) and number of publications and citations [24]. Additionally, a cross-sectional study of

academic medical conferences between March 2017 and November 2018 reported that only 30.1% of speakers were women, with 36.6% of panels being all-male [27]. The study also noted a significant positive correlation between the proportion of women on planning committees and representation of women as speakers.

Institutional Bias

Institutional bias is the "tendency for particular institutions to operate in ways that favour certain social groups and devalue others". [28]. Institutional bias provides a lens through which to examine gender inequity that focuses on systems rather than placing responsibility onto people of marginalised genders. Institutional bias also provides an explanation for why despite there being a growing presence of people of marginalised genders in clinical practice and academia they are unable to access opportunities necessary for career advancement [29, 30]. While parental leave and raising children are often suggested as reasons for the difficulties that people of marginalised genders experience in obtaining research opportunities and career progression, it has been shown that the number of children or working hours did not explain gender inequity in clinical practice or academic research [31].

Pay Gap

In 2021, the national pay gap between men and women in Australia was shown to be 13.4%. This is an improvement from 2020, when the pay gap was 14% [32]. When looking into the medical field in Australia, the Royal Australia College of General Practitioners reports that female physicians earn up to 25% less than their male colleagues, with another study suggesting a gap as high as 45% [33, 34]. No data was provided on TGD people. Although it was reported that both male and female physicians work the same number of hours, the pay discrepancy still exists [35].

The cause for this disparity is multi-dimensional. It seems that within the same specialties, women are more likely than men to volunteer or be volunteered for unpaid work [36], to have more complex, time-consuming conversations with their patients (sometimes due to the referral of patients to women for this specific reason), to see less patients [33], and to be referred less cost-effective cases [35]. Across the medical field, women also tend to be concentrated in roles and specialities that pay less [35]. Furthermore, women are more likely than men to use parental leave and modify work hours to care for children, leading to significant salary discrepancies. The link between childcare and income is demonstrated by the discrepancy in salary between women with and without children [37]. Finally, the lack of transparency and audits on salaries can be a barrier to equal pay as data shows that women negotiate for lower compensation than men do only in the absence of clear industry salary standards information [38].

Higher social status is commonly associated with high authority positions, as compared to lower authority positions in the workforce. In regard to this, cis men are often viewed as more status-worthy than women. This is known as workplace authority [39]. Workplace authority is a recurring factor in the gender pay gap and this includes access to promotions and hiring [40]. This is an important factor because workplace authority directly influences an individual's career trajectory [40]. A disparity in access to workplace authority is when equally qualified individuals are not given opportunities for leadership or promotion due to discrimination of race, gender, sexual orientation and other factors [40]. In gender-based workplace authority

disparity, people of marginalised genders are systematically denied opportunities to positions of authority in the workforce or, even if they are offered authoritative positions, their level of authority might differ from cis men [40].

These institutional biases paired with cultural problems such as the absence of role models and incidence of sexual harassment are driving forces of gender inequity in opportunities, promotion and pay in the medical workforce.

Parental Leave

Nearly 40% of doctors look into the prospects of pursuing parenthood during residency [41]. Parental leave is designed to provide new parents with financial support without requiring them to be separated from their family. Literature has shown the benefits of parental leave, including lowered infant and child mortality rates, better maternal mental health, and increased breastfeeding rates [41]. Parental leave has also been associated with an improvement in parent-child engagement and relationships [41]. However, women continue to access a greater share of parental leave compared to their male counterparts [42]. There is significant gender inequity affecting parental leave provided to doctors, including unbalanced leave and cultural stigma.

New parents do not receive an equivalent amount of parental leave. In Australia, new parents can receive parental leave through the Government's "Parental Leave Pay" and "Dad and Partner Pay", as well as paid parental leave from their employer. Under the Government scheme, the mother, birthing parent, or a single member of an adopting couple is the primary carer. Their partner is considered to be the secondary caregiver. The primary carer is eligible for 12 weeks of paid parental leave, while the secondary carer only receives 2 [43]. In addition to this, new parents can receive paid leave from their employer. The Australian Medical Association found that, while primary carers receive up to 14 weeks of paid parental leave, their partners would only get 1 week of paid parental leave [44]. This places the majority of the burden on the primary carer and prevents their partner from adequately supporting them and their new child. This negatively affects the primary carer's opportunity for career progression, their participation in inflexible training programs, and can make them vulnerable to workplace discrimination [45]. As the primary carer is usually the mother or birthing parent, this contributes to gender inequity [43]. According to the NSW Hospital Health Check, both male and female doctors have expressed their increasing dissatisfaction with the amount of paid parental leave they are getting from their employers [44].

There is significant cultural stigma contributing to decreased uptake of parental leave among men. The AMA found that less men requested access to their parental leave and were more likely to be penalised or refused than women [42]. This makes the use of parental leave by men unconventional and contributes towards workplace stigma [46]. The pay gap (discussed above) also contributes to cultural opinions on parental leave by reinforcing the traditional heteronormative viewpoint that the role of the father is to be the "breadwinner" while the mother cares for her children [46]. This creates reluctance to take parental leave and may contribute to new fathers feeling pressured to continue working to provide for their families. Furthermore, LGBTQIA+ couples may face additional financial hardship if both partners are affected by the pay gap.

Medical Education

Institutional gender bias is reinforced by a lack of appropriate teaching about gender in medical curricula. Medical curricula are well established to shape the perceptions, attitudes and behaviours of doctors towards their patients and towards each other [47]. For example, a Swedish study of medical educators suggests a link between a physician's degree of gender awareness, their working climate, and the distribution of genders in medical specialities [48]. There is currently limited research surrounding the quality and quantity of medical education on gender in Australia. However, in a 2017 study on 15 medical schools across Australia and New Zealand, only 3 medical school curriculum administrators indicated that education on gender was provided at their institution [49]. Further research is required regarding the current state of medical education and the effect of more comprehensive education on gender. In the context of a lack of adequate published research in this area, the expertise and advocacy experience of AMSA Gender Equity and AMSA Queer have been relied upon to inform policy points.

<u>Interpersonal Bias</u>

Sexism

Discrimination towards people of marginalised genders continues toexist and also affects their career progression. Gender inequity largely derives from the social construct of gender norms, roles and relations [50]. Several theoretical frameworks have been used to explain how gender bias is formed and leads to gender inequity. The process begins with different assumptions about women and men [50]. This translates to either assuming the same experiences when there are genuine differences or assuming dichotomous stereotypes when there are none. One qualitative Australian study found that, even when presented with peer reviewed evidence, individuals in the medical field were unconvinced that women bear different experiences to men in the medical workforce [51].

Damaging stereotypes identified by studies include associating independence and self-assertion with men and emotional concern with women. The former traits were seen as more important than empathetic traits for success in scientific fields [52]. These assumptions contribute towards sexism and discrimination. Additionally, it is detrimental to the self-esteem of those experiencing discrimination, with women demonstrating bias against themselves and a tendency to downplay their own achievements [53].

Harassment

Harassment can take the form of derogatory remarks, inferior treatment or sexual harassment, which still has a high prevalence in medicine as detailed in the Sexual Harassment policy (2021) [54]. These are particularly present in TGD medical students and doctors who face an additional barrier of transphobia in addition to sexism [55]. Overall, harassment can be a physical form of the sexist culture within medicine and can prove a significant barrier to the presence of people of marginalised genders in certain specialities of the medical workforce or leadership roles. Additionally, cis men face lesser consequences for uncivil behaviours and harassment as compared to those of other genders [50].

Transphobia

TGD people are affected by discrimination, societal stigma, exclusionary language, and structural violence in both the community and in healthcare settings [56]. In a 2021 study by LGBTQI+ Health Australia, 56% of TGD individuals reported experiencing verbal harassment because of their gender or sexuality in the last 12 months [56]. The experiences of TGD medical students and healthcare professionals are inadequately reported in Australian data, creating a need for further research into the impacts of transphobia on these populations.

To protect themselves from discrimination and bias, some TGD people choose not to disclose their identity to their peers and more senior colleagues. An American study on TGD students and residents found that 50% of these students and 60% of these residents did not disclose their identity to their medical school and training programs respectively [18]. In many cases, this involved censoring themselves and disguising mannerisms to prevent unintentional exposure. Both those who disclosed their gender identity and those who did not do so experienced significant psychological distress, with one participant being asked to leave their practice after disclosing their identity [18]. This is the first study to assess the experience of TGD students and physicians and, despite the limited number of participants, demonstrates very clearly the significant gender inequity faced by these population groups.

<u>Strategies for Gender Equity</u>

Institutional Change

Positive action is necessary to achieve widespread change in institutions. Intention for change is the first step which includes collecting data from those of marginalised genders and minority groups and conducting research into the implementation of novel strategies to improve gender diversity. Initiatives like the special issues in academic journals or diversity panels within institutions allow a clearer view of the problem and establishment of solutions [6, 47]. Both qualitative and quantitative research on implemented changes should be collected and analysed as a marker of effectivity and a guide for future initiatives [57].

There are two methods through which the presence of people of marginalised genders can be quickly increased; these are quotas and targets. Quotas are mandatory, time-bound, measurable objectives enforced by an external body to achieve parity [58,59]. The AMA has put a quota on its elected positions of 40% male, 40% female and 20% flexible for any genders [57]. Quotas can aid in overcoming the implicit biases in selection and representation of people of marginalised genders within the workforce and positions of leadership [59]. This acknowledges that the "merit-based" system is vulnerable to institutional and interpersonal bias, where people of marginalised genders are less likely to receive opportunities for upskilling and career progression and more likely to trivialise past achievements. By encouraging the participation of people of marginalised genders and increasing their presence in leadership spaces, quotas are a powerful method of organisational change [59].

However, care must be put into the implementation of quotas for them to be an efficient tool, particularly at senior levels. There is the potential for backlash against people of marginalised genders who are perceived to have achieved their position through tokenism rather than capability in the initial phases of their implementation

[60]. Sustained use of quotas have shown that the normalisation of diversity in leadership promotes a cultural change, reducing this disruption [59]. Additionally, it is important to study the selection pool and ensure that there are sufficiently diverse applicants with adequate training within it, and to widen it if this is not the case. Strategies to allow this are diverse leadership and an inclusive culture, as explained in the next section, and easy accessibility of information about recruitment. People of marginalised genders will only apply for positions they are informed about, feel qualified for, and feel safe occupying [59, 60]. Revising interviews to minimise bias and ensuring transparency within the process can also allow the selection of more diverse, but equally qualified people [61].

In certain cases, targets can be more practical to implement than quotas. Targets set precise goals on more vague objectives. Advantages of these are that they are voluntarily undertaken and set by the organisation itself so are easily adaptable and more likely to be followed [58]. This is particularly beneficial in situations where over-representation of a specific gender can be beneficial or in smaller recruiting pools.

Use of either quotas or targets needs to be accompanied by widespread cultural change and education on gender equity. This includes training and education on workers' rights and how to access them.

Interpersonal and Cultural Change

The tools used to create institutional change are often limited in their impact on cultural change, which requires a broader focus and emphasis on vertical support structures. Workplace culture is built upon many foundations, including interpersonal relationships. Better reporting and support structures, promotion of gender diverse leaders and robust mentoring strategies from medical school and beyond will promote cultural change.

Reporting

Improved avenues for reporting and support against discrimination are required to highlight the need for cultural change. AMSA's Sexual Harassment policy provides detailed discussion of this area, and this policy agrees with the findings included. The need for support of gender diverse individuals extends beyond sexual harassment, and discrimination on the basis of sex acts as a barrier for medical promotion and leadership. More than 70% of women physicians have reported some form of gender discrimination [62]. Additional consideration is required for people of marginalised genders from culturally and linguistically diverse backgrounds [63, 64]. People from these backgrounds are often more susceptible to discrimination and support services should act accordingly [64,65].

Visibility and Mentoring

Achieving gender equity in male-dominated specialties requires increased visibility of leaders from marginalised genders. Evidence shows that exposure to positive role models in fields perceived as sexist and dominated by cis-men can improve medical students' perceptions of the inclusivity and safety of the field [12]. Similarly, American research into the gender structure of specialist departments found that the presence of women in leadership is associated with significantly greater numbers of women trainees [66, 67]. Therefore, recruitment, retention, and promotion of people of

marginalised genders within these specialties is critical to create change and build a culture that reflects gender diversity. These principles are similarly applicable to other areas of diversity, including culturally diverse people of marginalised genders, LGBTQIA+ people, and those with disabilities. Institutions should avoid viewing marginalised gender groups as a homogenous entity and instead embrace an intersectional approach to visible leadership that will create change in the medical workforce.

Promotion of people of marginalised genders in leadership can be achieved through robust mentoring strategies. Positive mentoring embedded in medical school and junior doctor years can drive cultural change. In one Australian study researching why trainees who were women resigned from surgical training, participants described insufficient role models as one of the factors for leaving surgical training [68]. One participant describes that by working with their mentor who was a surgeon and a mother, it showed them that it was achievable for women to have successful professional and personal lives [68]. The situation is improving, shown through the AMA's establishment of networking opportunities and targeted mentoring and sponsorship roles in the 2020-2022 Diversity and Inclusion Plan [57]. The promotion of mentors and strong women as role models from medical school onwards is a key tool to tackle gender imbalance within the medical workforce, as research has shown that mentorship programmes for women produced high satisfaction rates and increased promotions and retention of women in academic medicine [69].

AMSA as a Tool for Change

The AMSA organisation structure should strive to reflect the gender diversity of the student body it represents. In leading by example, AMSA will convey to its members and the wider medical community that it is committed to promoting gender diversity in medical leadership. Annual reporting and self-reflection will aid in this challenge. Furthermore, targets and quotas should be used to increase diversity within AMSA. Ensuring that recruitment is transparent and inclusive, alongside actively encouraging gender diverse applicants and grassroots initiatives, will help enact change in this area.

The AMSA events program is a key example where diverse mentorship can be encouraged. AMSA has four major conferences annually: National Convention, National Leadership Development Seminar, Global Health Conference and Rural Health Summit. Each attended by 90 to upwards of 1000 students each. These events feature academic programs hosted by accomplished speakers in a wide variety of fields. A focus on gender diversity in the AMSA academic program is crucial to establishing grassroots change about the role of people of marginalised genders in medical leadership. In striving for gender equity, it is important to take an intersectional approach and ensure gender diverse people are given equal opportunity. Merely focusing on gender parity of the speaker's sex limits gender equity initiatives to a two-dimensional approach and fails to capture the diverse experience of people in medicine. There needs to be a broader focus on the diversity represented by the speakers and delegates across gender, culture, religion, disability and socio-economic backgrounds.

Outside of events, AMSA also has a national Gender Equity (GE) team dedicated to building and incorporating a culture of Gender Equity. Some of the ways in which the GE team help AMSA members and volunteers to foster gender equity are through;

- Providing upskilling sessions related to gender equity for AMSA members at Councils.
- Proactively and reactively working with other teams in AMSA to help them create gender equity in their projects and advocacy.
- Providing feedback on policy.
- Coordinating the EMPOWERS mentorship program which connects people of marginalised genders and allows a safe space for discussing lived experiences and accessing opportunities.
- Running other events on gender equity topics such as the 2021 event 'What we aren't taught in Med school'.
- Creating an online community for people of marginalised genders through social media platforms.
- Online education campaigns.

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Policy Details

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History:

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Victoria Chin, Annora Kumar, Jade Guitera, Tanmay Gupta, Nanditha Hareesh, Fizra Hasan, Hannah Hassum, Fergus Stafford

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R. Navani, M. Foo, J. Ahn, N. Tomar, C. Dines Mutaneur, P. Macintosh-Evans

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