Chapter 10
Allies in Gender Equity Efforts in Pediatrics

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Introduction

Gender inequities are pervasive and long-standing in medicine. The field of pediatrics is not exempt. The root causes of gender inequity and its harmful impacts on all aspects of our profession are described in detail throughout this book. In this chapter, we will focus on the role men have in creating and perpetuating gender inequities in medicine and specifically in pediatrics. We will also address the responsibilities men have in recognizing and eliminating gender inequity, from our day-to-day interactions in the workplace and beyond to broader systemic interventions. Some readers may ask, why should men have a voice in gender equity efforts? And more specifically, why should men write a chapter in a textbook dedicated to Women in Pediatrics? In an article describing the existing gender inequities in the field of cardiothoracic surgery which is dominated by men, Wood correctly calls out men as having an outsized responsibility to address gender disparities while proposing a set of principles for allies who are men to follow [34]. As men, we embrace our role as allies in promoting gender equity with purpose and humility. We write this chapter not proclaiming to be experts, but as partners who seek a deeper understanding of the problems and solutions. In the article titled "The coin model of privilege and critical allyship: implications for health," Nixon describes systems of inequity as

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coins, with one side of the coin representing privilege and the other side representing oppression [20]. In our society and in medicine, women are the disadvantaged group when compared to men. As men, we recognize the inherent position of privilege we hold in our society and in our profession and how that privilege has served to create and maintain an unfair system which provides us multiple unearned advantages and benefits. As members of this privileged group, men should recognize that our experiences are different than those of women in our profession and that listening to women and believing them is critical our ability to understand the problem and engage in actionable change. We acknowledge that the burden of working toward dismantling oppressive systems does not lie with the oppressed and disadvantaged group. The work of men, as allies from an advantaged group, should be intentional, and it should focus not on correcting perceived flaws in women so they can succeed in inequitable systems. Working toward and achieving gender equity should not be viewed as a zero-sum game aiming to lift up women at the expense of men, but the goals of allyship should instead be directed to break down the unjust systems. As Nixon explains regarding solutions to inequity in the coin model, "The goal is not to move people from the bottom of the coin to the top, because both positions are unfair. Rather, the goal is to dismantle the systems (i.e., coins) causing the inequities" [20].

Defining Allyship

What does it mean to be an ally for gender equity and for women in healthcare? This is an essential question we must ask ourselves as we aspire to do the work of dismantling gender-based disparities in healthcare and beyond. In considering this question, Jain and colleagues emphasize that men should take deliberate action, that they should "walk the talk" [13]. How do we take deliberate action? It is important to first recognize that the journey toward allyship is dynamic and that allies and potential allies are often found along a continuum in terms of their readiness and ability to join the fray. Through this lens, we propose a practical and wide-ranging, although admittedly incomplete, definition of allyship composed of three main categories: listeners, amplifiers, and champions.

Listeners

Allyship has to start somewhere, and for some, being a listener can be the beginning of their allyship journey. Listeners give space and attention to the voices of those who are oppressed or disadvantaged. A listener may be someone who shows interest and wants to learn about gender equity but may not yet be ready to leap into a more active allyship role. Men can become allies through a commitment to

learning about gender inequity, by listening to the experiences of women they work with, by attending presentations and workshops on gender equity and gender-based disparities, and through self-directed review of peer-reviewed literature and lay literature by thought leaders in the areas. During group meetings and professional conferences, men can be allies through active listening to the ideas and contributions of their women colleagues. Importantly, men can be active listeners by not interrupting women. Leaders can support listener allyship through intentional expectation-setting in group meetings and conferences including explicit rules and behavior norms for equitable and inclusive participation from all members of the group while avoiding practices favoring contributions from one gender over the other whether those meetings are in-person or virtual [9]. Listener allies can be vital in creating spaces that allow psychological safety for gender equity work to occur from the point of view of women [28]. Psychological safety is created within an environment that allows a person to feel included, safe to learn, safe to contribute, and safe to challenge the status quo, and with no fear of repercussions.

Another important aspect of listener allies is their potential to influence others to emulate similar allyship behavior through role modeling. It is plausible to suggest that men would be more likely to become active listeners and allies themselves if they observe other men such as their colleagues, particularly those they see as role models, step into the space, and take part in listener allyship behaviors such as participating in gender equity trainings or attending work meetings about important gender equity policies such as pay equity and parental leave.

Amplifiers

Amplifiers are allies who promote equity by using their position of privilege to magnify the voices of those who are minoritized or have less relative power. An example of how men can be amplifier allies is through professional sponsorship. Sponsorship is necessary for successful professional advancement. Men often wield large spheres of power and privilege within academic or professional organizations. In their study on mentorship and sponsorship, Patton and colleagues compare the differences women experience in professional advancement when they are mentored by men and find that women with sponsors who were men were offered professional advancement opportunities more often than women who were only mentored by men [23]. When allies who are men are able to extend their network of influence for the benefit of women colleagues, it can be crucial for their professional advancement. Men can amplify the work of women through timely sponsorship that is focused on promoting women to positions of leadership and power [4]. Men can also be amplifiers through dissemination of the message by ensuring gender equity is given a platform in important meetings and discussions.

Champions

Champion allies are those who are actively working to end gender inequity. Champions stand up and confront sexist behaviors in the workplace. Allies who are men can be champions by partnering with women and taking on the responsibility for creating policy, curricula, and trainings which address gender disparities within the organization and enacting systems change in compensation, leadership structure, and succession planning. Champions can make a difference not only through their actions but through the expectations they set for themselves and for other men in the organization. There is evidence that allyship behavior among individuals increases when they observe others confronting sexism [4].

Awareness of Risks and Vulnerability

Allies can face backlash for their actions. Men may suffer penalties for rejecting stereotypical gendered norms that benefit them and may be looked upon as less competent by both men and women [6]. Men may also face criticism from the women they are allying with [14], and women may perceive an ally's actions as performative or may be skeptical of their intentions. Allies who are men can also risk jeopardizing women's action plans or proposals. "When aspiring male allies fail to understand the critical importance of partnering and collaborating with humility, there is a real risk that they may ultimately undermine women's initiatives by attempting to dominate them" [14].

How Men Contribute to Gender Inequity

In order to become key allies for gender equity, it is important for men to recognize the attitudes, beliefs, and actions responsible for creating, promoting, and maintaining inequitable systems. More importantly, it is crucial for men to acknowledge the substantial role we play in creating unequal and unsafe work environments for women through our perpetuation of stereotypes, biases, and systemic barriers to change.

Implicit bias is often defined as unconscious attitudes held by individuals about other individuals or groups. Everyone has implicit bias and while it may be difficult to eliminate, there may be ways to mitigate it. Examples of biases attributing negative qualities to women are numerous and are encountered frequently in medicine. They include beliefs that men are more capable leaders than women or that women should conform to specific roles in the workplace and in the home. A common instance of implicit gender bias is when women exhibit traits that are stereotypically associated with men, they are often labeled as "bossy" or "loud" or "aggressive,"

when men are often admired or rewarded for such behavior. Men contribute to gender inequities through the acceptance and amplification of these biases. Men are often in positions of power and are responsible for making individual and policy decisions about hiring, promotion, and compensation. Implicit bias influences men to make decisions in favor of other men and to the detriment of women. Active expressions of bias which contribute to gender inequity in the workplace are microaggressions. Periyakoil and colleagues describe microaggressions as actions and behaviors which can be subtle, verbal or nonverbal, and may arise from our implicit or explicit biases [24]. Biased comments and actions which may seem innocuous or harmless to men are often derogatory and injurious to women and contribute to eroding the psychological safety of the workplace. In their study, Periyakoil and colleagues found that women experience and report microaggressions in the workplace frequently, while men in the same workplaces are less likely to recognize that these microaggressions take place. In order to promote a more equitable workplace for everyone, men should confront these implicit gender biases and microaggressions, recognize them, challenge them, and work to eliminate them.

An even more blatant form of gender discrimination and bias is sexual harassment. Cross-sectional analyses of faculty and resident physicians have shown that sexual harassment is pervasive in medicine and contributes to unsafe working environments and lack of psychological safety. Sexual harassment and gender bias are primary reasons women leave the field of medicine [3, 16]. Men are not only responsible for creating and fostering a hostile workplace through active harassment, but they are also just as responsible when they are bystanders. When men ignore or tolerate sexual harassment, they send a clear message that women are not welcome in the workplace as peers and equals. A nourishing and psychologically safe work environment where everyone is given the opportunity to grow and thrive and women are treated equitably requires that men categorically and actively denounce sexual harassment in policy and day-to-day interactions.

It is important for men to recognize that gender bias and inequities are compounded when the victim of these transgressions belongs to or identifies as a member of another marginalized group in medicine and society. The term intersectionality initially was used to describe situations unique to Black women when compared to white women or Black men. The definition of intersectionality has expanded to include other instances where, as an example, one individual may be the victim of gender bias and racial bias at the same time and how that experience differs from individuals experiencing only one of those biases.

Another important factor to consider is how men contribute to gender inequity through building and sustaining systems that are inherently unequal. Leadership structures in medicine are often set up to propagate gender inequity through lack of transparent succession plans. Traditional medicine promotion structures facilitate gender inequity through the advancement of candidates who are similar in gender and ethnicity, (i.e., white men). Lack of defined term limits for high-level leadership positions also create disparities through promotion of a patriarchal structure without allowing opportunity for women or other underrepresented groups to gain power. Studies show that women benefit from men as sponsors in order to achieve positions

in leadership for which they are similarly qualified or more highly qualified for than men. The failure of men in leadership positions to recognize the opportunity to sponsor well-qualified women for leadership opportunities is a major driver of gender inequity.

The Case for Gender Equity

Internal Motivation for Gender Equity

As alluded to above, many men default to concerns that we exist in a zero-sum system regarding gender equity. This zero-sum model can be viewed analogous to a seesaw – in order to elevate one side of the seesaw, the other group must naturally be lowered. However, this model ignores an underlying evidence base which demonstrates that by lifting one group, both can achieve more. Put another way, creating space for women and others who have been historically marginalized doesn't necessarily consume space – rather the process has the potential to create more space for everyone.

Meaningful allyship, sponsorship, and other direct support often require us to reassess existing frameworks (see Chap. 12). For example, when describing or defining leadership traits, we often use different language to describe leaders who are men based on specific traits [27]. These traits may lead us to identify and hire leaders with leadership styles that are traditionally associated with men (e.g., top-down/autocratic leadership styles) which may or may not be well-suited to particular work environments. (It's important to acknowledge that existing biases may lead us to view these same traits less positively when they apply to women.) Lack of attention to gender-based perceptions leaves us vulnerable to hiring leaders with gaps in their skills sets related to emotional intelligence, more democratic approaches, and focus on inspiring and transforming individuals – traits which have become increasingly more important as our healthcare workforce continues to diversify.

There continue to be gender-based differences in perceptions of bosses and leaders – specifically that both genders tend to favor having a male boss [19]. This is likely multifactorial, but it is hard to ignore the ingrained stereotypes about what makes a "good leader." Linda Kaboolian writes about the challenge that leadership within healthcare has been mostly defined by examples of men and how this can "lessen the chances that women will be promoted into these coveted positions" [7]. As individuals rise through systems, they are more likely to have seen men in leadership roles, and also women leaders may be more likely to be impacted by stereotype threats. The burden must fall on allies who are men to help call out these stereotypes and create greater equity in leadership roles.

Inequity and lack of diversity in the workplace hurt everyone. There is a large body of data associating diversity with improved organizational outcomes. Women

in leadership roles may be more likely to coach and mentor junior faculty which benefits all by creating a stronger organizational pipeline [7]. Diversity in organizational leadership has been associated with improved organizational performance. A report by McKinsey found that companies in the top quartile for gender diversity on executive teams were consistently more likely to have above-average profitability – as much as 50% higher share performance – when women are well-represented in leadership [10]. However, this same study reported that more than half of companies have made "little or no progress, and some have even gone backward" with respect to diversity in their leadership teams. This is a reminder that there is much work to do, and men must be allies and accomplices in this work. As long as men remain disproportionately overrepresented in leadership, they continue to hold the power to change the system.

Specifically, in healthcare, women in leadership roles may help healthcare organizations grow more effectively than they would with men in those roles. For example, women may be more likely to promote family-friendly policies. These policies benefit all by making it less likely that individuals will leave their organization – turnover which the Association of American Medical Colleges (AAMC) estimates at $250,000 to almost $1 million per physician. In a time when more men are taking advantage of family leave policies and taking on larger roles in child-rearing, these policies may have substantial impact on supporting the workforce [21].

Beyond "profit motivation" or "bottom line," there are some very practical and likely more compelling reasons to promote gender equity within healthcare. Perhaps the most basic and practical is improved mortality for our patients. We have data that men and women practice differently, and in fact these differences may lead to the result that patients cared for by women may have improved outcomes [30]. This difference has been seen more specifically in surgical populations, in which patients cared for by female surgeons may have decreased mortality [33]. In patients suffering from heart attacks, having a female provider actually eliminated a well-documented disparity: rather than decreased survival in female patients, when the treating physician was female, men and women had equivalent outcomes.

These reported differences in survival may be due to many factors – likely some combination of the fact that women are more likely to follow established clinical guidelines and provide more patient-centered communication and more psychosocial counseling. An interesting proposition in the surgical report by Wallis et al. is that there may be greater openness to collaboration, "which might avert scenarios that could otherwise result in the 'failure to rescue' phenomenon" [33].

Finally, in the realm of academic pediatrics, we must acknowledge historical and current disparities resulting in disproportionately fewer women in medical research – both as researchers and as subjects. Women represent a smaller share of authors on published research than men – and though this disparity is improving, women still represent less than 50% of authors and are substantially less likely to be in the senior author position [11]. This, together with the fact that men and women are likely to focus on different areas of research, suggests that we may face significant gaps in the medical literature which can be closed if more women are supported doing research.

Women have also been historically underrepresented as subjects in clinical trials. Beyond the ethical disparity this creates, there is also a financial cost resulting from delayed identification of side effects which may affect half of the population. The US General Accounting Office reported that over the years from 1997 to 2000, eight of ten drugs removed from the US market were removed due to side effects which occurred disproportionately, or exclusively, in women [22]. While we could not find specific evidence that women are more likely to include women in their clinical trials, and the FDA currently requires that women and minorities be included in government-funded clinical trials, we feel comfortable postulating that increasing the number of clinical trials overseen by women could potentially decrease disparities in outcomes.

Men as Allies in the Workplace

Women make up 36.3% of the physician workforce in the USA and 64.3% of active pediatricians [1]. They are 60% of faculty in departments in pediatrics yet only 31% of the chairs of these departments [2]. As we consider allyship in a workplace that boasts a substantial presence of women, we must address both structural and individual factors [5].

On the structural side, leaders who are men must pay attention to the policies which drive equity and the culture which bolsters or undermines these policies. This includes workplace flexibility, workforce and talent development, pay parity and transparency in the organization, and the creation of a safe environment and consequences related to sexual harassment and gender bias. On the individual side, it is imperative that allies progress along the continuum from listener to amplifier to champion as outlined earlier. Examples are outlined in Table 10.1.

Regarding structural allyship, here are four domains that every leader should address at their workplace:

Workplace Flexibility The trend toward flexible workplaces began years ago but has accelerated markedly in the COVID-19 pandemic as many individuals have

Table 10.1 Five case scenarios of allyship

Scenario	Listeners	Amplifiers	Champions
Academic: A mid-career woman colleague is seeking promotion to associate professor, but the leadership roles in the department are predominantly filled by men with little turnover	You listen to the concerns of your colleague	You elevate this concern to the chair, vice chair, or division director with the permission of the woman colleague	You use your leverage as a leader or you advocate with the appropriate leader(s) to create succession planning and an inclusive search process for leadership roles at all levels. You challenge the professors and senior faculty to sponsor women and BIPOC candidates for leadership roles both within and outside of the department

Table 10.1 (continued)

Scenario	Listeners	Amplifiers	Champions
Administrative: An early career woman pediatrician compares notes with a male colleague and discovers that she was offered 10% less on her starting salary	You actively listen to your colleague and commiserate with the unfairness of the situation	With the permission of your colleague who is a woman, you bring this pay discrepancy up with your immediate supervisor	You are continuously campaigning for gender pay equity and transparent pay practices at your workplace. If you are in a leadership role, you have worked with your DEI leadership to ensure pay parity is monitored and corrected
Clinical: A patient addresses the PGY-3 woman physician by first name during rounds but addresses the male intern as "doctor"	After rounds, you listen attentively to your female colleague as she states how commonly this occurs	During rounds, you speak up in the moment to correct the patient and address your colleague as "Dr. X"	You speak up in the moment and bring this example as an agenda item to the monthly faculty meeting and graduate medical education team. You highlight that this behavior occurs frequently and that it is the attending physician's role to address the behavior immediately. You work with your leadership team to arrange bystander training for attendings and trainees
Culture: The required department meeting is scheduled at 5 p.m. on a weekday. This conflicts with childcare responsibilities for many young parents – especially women faculty	You solicit and listen to the concerns from women colleagues	You elevate these concerns to the next level so that department leadership is aware. You bring up the concept of face time bias to leaders	You advocate with the senior leadership team to poll the faculty on the best times for meetings. You reschedule the meetings that you chair to coincide with the recommendations of parents of young children.
Regulatory: a medical student confides that she was sexually harassed by a male chief resident in the program.	You listen and report this concern to your title IX coordinator	You listen and report this concern to the title IX coordinator. You offer to bring this up to the GME, student affairs and faculty affairs leadership teams, if the student gives permission	You listen and report this concern to your title IX coordinator. You ensure that sexual harassment training is more than a "check box" compliance module, but a regular theme to be discussed via grand rounds, interview preparation, etc. you follow through with your leadership team to ensure that confirmed perpetrators are disciplined

been working from home or working hybrid schedules. Women are facing amplified work-life conflict due to the gendered expectation that women will remain the primary caretaker for families – both children and aging parents or relatives. As COVID-19 disrupted schools and childcare providers and created acute and chronic

care needs for loved ones, it has placed tremendous and disproportionate strain on women [18]. The role of allies is to organize listening sessions for women in the workplace and to advocate for policies to support flexibility in caregiving roles. This could take the form of direct financial support for women and their families, investing in childcare infrastructure, and implementing family supportive policies. Practically, this could mean moving meeting times to avoid drop-off/pickup times for parents of school-age children. However, policies alone are not enough to change culture. One study of biomedical faculty showed a significant gap between utilization and expressed need for workplace flexibility: 33.4% of women faculty reported using the benefits available to them, while 44.4% of women reported wanting to use them [25]. A "culture of overwork" was cited as a significant barrier to fully utilizing workplace flexibility benefits due to the inexorable push for publications, clinical productivity, etc. In other words, allies must not rest when an inclusive policy is passed. They must anticipate cultural barriers and address them to ensure that women are not penalized for utilizing flextime policies.

Workforce and Talent Development In many academic health centers, significant attention is paid to the diversity of the pipeline at the front end: medical students, residents, and early career faculty. However, relatively less attention is paid to talent development for women in their mid-career who aspire to assume senior leadership roles as evidenced by the ongoing gap in promotion to professor and the gender disparities in senior academic leadership roles such as chair or dean. One simple measure of the health of the pipeline is to ask every leader who is a man in a senior leadership team, "How many women are you personally sponsoring or mentoring? How many of them identify as underrepresented in medicine? How many are mid-career?" From training search committees in inclusive practices to nominating women for awards and leadership roles to creating term limits for succession planning, allies must be proactive in workforce development. Allies can also nurture talent development by supporting executive coaching for women at all career phases.

Pay Equity and Transparency Reams of data have demonstrated that women in medicine continue to face disparities in equitable pay. Most of the gender pay gap literature continues to be generated by women and is often unfunded [17]. For example, one analysis of 39 physician compensation studies reported no funding or no relevant funding in 59% of those studies. Allies can take tangible steps to achieve gender pay parity in departments and in organizations by speaking up about existing gender pay gaps, employing transparent methodologies to close the gaps, and funding ongoing research and consultation on gender pay gaps. The onus for change lies primarily with senior leaders including chairs and deans of academic health centers and HR and C-suite members of hospital leadership teams. Structured compensation may be one path toward creating transparent pay steps and increments for women, but true pay equity will require a concerted approach to increasing the representation of women in the most highly compensated specialties and senior leadership roles [12]. Equitable pay for women physicians may aid in overall resilience as there is emerging data that debt burden increases burnout for women physicians [31].

Workplace Safety and Sexual Harassment Decades of data underscore that sexual harassment of women continues to be a persistent, pervasive problem for women at all levels of healthcare and academia [8]. As Paula A. Johnson and Sheila Widnall, Co-Chairs of the Committee on the Impacts of Sexual Harassment in Academia for the National Academies of Sciences, Engineering, and Medicine (NASEM) state: "*We are encouraged by the research that suggests that the most potent predictor of sexual harassment is organizational climate – the degree to which those in the organization perceive that sexual harassment is or is not tolerated*." Allies must do more than direct women colleagues and trainees to the Title IX Coordinator if an infraction occurs. Allies must also take steps to address culture by speaking up about the need for psychological safety at work and supporting infrastructure to create an inclusive environment. This includes being proactive to support climate surveys, engaging in training programs that target behavior, encouraging leaders to speak up about behavioral expectations both at work and in work-related settings such as conferences, and specifying consequences when those expectations are violated. Ultimately, the goal should be to create a culture of transparency and accountability regarding sexual harassment and workplace safety.

Men as Allies outside the Workplace

Men have a large role to play in gender equity outside the workplace as well. While not all professional women are in domestic relationships with partners who are men, a very common scenario in our society is for professional women to be married to or partnered with a man who also has professional duties outside the home. In this section, we will focus on allyship by men in these relationship structures. Household inequities between working partners have a significantly detrimental impact on the career arc of women physicians. A study by Starmer and colleagues examining factors associated with the division of household responsibilities for pediatricians in the early or middle of their career demonstrated existing inequities between men and women in domestic relationships including the findings that pediatricians who were men spent less time on concrete household tasks than women, and that women were more likely to carry the primary responsibility of completing most household tasks [29]. Jones and colleagues describe how the COVID-19 pandemic has not only contributed to exacerbating gender inequities in the workplace but has also served to further shift the already existing imbalance of home responsibilities toward women due to school closures and childcare disruptions [15]. A recent study examining the experiences of men and women in spousal relationships as they negotiated time and space working from home during the COVID-19 pandemic showed that men's workspace and time for work at home were more defined with clear boundaries than that of women, who often had to spread their worktime throughout the day and were required to find workspace throughout the home [32]. In their article "Gender Equity Starts in the Home," Smith and Johnson assert that equity in domestic partnerships can promote gender equity by increasing the potential for

women to be more productive and successful at work [26]. This argument proposes that equal partnerships at home provide both partners the opportunity to be flexible in finding balance between responsibilities at work and at home without the need for one partner to sacrifice career growth and development at the expense of the other.

Conclusion

Gender inequity hurts everyone; it is not a problem affecting only women. The field of pediatrics is not exempt from gender inequity despite being a specialty where the majority of physicians are women. Men have an outsized role to play in the elimination of gender inequities through meaningful allyship in the workplace and as equal partners outside the workplace. The case for gender equity is clear on an individual and an organizational level. Achieving gender equity is not a zero-sum game; everyone benefits from more diverse and equitable work environments. As members of a privileged group, men should take responsibility and work to enact change in their day-to-day interactions, as allies, sponsors, and mentors, and as advocates for policy and systems change.

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