Diversiteit & Inclusie in de zorg

VNVA 13 september 2023

Marian Mourits

Introductie

- What is the issue?
  - Mid career gap
  - Gender pay gap
- On gender stereotyping
- What are the effects?
- How to improve?

What is the issue?

- Observations
- Stories
- Facts & figures

We have an issue on gender inequality

Observations and stories

- Obstacles in academic career steps
  - Recognition of ambitions
  - Acknowledgement of competencies
  - Nepotism
  - Sexism

“Waarom wil je zoveel verdienen, je man verdient toch ook goed? “

Figures academic career positions M / F in the UMCG

- Professor 75% / 25%
- Head of division 84% / 16%
- Head of department 88% / 12%
- UHD 86% / 14%
- UD 84% / 16%
- MS with PhD 35% / 65%

ARTIKELEN / OPINIE / TER DISCUSSIE /

Zo komen we er niet met diversiteit in de UMC's

Geef leidinggevenden een formele rol om diversiteit te vergroten

25 AUGUSTUS 2022

Derya Yakar Stephanie C.E. Schuit Michiel T.G. Kahmann Thomas C. Kwee Marian J.E. Mourits

Citeer dit artikel als: Ned Tijdschr Geneeskd. 2022;166:D6659 ABSTRACT

Het aantal vrouwen in de Nederlandse UMC's blijft achterlopen op het aantal mannen als het gaat om leiderschapsposities. Hoe komt dat? 'Sponsorschap', de ondersteuning van talentvolle mensen door

OP DEZE PAGINA

De volledige inhoud van dit artikel is

Mid-career dip

Women are
'over-mentored'
'over-trained'
'over-coached'
….but 'under-sponsored'

Derya Yakar D, Stephanie C.E. Schuit, Michiel T.G. Kahmann, Thomas C. Kwee, Marian J.E. Mourits, NTvG 2022; 166:D6659

Closer look at the **gender pay gap** in UMCG

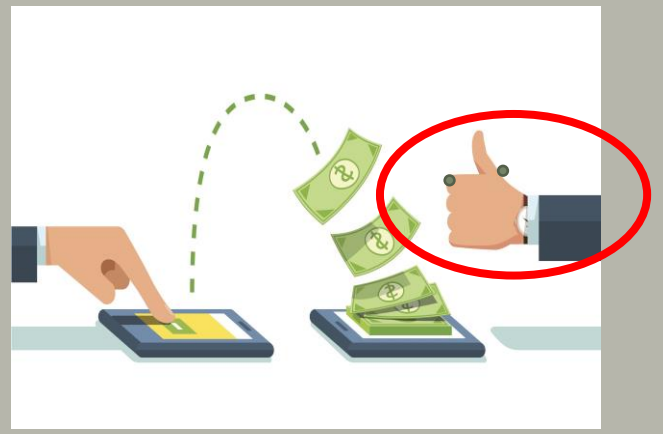
- Salaris bestaat uit
  - Basis salaris *('CAO)*

  - ***Toelagen***
  - ***Gratificaties***

Closer look at the **mid-career dip** in UMCG

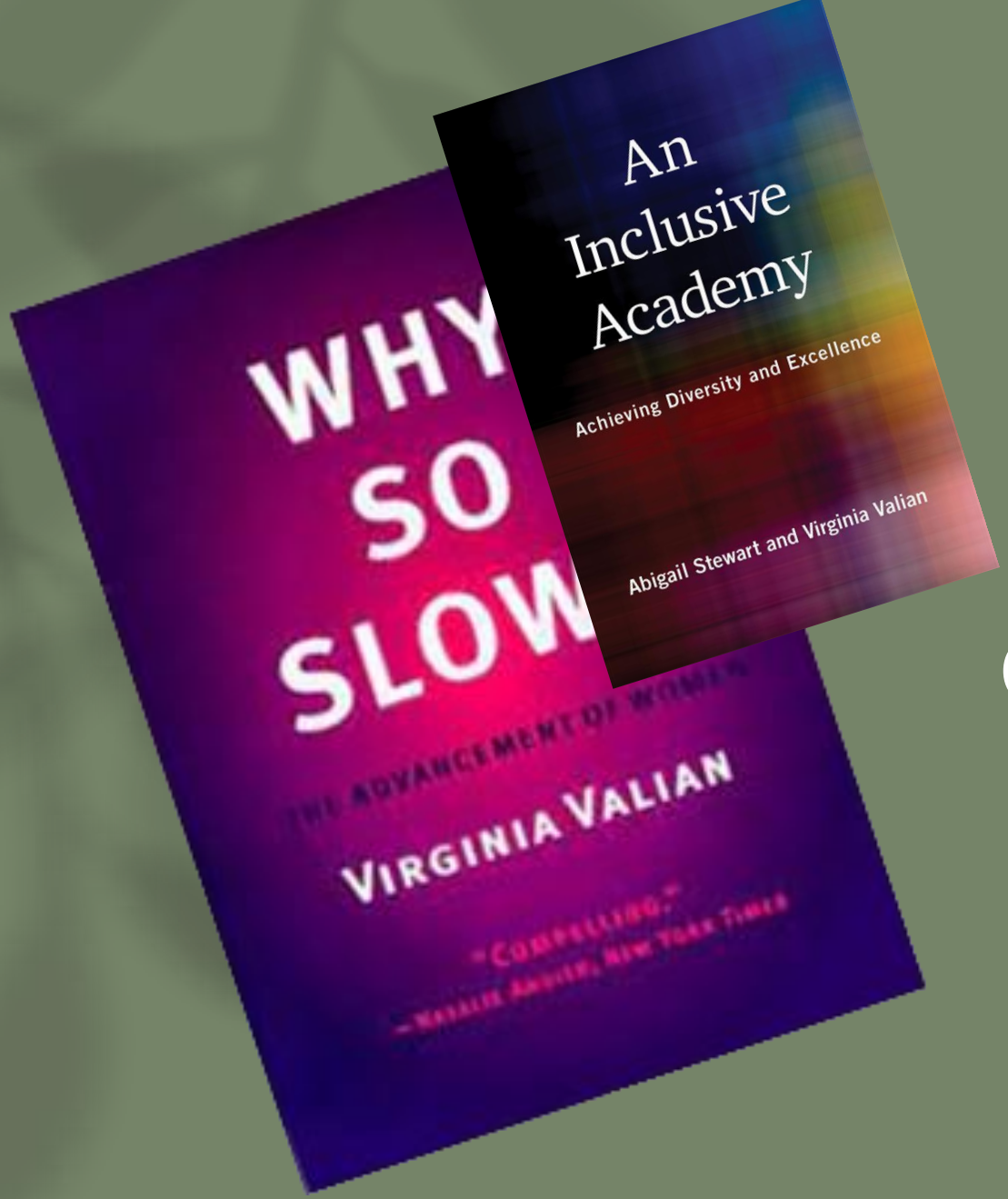
- *Eerste aanstelling is gebaseerd op een overeenkomst*

- **Vervolstappen zijn gebaseerd op erkenning (‘acknowledgements’)**



Twee zijden van dezelfde medaille

Waarderen en waarde toekennen



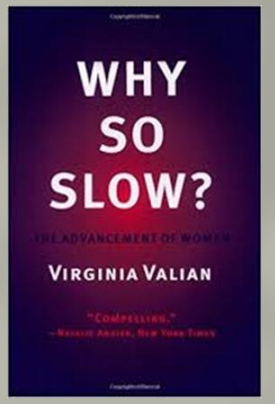
Gender stereotyping

Why so slow. 1999

An Inclusive Academy: Achieving Diversity and Excellence, 2018

Why so slow?

Valian (1999)



"***Gender schemas***

- *influence our interpretations of information.*
- *influence our expectations*
- *influence the way we view people's actual performance.* "

Vi. Valian. Why so slow? The advancement of women. MIT Press 1999

Gender stereotyping

On warmth & competence

- Men are valued *higher* on competence, *lower* on warmth

- Women are valued *higher* on warmth, *lower* on competence

- No matter what…

Susan Fiske , Dept Psychology, Princeton University

How to close the gap?

Awareness

- Transparency in salay, especially in acknowledgements & grants
- Registration & monitoring & closing the gap
- Research on the causes of disparities

Awareness

- Gender stereotype – unconscious bias
- *'Bij gelijke geschikheid'* disadvantages women
- Don't fix the women, fix the system
- Sponsorship programme

RUG prefers a woman as rector, ‘bij gelijke geschiktheid’….

Leden van de raad vroegen toen waarom *wel diversiteit* en *niet kwaliteit* de leidraad zal zijn bij het kiezen van een nieuwe rector.

Volgens algemeen directeur Stephan van Galen is dat ‘… *altijd een moeilijke afweging’*, omdat ‘*beide belangrijk’* zijn.

Physicianhood as a masculine construct

Shifting to a more gender diverse construct of physicianhood
is an exciting prospect, contributing to both the science and the art of medicine.

The NEW ENGLAND JOURNAL of MEDICINE

MEDICINE AND SOCIETY

Debra Malina, Ph.D., *Editor*

Medicine Is Not Gender-Neutral — She Is Male

Kiki M.J. Lombarts, Ph.D., and Abraham Verghese, M.D.

In 1849, Elizabeth Blackwell became the first woman to graduate from medical school in the United States. Today, women make up 35% of the U.S. physician workforce, and among physicians 35 years of age or younger, women actually outnumber men. Many European countries have had a female-majority medical workforce for some years.[1] With more women in medicine, one would expect that "physicianhood" will be reshaped and redefined by women, just as it was defined by men for centuries.

But discussions in academia and health care about women in medicine often seem to begin with the unspoken assumption that physicianhood — the construct of the medical professional, whose definition encompasses the ideals of the art and calling of medicine — is gender-neutral. These discussions focus on numbers of women in the pipeline, the glass ceiling, and the unique challenges women face in medicine, but not on physicianhood. The feminist novelist Virginia Woolf once observed, "Science, it would seem, is not sexless; she is a man."[2] In the same spirit, one could argue that medicine is not gender-neutral — she is male.

[illegible] physician [illegible]able truth: [illegible]ine for the [illegible]kforce has [illegible] This real- [illegible]omen who [illegible]s taken for [illegible]o — many [illegible]n in medi- [illegible]women of color, women from low-income backgrounds, and LGBTQ women[6,7]; these underrepresented groups face the added complexity of intersectionality with minority race or ethnicity, gender identity, sexual orientation, or other visible or invisible aspects of identity.[6,8]

It is vital that we also look beyond gender inequity among physicians themselves to focus on an important consequence of the male-gendered construct of physicianhood: its failure to deliver for patients the highest standards of care and caring. A deeper understanding of gender issues in medicine may therefore enable the profession to improve not just the experiences of its constituents of female and other genders but also the care of our patients.

We should avoid construing this exploration of physicianhood as a battle of the sexes; every physician's best effort is needed to provide the best care. All physicians, like all people, have some qualities that would traditionally be viewed as "feminine" and others typically viewed as "masculine." Some of these qualities are advantageous in medicine, and others less so. Our concepts of feminine and masculine qualities do not rest on a bedrock of fact, but rather are "narratives of origin" that reflect how the world as we know it came into being.[9] Nevertheless, we describe traits here using this shorthand only because it is familiar and easily grasped.[10]

PHYSICIANHOOD AS A MASCULINE CONSTRUCT

Social sciences, in particular psychology and sociology, teach us that throughout the course of our lives we form our identities as individuals — our sense of self — by combining our personality, experiences, and narratives about our sociohistorical, familial, moral, and cultural contexts into a meaningful whole. Professional identities are no exception.[11] A physician's identity begins to be formed during medical education and training, when the entrenched values of the profession and prevalent beliefs about what it means to be a physician are transferred and assimilated. On completion of training, physicians' behaviors and performance reflect the values and beliefs they have internalized, including beliefs about

Original Investigation

FREE

December 8, 2021

Association of Surgeon-Patient Sex Concordance With Postoperative Outcomes

Christopher J. D. Wallis, MD, PhD[1,2,3]; Angela Jerath, MD, MSc[4]; Natalie Coburn, MD, MPH[5]; et al

» Author Affiliations | Article Information

JAMA Surg. 2022;157(2):146-156. doi:10.1001/jamasurg.2021.6339

Editorial Comment

Related Articles

Key Points

Question What is the association of surgeon and patient sex concordance with postoperative outcomes?

Findings In this population-based cohort study of 1320108 patients treated by 2937 surgeons, sex discordance between surgeon and patient was associated with a small but statistically significant increased likelihood of adverse postoperative outcomes. This was driven by worse outcomes for female patients treated by male physicians without a corresponding association among male patients treated by female physicians.

Meaning This study found that sex discordance between surgeons and patients (particularly male surgeons and female patients) may contribute to worse surgical outcomes.

JAMA Surgery | Original Investigation

Differences in Cholecystectomy Outcomes and Operating Time Between Male and Female Surgeons in Sweden

My Blohm, MD; Gabriel Sandblom, MD, PhD; Lars Enochsson, MD, PhD; Johanna Österberg, MD, PhD

IMPORTANCE Female surgeons are still in the minority worldwide, and highlighting gender differences in surgery is important in understanding and reducing inequities within the surgical specialty. Studies on different surgical procedures indicate equal results, or safer outcomes, for female surgeons, but it is still unclear whether surgical outcomes of gallstone surgery differ between female and male surgeons.

OBJECTIVE To examine the association of the surgeon's gender with surgical outcomes and operating time in elective and acute care cholecystectomies.

DESIGN, SETTING, AND PARTICIPANTS A population-based cohort study based on data from the Swedish Registry of Gallstone Surgery was performed from January 1, 2006, to December 31, 2019. The sample included all registered patients undergoing cholecystectomy in Sweden during the study period. The follow-up time was 30 days. Data analysis was performed from September 1 to September 7, 2022, and updated March 24, 2023.

EXPOSURE The surgeon's gender.

MAIN OUTCOME(S) AND MEASURE(S) The association between the surgeon's gender and surgical outcomes for elective and acute care cholecystectomies was calculated with generalized estimating equations. Differences in operating time were calculated with mixed linear model analysis.

RESULTS A total of 150 509 patients, with 97 755 (64.9%) undergoing elective cholecystectomies and 52 754 (35.1%) undergoing acute care cholecystectomies, were operated on by 2553 surgeons, including 849 (33.3%) female surgeons and 1704 (67.7%) male surgeons. Female surgeons performed fewer cholecystectomies per year and were somewhat better represented at universities and private clinics. Patients operated on by male surgeons had more surgical complications (odds ratio [OR], 1.29; 95% CI, 1.19-1.40) and total complications (OR, 1.12; 95% CI, 1.06-1.19). Male surgeons had more bile duct injuries in elective surgery (OR, 1.69; 95% CI, 1.22-2.34), but no significant difference was apparent in acute care operations. Female surgeons had significantly longer operation times. Male surgeons converted to open surgery more often than female surgeons in acute care surgery (OR, 1.22; 95% CI, 1.04-1.43), and their patients had longer hospital stays (OR, 1.21; 95% CI, 1.11-1.31). No significant difference in 30-day mortality could be demonstrated.

CONCLUSIONS AND RELEVANCE The results of this cohort study indicate that female surgeons have more favorable outcomes and operate more slowly than male surgeons in elective and acute care cholecystectomies. These findings may contribute to an increased understanding of gender differences within this surgical specialty.

Invited Commentary

Supplemental content

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Com…

Related Articles

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Meaning This study found that sex discordance between surgeons and patients (particularly male surgeons and female patients) may contribute to worse surgical outcomes.

What is surprising and troubling is that negative outcomes, including complications and death, were linked to sex discordance. Unfortunately, this association disproportionately affected female patients.

JAMA Surgery | Original Investigation

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Seksisme in geneeskunde

- Zie het, lees erover, begrijp het
- Wees (word) jezelf & pas je niet (teveel) aan
- (H)erken genderstereotypering ook in jezelf
- (H)erken ambities van vrouwen om je heen
- Wees een mentor/sponsor als je kunt
- De term ‘bij gelijke geschiktheid’ is door genderstereotypering in het nadeel van vrouwen

Dank voor jullie aandacht

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RUG FEB: Gerben van der Vegt, Peter Essens