UNIVERSITY OF CALGARY
CUMMING SCHOOL OF MEDICINE
Department of Pediatrics

2020-2021

DEPARTMENT OF PEDIATRICS
GENDER EQUITY AND DIVERSITY REPORT

GENDER EQUITY AND DIVERSITY TASK FORCE

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EXECUTIVE SUMMARY

The Gender Equity and Diversity (GED) Task Force was created to assess gender equity within the Department of Pediatrics (DOP). The GED Task Force approached this through:

- A survey of department physicians and faculty to understand member perceptions of gender equity,
- The collection of objective metrics from within the DOP,
- Timely reporting of findings and recommendations to the DOP.

Over the last 10 years, DOP leadership has made an effort to support and promote women physicians, but some gender gaps still remain. In this study, gender was reviewed as binary due to a lack of more inclusive data. Our review identified the following findings with respect to gender:

Leadership – Mid-level leadership roles reflect gender proportions of the DOP. The DOP has never had a woman department head.

Gender Pay Inequities – In the DOP, more men are paid through a cARP and more women paid by FFS. Further remuneration data was not available for FFS and cARP physicians. The AMHSP is equally accessible to both women and men. A gender pay gap exists within the grid-system of the AMHSP, with more men in higher paid positions than women.

Career Profiles – Within the AMHSP, distribution of FTE across CARE pillars is equitable.

Research Support and Productivity – Despite similar proportions of research FTE and a comparable productivity, more research workstations are allocated to men than women department members.

Committees – Of influential DOP committees, the composition of the ZPEC represents gender composition of the department. The membership of the AMHSP Committee is predominantly men. There is a paucity of terms of reference (including selection of membership) that include principles of EDI across core committees within the DOP.

Promotions and Recruitment – Tracking of applicants and successful promotions is not currently monitored by the DOP. A trend for successful promotions was not identified. There are proportionately more men than women at the ranks of associate and full professor.

Support for Family – There is inconsistency across sections in support of taking parental leave though there is greater support for women than for men. There is also a perception that women who make time for family are less committed to their careers.

Grand Rounds – There appears to be gender equity amongst DOP grand rounds speakers.

The GED Task Force recommends:

1. Increased opportunities for DOP members to self-identify as members of under-represented or equity-deserving groups to assist the department with improving diversity and inclusion,
2. All core DOP committess should have terms of reference that include principles of EDI,
3. The creation of a DOP Search and Selection Oversight committee to oversee commitee membership and processes,
4. The creation of a DOP Nominating Commitee for oversight of award nomination and sponsorship,
5. Increase drop-down office and research space availability to all members,
6. Development of a departmental EDI committee to support ongoing efforts to address inherent bias and systemic racism in our workplace, including some of the key issues addressed in this report.

The DOP is committed to acknowledging and addressing inequity in our workplace. While the language and learnings of this report may become outdated, this work provides an opportunity to start conversations and a commitment to a future where our differences are celebrated.

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INTRODUCTION

The future of an effective and therapeutic health care system in Canada is one that is equitable, diverse, and inclusive.

The future of an effective and therapeutic health care system in Canada is one that is equitable, diverse, and inclusive. The medical profession has a responsibility to meet the needs of Canada's increasingly diverse population (1). Studies have demonstrated diversity of the physician workforce leads to higher levels of patient satisfaction, better health outcomes and enhanced communication (2, 3). It is recognized that increasing the racial and ethnic diversity of the physician workforce is key in reducing health disparities. Physicians of different genders offer their patients a different therapeutic experience (4). Female doctors generally exhibit more empathy, partnership building, engaging in more positive talk, question-asking and information giving (5). For the benefit of our patients, there is a role for all practice types within the medical field. While gender and ethnicity are often the easiest groups to identify, inclusivity of all can only improve the care we deliver.

The Department of Pediatrics (DOP), Cumming School of Medicine (CSM) has recognized the importance of equity, diversity, and inclusion (EDI). With women comprising the majority of members, the department is invested in a closer study of our work environment. Consideration of gender equity is a place to start for the department and there is a commitment to consider the inclusivity of 5 equity-deserving groups: members of visible minorities and other racialized groups, women, indigenous people, persons with disabilities and those belonging to LGBTQ2S+. Medical literature describing gender disparity often refers to a gender in a binary fashion. The authors would like to acknowledge that gender is not binary, and much work is required to describe the experience of those non-binary in medicine.

GENDER INEQUITY

Although women have had a prominent presence in Canadian medical schools for over 25 years, gender inequity exists in compensation, career advancement and in discriminatory treatment by peers and patients (6, 7). As per data released from the Canadian Institute for Health Information (CIHI) in 2019, women comprise 43% of the physician workforce and yet discrimination continues to exist at both the individual and systemic levels creating barriers for advancement and career sustainability (7, 8).

In 2019, women comprised

43%

of the pysician workforce

At the national level,

8 *of the* **152**

past presidents of the CMA were women.

MEDICAL LEADERSHIP

Despite women reaching a parity in Canadian medical schools in 1995, women are not proportionately represented in medical leadership roles (7, 9). It is projected that by 2030, female and male physicians will be equally represented among physicians. It is time to address the barriers to female representation in medical leadership (7). At the national level, only 8 of the 152 past presidents of the Canadian Medical Association were women (10). The first female dean of a medical school occurred in 1999 and there have only been 8 women deans since this time. Within Alberta Health Services, the distribution of female physician leaders lags behind the current gender distribution for medical staff (11).

As of 2018, women held:

46%
assistant professorships

22%
full professorships

within the Canadian medical education system

MEDICAL ACADEMIA

Literature has demonstrated a deep-rooted gender inequity in academic medicine. Gender gaps exist in CIHR grant funding due to less favourable assessments of women as primary investigators, rather than based on assessment of their proposed research (12,13).

Women physicians are under-represented on panels that develop Clinical Practice Guidelines, as they are generally determined by informal invitation (14). Women are less likely to reach higher academic ranks than men even after controlling for age, experience, productivity, and specialty (15).

In a local study of five Canadian university-affiliated hospitals, academic rounds were presented by an average of 17% fewer women than men (16). After controlling for age and experience, these metrics further influence a woman's career trajectory. Since more productive faculty members attract more trainees, success and productivity continue to be compounded over time.

As of 2018, women held 46% of assistant professorships and only 22% of full professorships within the Canadian medical education system (17).

Academia has traditionally been entrenched in a masculinized model of success with meritocratic principles that favour the stereotypical traits of men with regards to work practices, preferences, and styles (18). Often, when women do excel in this environment, they are criticized for behaviours that clash with the societal expectations of women (19).

GENDER PAY GAP

Women face subtle bias in recruitment and hiring. With less opportunity for leadership positions, there is less opportunity for the associated higher income.

The gender pay gap is the difference of financial earnings between men and women for roughly equivalent work. There are many layers to gender inequity in physician remuneration. The first is based on specialty of practice. In Canada, women make up less than 35% of physicians among the top 10 specialties with the highest gross and net incomes yet account for 47, 48 and 62% of physicians in the specialties with the lowest net income (family medicine, psychiatry, and pediatrics respectively) (6). This subtle and inherent shunting of female physicians towards lower paying specialties is a component of what has been termed “the hidden curriculum.”

In an Ontario study, male family physicians earn 30% and male specialists earn 40% more than their female counterparts (20). This 40% gap equates to $125,000 per year. Even within surgical specialties, female physicians are paid less than their male counterparts after adjustment for age, years in practice, patient factors and specialty (21). This financial disparity rooted in Fee for Service (FFS) billings is not based on fewer hours worked.

A 2019 Canadian Medical Association National Physician survey demonstrated that women work 4.7% fewer hours per week and 8.6% fewer hours on call per week (22). These small differences do not reflect the disparity in income. In a 2017 study in British Columbia, women primary care physicians were found to make 36% less than their male colleagues despite working only 3.2 hours per week less (23).

Women do not receive equal pay for equal hours of work, and this seems to be rooted in the type of work women do, rather than due to patient volume or efficiency (6). This gender pay gap is propagated by multiple factors including a fee system itself that favours procedures and time-spent rather than complexity or value-based care. In outpatient settings, women spend more time per patient and deal with more issues per visit which is less valued in a FFS model (23).

Women may also face subtle bias in recruitment and hiring (24). With less opportunity for leadership positions, there is less opportunity for the associated higher income. Depending on the terms of AMHSP remuneration, lower academic rank, and recruitment early in one’s career also may compound disparity in income.

DISCRIMINATORY BEHAVIOUR

Women in medicine continue to face gendered stereotypes due to both explicit and implicit bias. Implicit bias, or unconscious bias, are mental associations based on internalized schemas that drive discriminatory behaviours without conscious intent (25).

Experiences of discrimination in the workplace continue to occur. Women are five times more likely to experience opposition to career advancement and three times more likely to experience actions perceived as disrespectful in the workplace (26). In a recent study of clinician-researchers, 30% of women reported experiencing sexual harassment compared to 4% of men (27). Of these women, 47% reported that these experiences negatively affected their career advancement. Discrimination in the workplace is real and continues to occur.

Women are 5x more likely to experience opposition to career advancement

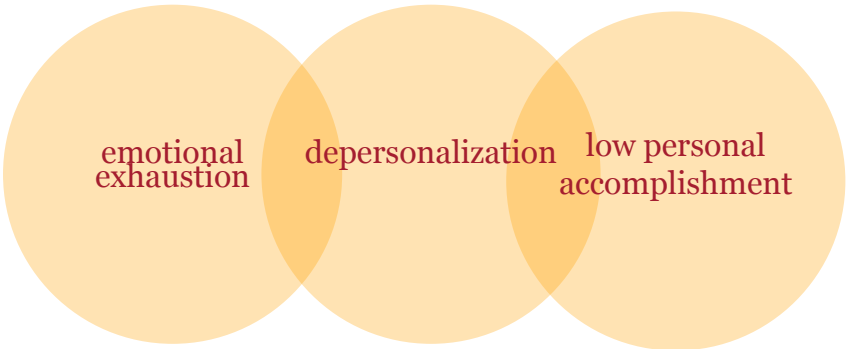
Women are 3x more likely to experience actions perceived as disrespectful in the workplace

HEALTH AND WELLBEING

There is increased appreciation for physician burnout and the toll it takes on patients and on the health care system. Burnout is defined as consisting of 3 dimensions: emotional exhaustion, depersonalization, and low personal accomplishment (28). Rates of physician burnout amoung pediatricians ranges between 35 to 40% (29).

The findings of the 2020 Physician Wellness Measurement by Well Doc Alberta demonstrated rates of burnout within the CSM Department of Pediatrics are generally consistent with this literature (30). When delving into contributors, mistreatment in the workplace has been linked to physician burnout (31). Unequal career opportunity, limited career trajectories, discrimination, and harassment affect the well-being of physicians in the workplace.

The DOP is committed to the health and wellbeing of its members and aims to address these systemic inequities to promote the voice of all.



35 to 40%

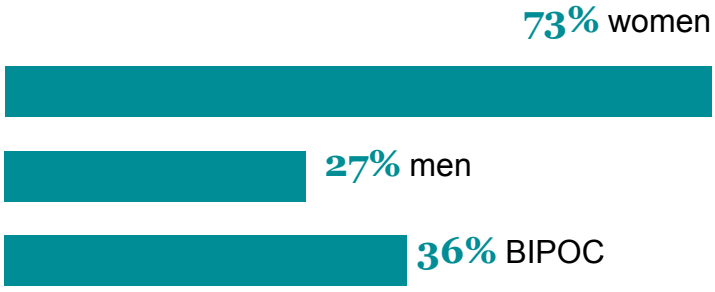
burnout rate amoung pediatricians

METHODS

At the recommendation of department leadership, a task force to address equity, diversity and inclusivity was assembled from a pool of applicants. The mandate of the task force was to provide recommendations to the department on improving diversity and inclusion amongst clinical and non-clinical faculty within one year. The group, coined the Gender Equity and Diversity (GED) Task Force, opted to start by addressing gender equity with the intention to subsequently look at inclusivity for other equity-deserving groups.

The task force is comprised of 73% women, 27% men, with 36% Black, Indigenous and People of Colour (BIPOC) representation.

Composition of the GED Task Force:



A survey of department members, physicians and faculty, was conducted over a three week period in the 2020-21 academic year. This survey utilized a number of questions from the "Culture Conducive to Women's Academic Success" (CCWAS) survey and the University of Michigan Faculty Survey in addition to some novel questions tailored specifically to our department (32, 33). The purpose of this study was three-fold:

1. To raise awareness of EDI
2. To get a general understanding of department members' perceptions, a "pulse check"
3. To compare perceptions of our members against department metrics.

A list of metrics was developed and mapped to each of the survey questions (Appendix A).

Due to limitations in data historically collected across the department, gender will be described in this report as "women" or "men." One of our first and most important learnings is that as a department, we can neither assume nor describe the gender of our colleagues without allowing for self-identification.

The language used to describe and address social inequities will likely change over time. The authors of this report are physicians and researchers within the University of Calgary and the Department of Pediatrics and are not experts in areas of social justice. The authors are, however, committed to ongoing listening and learning and are open to changes in the way this discussion is structured.

RESULTS AND DISCUSSION

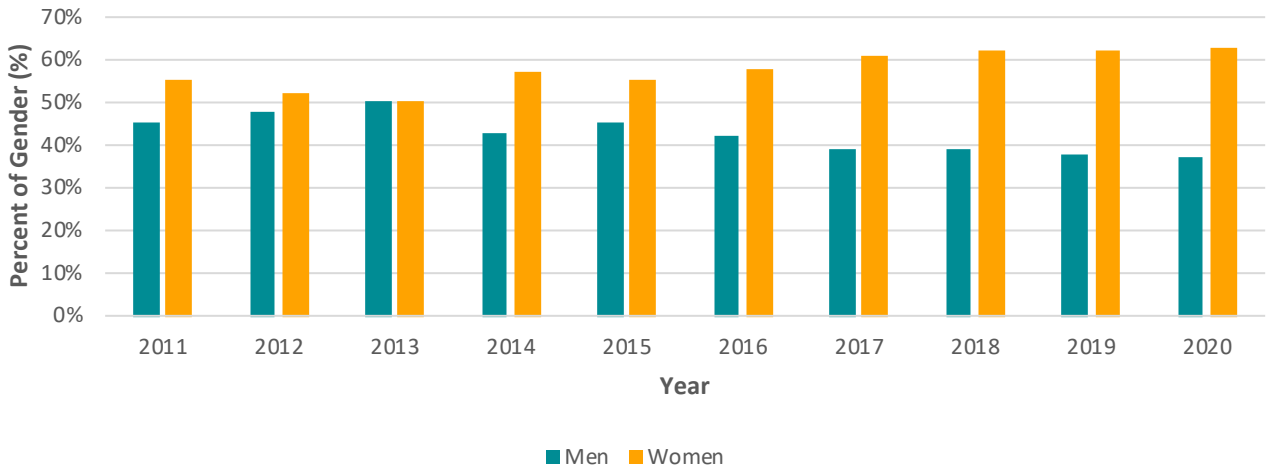
Survey Demographics (Appendix B)
Response rate: 187/493 (38%), of respondents:

- 57 identified as men (30%)
- 128 identified as women (70%)

This is compared with the current department primary appointment composition (Figure 1).

- 122 men (37%)
- 209 women (63%)

Figure 1. Distribution of Gender in the Department of Pediatrics
(2011 - Present)



Ethnic Minority

- 43 (23%) identified as an ethnic minority
- 141 (75%) did not
- 3 (2%) preferred not to answer

Role within the department:

- In training → 22 (12%)
- Primary clinical faculty → 107 (57%)
- Supplementary clinical faculty → 31 (17%)
- Non-clinical faculty → 12 (6%)
- Other → 15 (8%)

Career stage (years in practice):

- Early Career (< 10y) → 66 (35%)
- Mid-Career (11 – 20y) → 71 (38%)
- Late Career (> 21y) → 44 (24%)
- Other → 6 (3%)

Primary location of practice:

- ACH: 127 (69%)
- Hospital site outside of ACH: 22 (12%)
- Community Clinic: 24 (13%)
- Other: 11 (6%)

Remuneration model:

- Academic Medicine Health Services Program (AMHSP) → 67 (33%)
- Fee-for-Service (FFS) → 61 (30%)
- Clinical Alternative Relationship Plan (cARP) → 22 (10%)
- Other (eg. resident contract, UCalgary salary, honoraria) → 36 (18%)

Medical / Doctorate degree obtained from a Canadian University:

- Yes → 139 (75%)
- No → 45 (24%)
- N/A → 2 (1%)

Respondents with children:

- Yes: 151(81%)
- No: 35 (19%)

LEADERSHIP OPPORTUNITIES FOR WOMEN

67% of survey respondents perceived equal access to career development opportunities regardless of gender

50% of respondents felt women are frequently considered for leadership opportunities

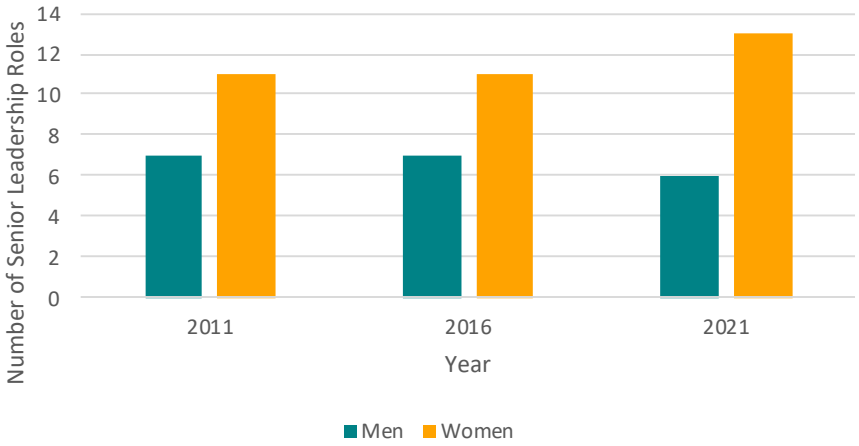
47% of respondents felt women are appropriately represented in senior leadership positions

Despite these perceptions, review of our department leadership demonstrated:

- 66% of DOP program directors are women
- Of DOP leadership roles (composition of the Zone Pediatrics Executive Committee includes facility leadership, quality and safety leaders and section chiefs), 58% are held by women
- Of senior leadership roles within the DOP Pediatrics (Department Head, Department Deputy Heads, Department Manager and Program Directors), 61% of these roles were held by women over the last 10 years.

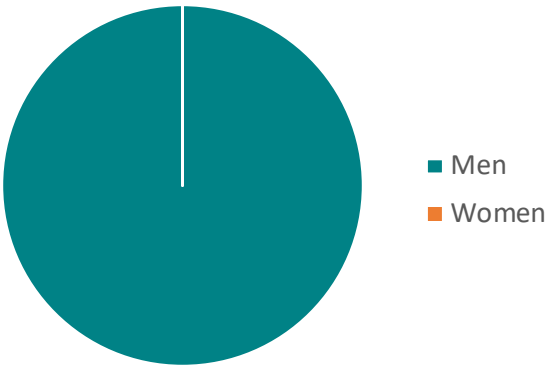
Currently, 68% of these senior roles are held by women. This is in comparison to gender composition of the department, where 63% are women. This is appropriate representation of gender distribution within the department.

Figure 2. Senior Leadership Roles by Gender



Dating back to the first Department Head in 1967, there has not been a woman in this role.

Figure 3. DOP Department Head by Gender
(1967 - Present)



REMUNERATION

There are 5 different models of remuneration within the Department of Pediatrics:

Many members within the department are involved in a combination of the above remuneration plans. As such, the predominant form of remuneration was utilized. Due to low numbers, those on AHS salaries were excluded from the table below. Also note, those on cARP and AMHSP (>0.4 FTE) are unable to be remunerated by any other means.

Table 1. Gender distribution and remuneration models

		Gender	Frequency	Percent
AMHSP		Male	37	37%
		Female	62	63%
cARP	NICU	Male	17	61%
		Female	11	39%
	PICU	Male	5	42%
		Female	7	58%
	Total	Male	23	56%
		Female	18	44%
FFS		Male	53	32%
		Female	113	68%
University of Calgary		Male	8	30%
		Female	20	70%

Amongst clinicians, there is a higher representation of women in an FFS model and a predominance of men in the cARP. Of clinicians within an AMHSP, the gender distribution is representative of the gender distribution of the department.

AMHSP GENDER PAY DISTRIBUTION

The rates of remuneration under the AMHSP contract are dependent on an entry pay level, commonly referred to as the "grid." An individual department member will sort to a remuneration level on this grid based on two factors:

1. The number of years since receiving their FRCPC
2. University appointment

Once a department member enters this grid, the remuneration level remains the same regardless of promotion or number of years in the department.

The grid was implemented about 10 years ago and only new AMHSP members entering into a contract have used this grid system. Remuneration levels prior to use of the grid were continued for pre-existing department members.

Note: Due to lack of an Information Sharing Agreement, the department does not have access to data for other payment models, such as FFS or clinical ARP.

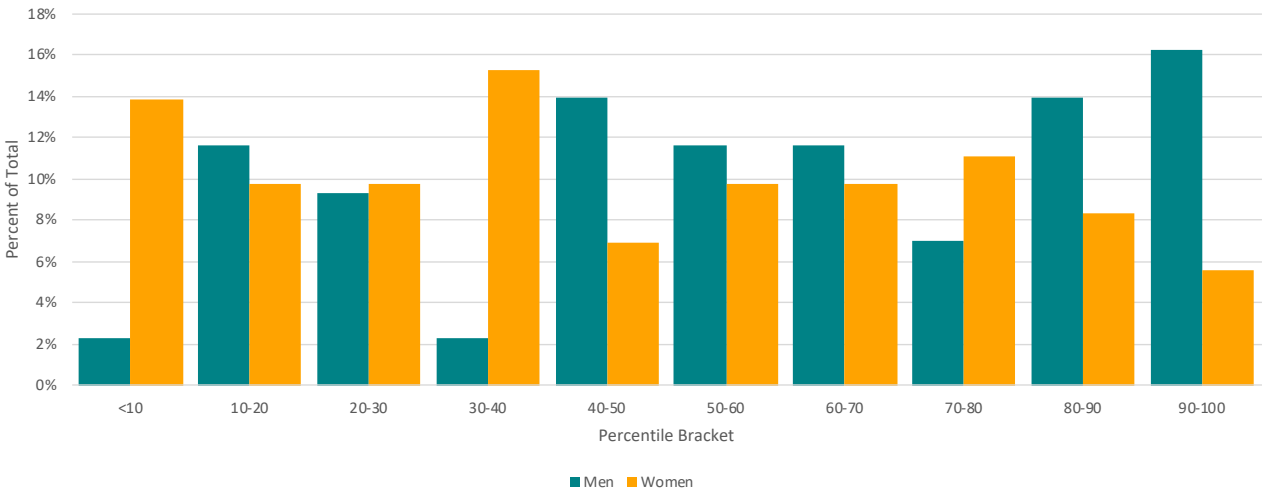
Table 2. DOP gender distribution of AMHSP remuneration by percentile

Total AMHSP Earnings in Percentile	Percent Women	Percent Men
<10	14%	2%
10-20	10%	12%
20-30	10%	9%
30-40	15%	2%
40-50	7%	14%
50-60	10%	12%
60-70	10%	12%
70-80	11%	7%
80-90	8%	14%
90-100	6%	16%
	100%	**100%**

Within the Department of Pediatrics AMHSP, there is a predominance of men within the higher remuneration percentiles and, conversely, a higher remuneration of women within the lower percentiles.

Put another way, 50% of men on AMHSP within the Department of Pediatrics fall within the top 40% and 50% of women on AMHSP fall within the bottom 40% of remuneration percentiles.

Figure 4. Total Earnings Distribution of Men and Women under AMHSP by Percentile



CAREER PORTFOLIOS

In the DOP AMHSP:

- 66 members (61%) are women
- 41 members (38%) are men
- Total of 99.2 FTE.
- Women make up 58.8% of total AMHSP FTE, men 39.9%
- Average total FTE per man and women in the DOP are 0.97 and 0.89 respectively.

This reflects that more women members have a part-time FTE. When looking at CARE pillar break-down of the AMHSP contract, the percentage of FTE occupied by men and women in each pillar are comparable:

Figure 5. CARE Breakdown by FTE (Men)

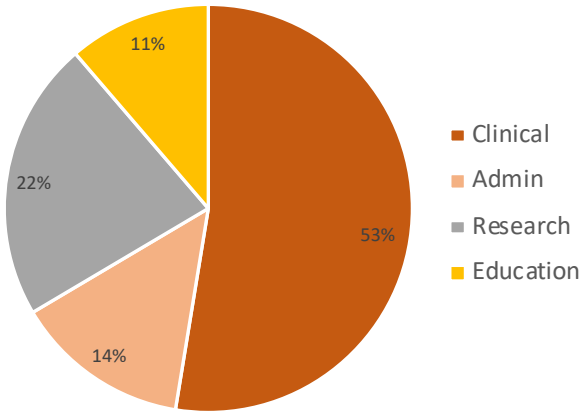
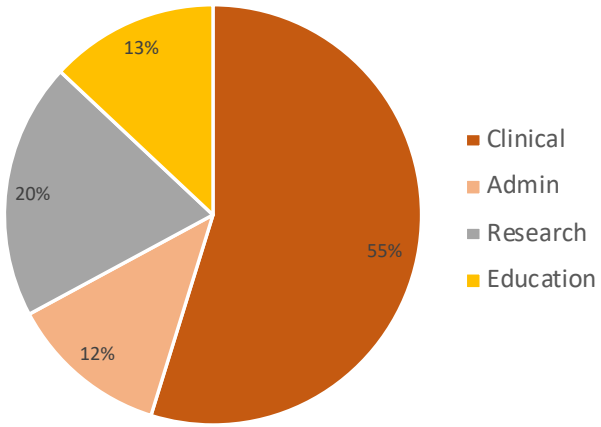


Figure 6. CARE Breakdown by FTE (Women)



The absolute amount of FTE within each pillar based on gender is:

Table 3: Numbers in parentheses are proportions corrected for composition of department, gender FTE per total gender FTE.

Table 3. Total amount of CARE pillar FTE in the Department of Pediatrics based on gender

	Clinical	Admin	Research	Education
Men	21.0 (0.53)	5.6 (0.14)	8.9 (0.22)	4.5 (0.11)
Women	32.5 (0.55)	7.3 (0.12)	11.7 (0.20)	7.7 (0.13)

CARE Profile and FTE distribution is fairly similar across genders.

RECOGNITION OF WORK

The survey examined perceptions of department members regarding gender equity and recognition of the work we do.

49% of respondents felt comments made by women faculty in meetings are given as much credit and attention

More than half of survey respondents felt women are as frequently recognized for their work and are as frequently nominated for awards and honours

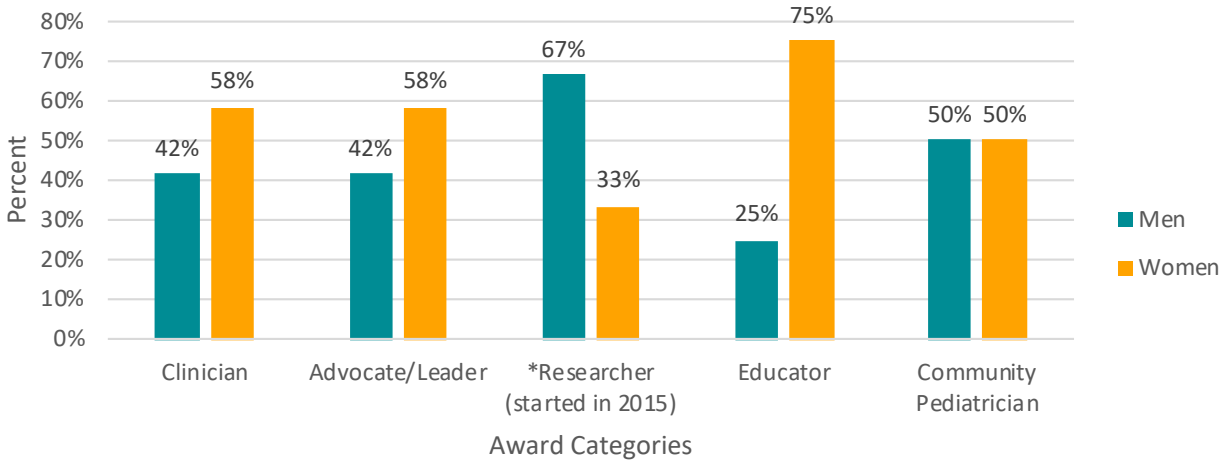
On the other hand, 40% of respondents felt women faculty are more likely to allow others to take credit for their work

The Department of Pediatrics initiated the CARE awards in 2009. These awards recognize department members who have gone above and beyond in each of the CARE pillars of the department: Clinician, Advocate/Leader, Researcher, Educator.

Since 2009:

- 58% of both the Clinician and Advocate/Leader awards have been given to a woman. This proportion is representative of department gender composition.
- Education award recipients have been 75% women over the last 12 years.
- The Research award started in 2015. Since this time, recipients have been 67% men despite holding an equivalent proportion of FTE in research to women.
- The Community Pediatrician of the Year award has been received equally by both genders since its inception in 2009.

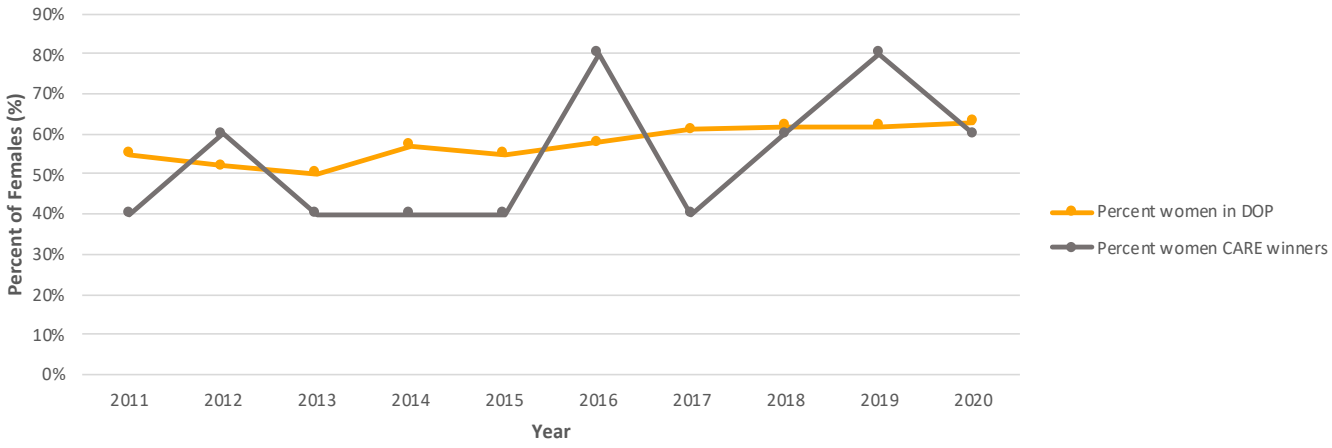
Figure 7. Percent Men vs. Women Recipients of CARE Awards and Community Pediatrics Award (2009 - 2020)*



RECOGNITION OF WORK

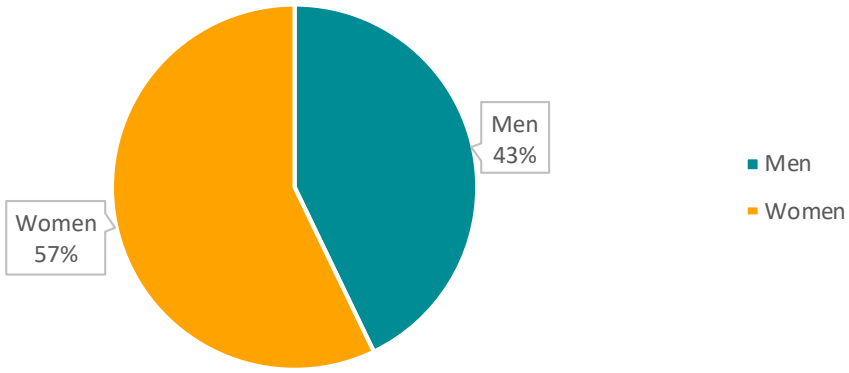
When comparing the proportion of women CARE award recipients over the past 10 years with the proportion of women in the department, the proportion of women recipients has been equal or greater to their proportion in the department half of the time. This has been particularly evident over the past three years.

Figure 8. Percent Women in the DOP vs. Percent Women CARE Award Recipients



The Distinguished Career Award recognizes a department member who has made significant contributions to the Department of Pediatrics. With its inception in 2018, the award has recognized 58% women in the department, again representative of the gender composition of the department.

Figure 9. Distinguished Career Award Recipients
(2018 - 2020)



RESEARCH FTE AND PUBLICATIONS

The Department survey found:

41% of respondents felt women receive as much guidance about potential research opportunities as men, **22%** disagreed with this statement.

32% felt women have access to as much research space or equipment as men, **18%** disagreed.

Respondents were split on whether women have less protected research time: **31%** of respondents felt there is no disparity, whereas **24%** felt there is.

As presented above, women hold 11.7 absolute FTE assigned to research within the DOP, whereas men hold 8.9 FTE in research. When correcting for FTE in research to total FTE per gender, men hold 0.22 FTE and women hold 0.20 FTE (See Table 3). It is recognized that a comparable aggregate of research FTE doe not necessarily correlate with research productivity.

Table 3. Total amount of CARE pillar FTE in the Department of Pediatrics based on gender

	Clinical	Admin	Research	Education
Men	21.0 (0.53)	5.6 (0.14)	8.9 (0.22)	4.5 (0.11)
Women	32.5 (0.55)	7.3 (0.12)	11.7 (0.20)	7.7 (0.13)

The University of Calgary Library keeps record of publications for members of the Department of Pediatrics. Between 2015 to 2020, women department members published 2983 times and men published 2122 times.

This works out to equivalent publications per gender, 12 publications per both men and women DOP members (primary and adjunct). It is recognized that the absolute number of publications does not reflect productivity nor the type of output our research colleagues are able to achieve with their FTE.

2983
Publications by women department members

2122
Publications by men department members

SUPPORT FOR RESEARCH

When asked if department members felt women have less protected time for research

- 24% of respondents agreed with this statement,
- 31% disagreed
- 46% neither agreed nor disagreed.

As described in Table 3, the research FTE allocated to men and women is approximately the same, 0.22 vs 0.20 respectively.

There are 82 research workstations available in the Department of Pediatrics which works out to 105 research spaces for allocation.

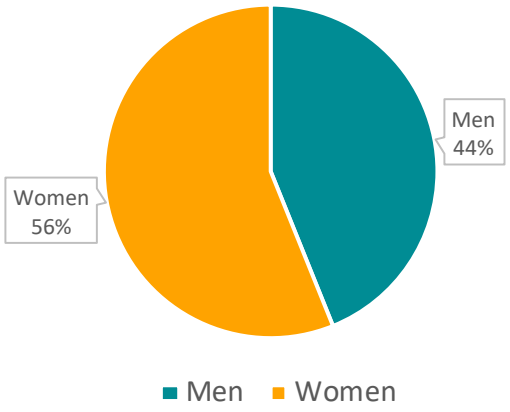
These workstations are allocated using specific criteria including:

- Numbers of grants awarded,
- Total grant funding,
- Total grants supporting research staff salaries,
- Total FTE research staff,
- Proportion of FTE research staff working on-site,
- Availability of other space for research.

Research workstations are allocated on an annual basis. Once a research workstation is allocated to a faculty member, they determine how their research staff use the space (i.e. single user, shared space).

In 2019, men department members had 59 (56%) allocations and women had 46 (44%).

Figure 10. Research Workstations Allocated by Gender



Many measures used to describe productivity, however, are deeply affected by inherent bias in the system. Out of the department members who bring in the most total research revenue over the past two years, 2019 and 2020, three out of five are men.

When considering the most active researchers, all with primary appointments to pediatrics, 73% are women and 27% are men. The complexities of the research culture makes the utilization of specific metrics challenging to study.

But what is clear is the department needs to be aware of internal and external barriers and to be deliberate in dismantling these barriers to support our research faculty.

MENTORSHIP OF WOMEN FACULTY

50% of survey respondents felt women receive as much mentoring from senior faculty, 20% of members did not

Literature has shown that members of equity deserving groups (women, aboriginal peoples, persons with disabilities, members of visible minorities, LGBTQ2S+) benefit from encouragement in applying to leadership roles.

This has been referred to as the "tap on the shoulder". Eleven of eighteen section chiefs within the DOP self-report to make an effort to encourage section members of equity-deserving groups to apply to leadership roles (see Appendix C).

The department does not have a formalized process to tap members on the shoulder for leadership roles or for awards and recognition. Currently, the process is ad hoc and there are not systematic means to consider principles of EDI in the tap on the shoulder.

COMMITTEES

The Cumming School of Medicine has begun work to ensure principles of EDI on important committees. They have recommended departments develop terms of reference that incorporate EDI principles for significant committees.

The department survey asked members if it is perceived that women sit on prestigious committees as often as their male counterparts:

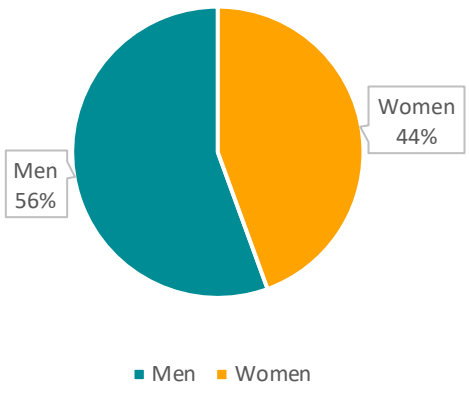
- 37% of respondents agreed
- 25% of respondents disagreed.

The survey also asked members if it is perceived that women play an equally important role in decision making:

- 56% of survey respondents felt women play an equally important role in decision making
- 16% felt they did not.

Of committees within the Department of Pediatrics, the AMHSP Committee is likely the most influential. Composition of this committee is 55% men and 44% women. The terms of reference for this committee were revised in 2020 and do not address EDI in selection and composition of membership.

Figure 11. Gender Distribution of AMHSP Committee Membership



UNIVERSITY APPOINTMENTS

The breakdown of university appointments across the Department of Pediatrics is:

Table 4. Gender distribution of Department of Pediatrics university appointments				
Rank[1]	Number of Men	Number of Women	Percent Men	Percent Women
Assistant Prof	1	2	33	67
Associate Prof	12	13	48	52
Clinical Assistant Prof	36	67	35	65
Clinical Associate Prof	23	29	44	56
Clinical Lecturer	17	67	20	80
Clinical Prof	6	0	100	0
Honorary Clinical Prof	1	0	100	0
No University Appointment	5	16	24	76
Prof	16	9	64	36
Prof Emerita of Peds	0	1	0	100
Research Assistant Prof	1	2	33	67
Research Associate Prof	0	1	0	100
Research Prof (Multiple positions)	0	1	0	100

1. Abbreviation "Prof" for Professor

Excluding the research appointments (which work differently), when considering positions Associate Professor or higher:

- Men hold 53% of these positions,
- Women hold 47% of these positions.

Despite composition of the department being predominantly female, more senior university appointments are held by men.

PROMOTIONS

At the university level, recognition through promotions has been historically low for Pediatrics. Over the last 10 years, there have been efforts to improve our profile at the University of Calgary.

There is no data available to track which applicants for a promotion are successful or unsuccessful. Anecdotally, over the last three years, all applicants who have put their names forward have been successful. With this limited data, a gender bias was not identified in the promotions process.

We tracked promotions by gender for each university rank over time for the department. No clear trends were identified (see Appendix D).

Of note, there were no promotions of Clinical Associate Professor to Clinical Professor between the years of 2015 to 2020. In 2021, 3 applicants were successful in their promotion to Professor (see Appendix D).

NEW APPOINTMENTS

When considering onboarding of new department members, the question was asked if there is gender bias in recruitment of senior faculty.

Tracking of new recruits was done over the last three years. Most new hires during this time were women (see Figures 17 and 18). One person, a man, was appointed into the level of Clinical Associate in the last three years and there were no recruits at the level of Clinical Professor.

Due to low numbers, it is difficult to appreciate a trend. It is noted, however, that most new clinical recruits occur at the Clinical Lecturer rank (see Figure 17).

Figure 17. New Appointments - Clinical Lecturer

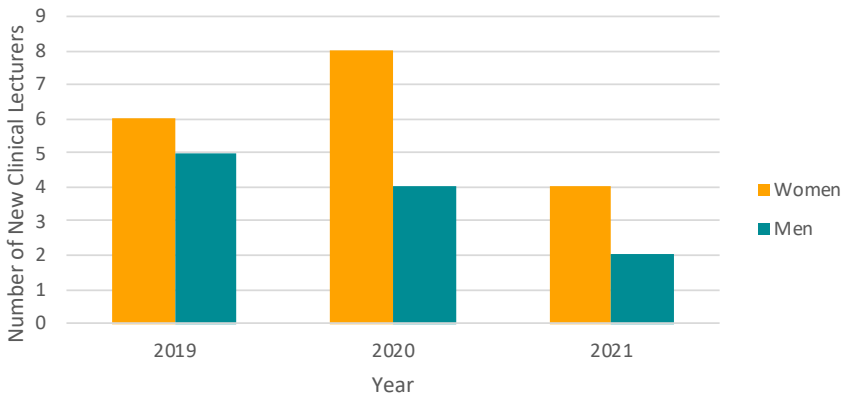
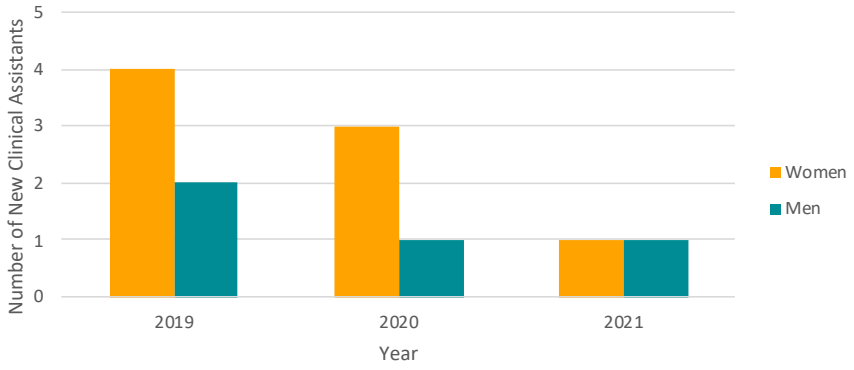


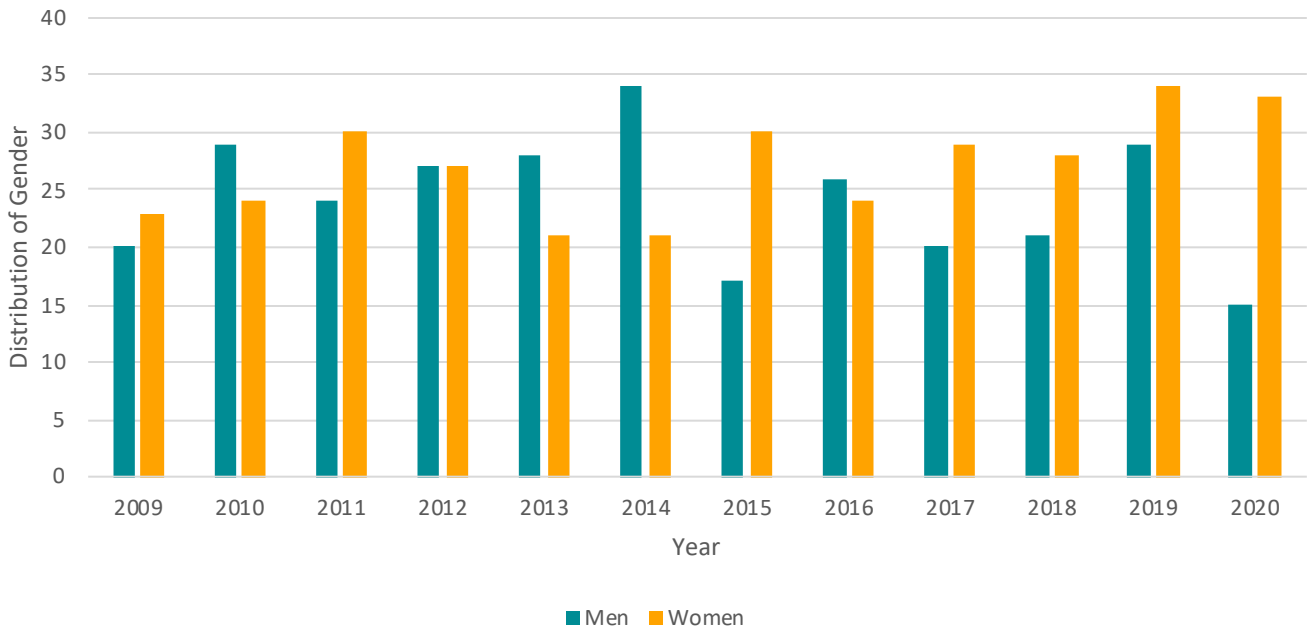
Figure 18. New Appointments - Clinical Assistant



GRAND ROUNDS

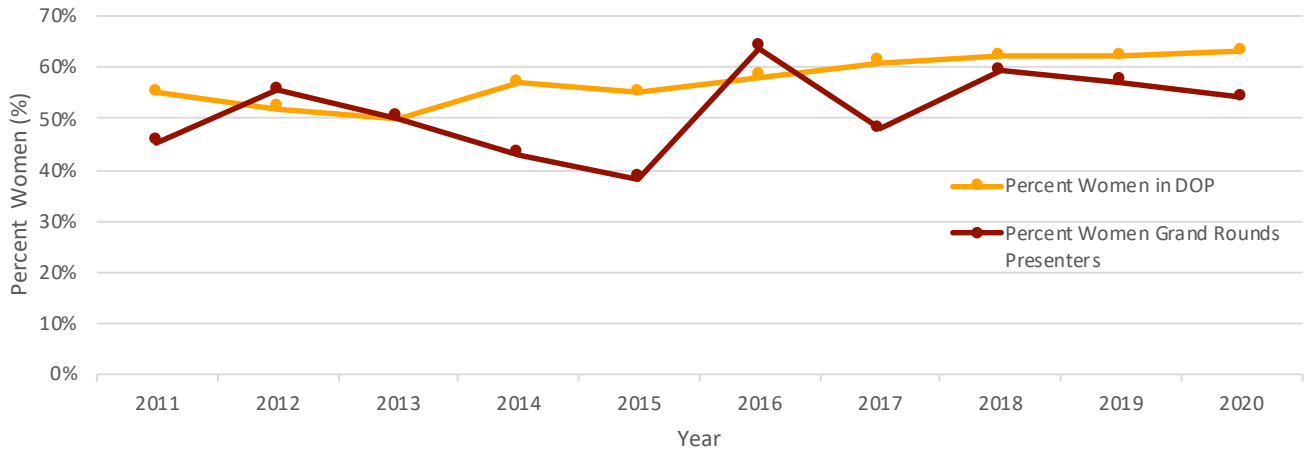
The gender distribution of presenters at Pediatrics Grand Rounds was studied over the last 10 academic years (see Figure 19).

Figure 19. Grand Rounds Presenters by Gender (2009 - 2020 Academic Years)



The percentage of women presenters at Pediatrics Grand Rounds over the last 10 years has overall come close to approximating the gender composition of the department.

Figure 20. Percent of Women in the DOP vs. Percent of Women Grand Rounds Presenters (2011-2020 Academic Years)



OFFICE SPACE

Over half of survey respondents felt women get as much office space as men, whereas 12% of respondents disagreed.

AHS office space available to DOP members is tracked on a master document and is allocated using a specific critera (available upon request). In the year 2020-21, 98 women (47% of women in the DOP) had allocated office space and 69 men (57% of men in the DOP) had allocated office space.

This metric does not reflect the need for office space as some members would rather they be located outisde of AHS.

47%

of women had allocated office space

57%

of men had allocated office space

SUPPORT FOR FAMILY

To determine the sense of support for family and parental responsibilities in the department, the survey found:

- 59% of respondents felt women are supported to take time off for family, but only 47% felt men are supported for the same,
- 54% of respondents felt that women who reduce their workload are viewed by their colleagues to be less committed to their careers, but only 39% felt this way for men,
- 69% of respondents agreed that a reduction of workload hurts chances that women faculty will succeed, but only 40% felt men would feel this to the same degree,
- 70% of respondents felt that amongst their section, women faculty are encouraged to take parental leave. In comparison, only 35% of respondents felt men are encouraged to take parental leave,
- 33% of respondents felt they were able to take as much time for parental leave as they had requested, whereas 10% did not take as much time for parental leave as desired. It is acknowledged that reasons for not taking as much time as requested for parental leave are multi-factorial.

Section Chiefs were surveyed (Appendix C) to help understand consistency of process in tracking leaves of absence.

At this time, the Department has no consistent means of formally tracking leave of absence (LOA) or parental leaves. A leave from work duties can be informal and may or may not involve discussions with one's Section Chief. Awareness of LOAs amongst Section Chiefs were variable. There is no formalized oversight for parental leave within the DOP.

The comments section of the survey provided some insights into the culture of taking parental leave (Appendix C).

QUALITATIVE ANALYSIS

The comments section of the department survey provided a great deal of narrative to the findings above. See Appendix E for a qualitative analysis of respondent comments.

DISCUSSION

Over the last 10 years, leadership within the DOP has made an effort to support and promote women physicians. This effort is noticeable upon review of the perceptions of department members and upon review of several department-level metrics.

There is proportionate representation of women at the level of leadership within ZPEC, amongst presenters at grand rounds and amongst recipients of the Distinguished Career and the Advocacy/Leader and Clinician CARE awards.

While many respondents of the DOP survey perceived equity in support, opportunity and remuneration, there was a consistent message from department respondents that the playing field is not necessarily equitable. While gender distribution of leadership roles within the DOP are reflective of the composition of the department, the fact that there has never been a woman Department Head is a powerful indicator of a remaining inequity.

A gender pay gap was recognized within the DOP AMHSP remuneration. The causes for this gender discrepancy is unknown and may relate to rate setting prior to the implementation of the entry pay level system, called the "grid," almost 10 years ago. Causes for this gender pay gap requires further investigation.

Men and women have a similar research FTE and publication volume. However, the 2019 workstation allocation resulted in more men than women being allocated space for research staff. The DOP CARE research award has also under-represented women for their contributions to research. Despite a strong workforce of women in research with adequate FTE, women researchers face a number of internal and external barriers to success and productivity. To better support our women in research, department leadership needs to acknowledge and address these barriers.

Men department members are more likely to be provided with office space and are overall ranked higher in university appointments. Men are less likely to feel supported to take parental leave than women but when men take time out of their career for family, it is less likely to be perceived as a lack of commitment to one's career. Further, men are less likely to be recognized by the DOP for their work in education despite also having equivalent FTE within the education pillar. This type of systemic bias is deep-rooted in the culture of medicine and in society as a whole.

Despite years of making gender equity front of mind, revision of terms of reference for influential committees within the DOP continue to fail to include principles to promote EDI.

RECOMMENDATIONS

In response to the above findings, the GED Task Force recommends:

1. Demographics collected within the DOP should be broadened to allow department members the option to self-identify as a member of an under-represented or equity-deserving group, including (but not limited to): non-binary genders, visible minorities or racialized groups, indigenous peoples, persons with disabilities, LGBTQ2S+. This will assist the department with improving representation of diversity.

2. All core committees within the DOP should have a formalized Terms of Reference that include principles to address EDI.

3. A number of research and office workstations should be transitioned into drop-down work areas, to be utilized on an as-needed basis. This would increase availability for those who need a physical space on site.

4. The development of a DOP Search and Selection (S&S) Oversight Committee that reports to department leadership. This committee should oversee S&S processes to ensure EDI principles are reflected in our recruitment strategies

5. The development of a Nominating Committee within the DOP to oversee fair and equitable process and procedure for award nominations and development of our emerging leaders (including sponsorship and mentorship).

6. The development of a departmental EDI Committee to support an ongoing commitment to address inherent bias and systemic racism in our workplace, including some of the key issues addressed in this report.

CONCLUSION

The Department of Pediatrics has been a frontrunner in recognizing and addressing gender inequity in medicine. We acknowledge and appreciate the work of previous department leaders in addressing this issue before it was so widely acknowledged. The department has made impressive gains in raising the profile of women. After a review of a number of metrics within the DOP and the perceptions of many department members, inequity remains for many under-represented groups.

The department is committed to listening and learning from our colleagues. We will continue to work towards a culture of raising up our colleagues for their strengths and their differences rather than disadvantaging anyone based on historic societal structures. We see a future where our differences make us stronger.

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Appendix A. GED Map of Metrics

Appendix B. Department of Pediatrics Gender Equity & Diversity (GED) Survey

The quantitative results of the Department of Pediatrics GED survey can be viewed using this link.

Appendix C. Section Chief Survey

The Department of Pediatrics believes we are our best as a diverse collective and that innovation comes from enabling all voices to be heard, including those who have been systemically under-represented. The following survey is from the Department of Pediatrics, Gender Equity and Diversity (GED) Task Force. The purpose of this survey is to get an idea of how our department is doing in terms of equity, diversity and inclusivity. All responses will be anonymized to maintain the confidentiality of you and your Section members. Data from this survey will be compiled into Department-wide metrics and will not identify individuals or Sections in any way. The GED Task Force is looking to provide recommendations to Department leadership in order to create an inclusive and diverse work environment. If you have any questions or concerns, please do not hesitate to contact Dr. Sarah Hall, sarah.hall@ahs.ca.
Thank you in advance for your participation and support!

1. What section do you lead?

2. How many of your members identify as:

A man	
A woman	
Non-Binary	
None of the above (please specify if possible)	

3. From June 30, 2019, to June 30, 2021, how many of your section members have taken leave for the following reasons?

Parental Leave	
Leave of Absence	
Sabbatical	
Unspecified	

4. How many of these members identify as women?

Parental Leave	
Leave of Absence	
Sabbatical	
Unspecified	

5. Literature has shown that members of equity deserving groups (women, aboriginal peoples, persons with disabilities, members of visible minorities, LGBTQ2S+) benefit from encouragement in applying to leadership roles. Do you regularly (on an annual basis) encourage equity deserving group members in your section to apply to such roles?

- ◯ Yes
- ◯ No

If not, how can we help support you to better sponsor equity-deserving section members in seeking advancement and promotion?

Appendix D. Gender Distribution of Clinical and GFT Promotion

Figure 12. Clinical Lecturer to Clinical Assistant Professor

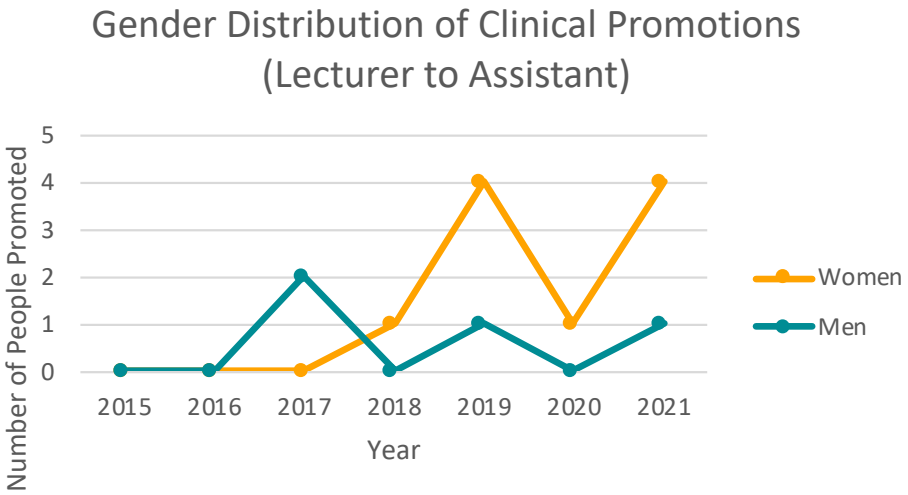


Figure 13. Clinical Assistant to Clinical Associate

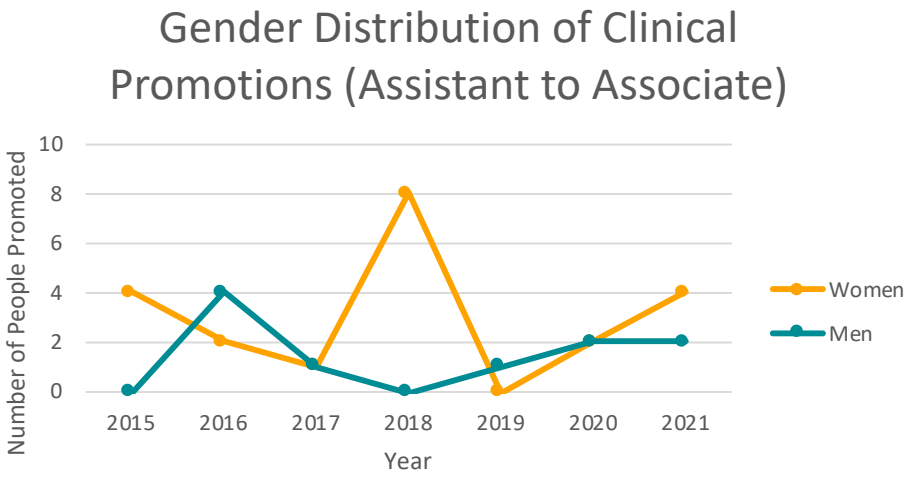


Figure 14. Clinical Associate to Clinical Professor

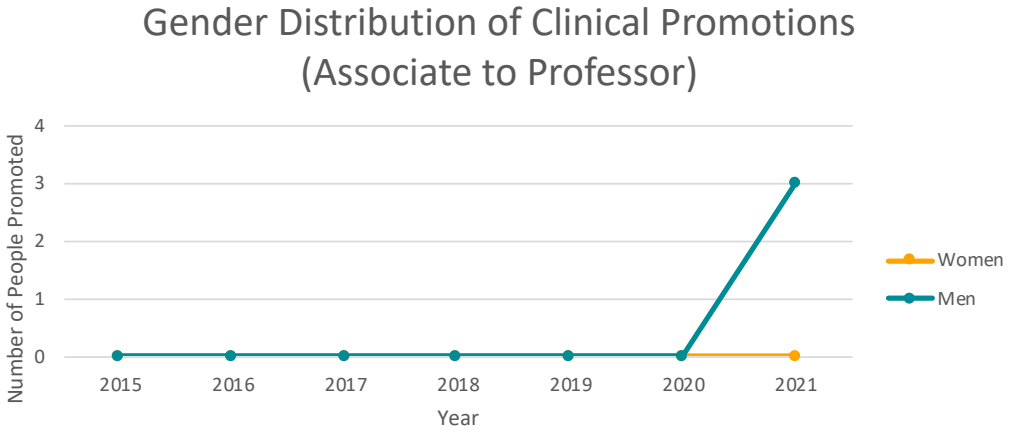


Figure 15. Geographic Full Time (GFT): Assistant to Associate

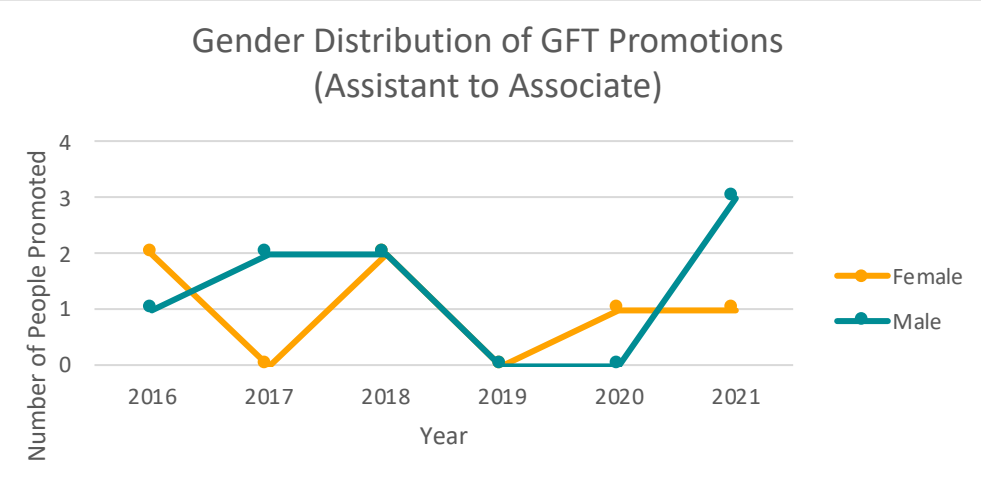
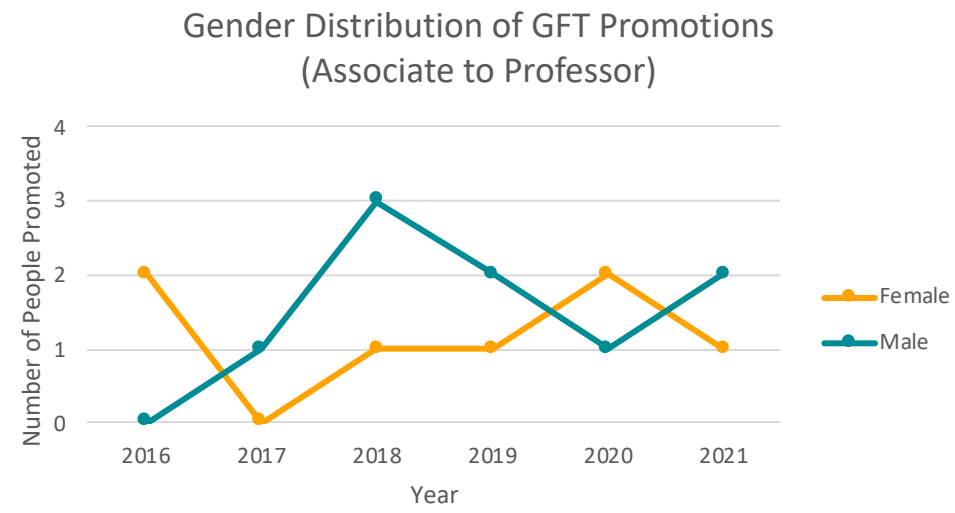


Figure 16. Geographic Full Time (GFT): Associate to Professor)



Department of Pediatrics Survey – Qualitative Results

Kristin Flennons

Responses to the long-answer questions were grouped into three main overarching themes: descriptions of structural and cultural issues within the department; experiences of discrimination; and interventions or recommendations made by survey participants.

Structural & Cultural Issues within the Department of Pediatrics

Parental Leave

Section Pressure

Respondents noted that the policies and culture around parental leave are highly section-specific, but within many sections there is structural and cultural pressure against taking parental leave. This pressure may be covert or direct; for instance, one participant noted that *"In our section… some younger female(s) were explicitly told that they better not get pregnant in the first few years of coming on staff,"* with other participants mentioning 'eye rolling' and 'unspoken comments' from colleagues. Participants also highlighted that parental leave policies are sometimes overly burdensome, discriminatory, or punitive, thus discouraging physicians from seeking leave, or taking a shorter leave than they would wish or need.

The role of leadership in enforcing or tacitly condoning this pressure was also highlighted by participants, writing that "The leadership … appears to have neither the responsibility nor the authority to intervene when such behavior is demonstrated."

Letting Down Patients & Colleagues

Participants strongly emphasized the fear that, in taking parental leave, they would be "letting down" both their colleagues and their patients. This was tied closely to the size of section by respondents, who noted that the potential additional burden on colleagues was heaviest within smaller sections. As one participant wrote, *"The additional workload other colleagues have to take on when parental leave is taken is unfair to the person on parental leave and the working colleagues- huge limiting factor in making the process fair and doable."*

Finding Coverage

The fear of creating additional burden on one's colleagues was directly linked to the difficulty in finding appropriate coverage for a physician on leave. As one participant wrote, *"There is no slack in the HR system of care provision for doctors - when one leaves it is an extra burden to all others; poorly coordinated and poorly run. Never been pro-active."* This difficulty in providing adequate coverage for leave has consequences on the section, the staff covering for the physician on leave, and for the well-being of the person taking the leave, with consequences for physical and mental health: *"I returned part time at 8 weeks and full time by 5 months. I had a serious post partum depression because I returned to work too early… I recovered, survived but no one knew."*

Additional Concerns

Respondents also highlighted the financial difficulty they faced in taking parental leave; the negative impact that taking a longer leave is seen to have on career opportunities; the expectation to continue working during leave; and additional social pressures against male physicians taking parental leave.

Career Progression

The following themes speak to issues identified by participants that impede the career opportunities and progression of women physicians within the Department of Pediatrics.

Accessibility of Opportunities

Participants noted that, while most opportunities are ostensibly equally available to all, many factors contribute to a stratification of who is able to take advantage of those opportunities. This includes which trainees are given procedural learning opportunities, how trainees are mentored, how physicians are supported by allied health and administrative staff, and how expectations for additional labour are distributed (sitting on committees, organizing events, etc). Participants also noted that women often have a greater burden of domestic labour outside of the workplace, which also limits which opportunities may be accessible to them: *"It is more difficult for a woman to have the same amount of time for career development. Some of this is due to the known discrepancy in the proportion of childcare and household work that they do, other from unequal opportunities for advancement at work."*

Other issues around accessibility that were highlighted by participants was the distribution of GFT positions and Academic Medicine and Health Services Program members; average length of patient visits; and ability to 'protect' time for career-promoting activities.

Promotion Practices

Respondents raised concerns that systemic bias remains a factor in promotion decisions within the department, and that a lack of transparency in decision-making processes contribute to this environment. Several participants expressed that recognition is more liberally granted to male physicians:

"It is my sense that men who are more vocal and can get their point across to leadership, receive more favors (faster promotion, more resources and leadership opportunities) than women, and those of the ethnic minorities. I don't feel this is all that bad in our DoP, but I think it is worse in the general leadership of CSM."

"DoP is better than some other departments, but still there are residual perspectives that hold back the advancement of women; hopefully as more women move into more senior leadership positions this will evolve even more."

Mentorship

Participants frequently pointed to the fact that there has never been a woman in the department head role, noting that this may evidence a lack of adequate mentorship and preparation of women within the department:

"In a profession where most of the physicians are women, a majority of the leadership positions are held by men. This speaks to some problems in terms of leadership selection processes and the mentoring of women to enter these roles. Medicine is also a problematic profession in that a lot of unpaid work is expected for people to advance their careers and frankly, women already carry the burden of unpaid labour in every aspect of life outside of work."

"we really need to support preparation for these hard core roles in the department including both the training and mentoring to achieve this"

Balancing Family Concerns

Many participants noted that work obligations were rarely structured in such a way to be accessible for working parents: *"rounds, meetings and social events not planned to accommodate reality of child care that falls more to female than male staff."* Participants also noted that they have received discriminatory or disparaging comments about their abilities or seriousness as a physician when trying to balance work and family requirements. This has also impacted career development for multiple participants:

"As a woman in medicine with a young family, I may have 'access' to these work opportunities, but have to make difficult decisions about how that impacts my family/home life. Often, as a mother, I feel that I have to put family first and think about career development later much more than my male colleagues (or colleagues without dependents)."

Feedback, Evaluation & Recognition

Participants felt strongly that women physicians were often evaluated and given feedback and clinical respect very differently from their male colleagues: *"I feel like the gender discrimination is subtle. I find it's biggest effect is the clinical respect given by peers. I feel my male colleagues are more recognized despite at times having a lower skill level, lower knowledge and less non-clinical contribution."*

Participants noted that women receive feedback on their personal traits as opposed to their clinical performance, such as *"Comments on being quiet, being reserved or soft spoken but with no evidence of impact on patient care."* They have also been told that there are *"Areas of [their] personality that could be toughened up,"* whereas their male counterparts *"get comments on their actual skills and skill development and effectiveness in leadership roles."*

Respondents also noted that performance evaluation may not take into account the reduced work hours for physicians working less than 1.0 FTE.

Structural Factors

The following themes were identified by participants as key structural areas impacting equity within the department.

Women in Leadership

As mentioned above, the fact that the Department of Pediatrics has not had a woman serve as department head was one of the most cited issues by respondents. Participants did note that there has been improvement in representation of women in mid-level leadership positions, but would like to see this expand to include every level of leadership. Participants cited issues with pay equity, mentorship, and parental leave as barriers to women seeking and being recognized in higher levels of leadership. They also noted that *"Many women faculty are doing smaller leadership roles within the department with no protected allocation in contract to do this work."* Participants also noted that similar issues exist for members of visible minorities.

Workload & Unpaid Labour

Participants stressed how the expectations for unpaid labour disproportionately affect women in the department—in fact, sometimes efforts to increase representation of women in particular initiatives have the unintended side-effect of increasing the demand for unpaid labour: *"As a*

woman faculty I am constantly asked to join committees to ensure there is representation from women, which leads to less time dedicated to other aspects of my job."

Respondents also noted that, in general, medicine requires a great deal of unpaid work from its practitioners, however *"women already carry the burden of unpaid labour in every aspect of life outside of work."* And, as one participant noted, *"Non-clinical work is often not paid, I think women have a greater tendency to be taking on non-paid roles/responsibilities."*

Pay Equity

Respondents noted that there was a lack of transparency around compensation levels, and as such many felt unequipped to answer questions about pay equity. However, several still noted that a lower representation of women in leadership positions is also a pay equity issue, as is workload for those working a partial FTE:

"Regarding renumeration: faculty who work less than a 1.0 FTE often do as much work as those working a 1.0 FTE (eg same number of clinics, on service, often similar non-clinical accomplishments done with less time), and as a result are renumerated less for the work they produce. This disproportionately affects women faculty. This could be improved by having a merit system with either bonuses or increased pay where those who are producing more than their peers are recognized for the increased effort/ productivity."

Accountability & Disciplinary Processes

Participants expressed frustration with accountability and disciplinary processes that appeared to have no follow-through or incentive to resolve issues. Several respondents described incidents where they initiated a complaint which then had no follow-through from leadership, leading to the impression that either leadership was not interested in their needs, or that a greater priority was placed on protecting particular members over others. Participants noted that this has led to attrition of qualified staff, toxic work environments, and lowered quality of patient care.

Informal or Opaque Decision-making Processes

Participants noted that greater transparency in decision-making procedures would increase equity and confidence in leadership: *"way [too] many decisions about committee positions, finances and support are made in small and informal meetings...a practice that is proven to disadvantage women."*

Cultural & Interpersonal Environment

Experiences of inequity are equally shaped by the structural environment of a workplace, and the general culture or interpersonal environment of those who inhabit it. The following themes reflect issues that participants identified in the culture of the department that contribute to experiences of inequity.

"Demeanor" and being taken seriously

Many participants noted that they have received dismissive or derogatory comments from male colleagues about their comportment or demeanor, with the implication that they needed to behave in a more traditionally 'masculine' or aggressive way in order to succeed in their career:

"A very senior male member of the Department of Pediatrics told me if I wanted to get anywhere in my career I "need[ed] to be more of an asshole". It was exceptionally offensive and a reflection of the complete ambivalence and ignorance towards the challenges early career female physicians face in medicine and this department. It was utterly demoralizing in particular as this comment was made in front of allied health professionals."

These concerns were also reflected in comments regarding feedback and recognition (above), and a general experience that, as a woman physician, it is significantly more difficult to receive professional respect from colleagues, superiors, other medical professionals, and patients/families.

Microaggressions

The term microaggressions refers to comments or actions that communicate indirect, subtle, or unintentional discrimination against a particular group. Microaggressions are often considered inconsequential by the dominant group, and the victims thus made to feel over-sensitive or unreasonable when they try to report or communicate the harmful impacts. However, the aggregate effect of microaggressions serves to continually reinforce the difference, and often the inferiority, of the targeted group, and as such have a serious effect on both the individuals suffering these events and the larger culture they occur within.

Members of the department indicated that microaggressions are endemic to the department, writing that *"These discriminatory events were so frequent and I got so used to them that I did not even realize they were happening. It was not until the huge social movement to recognize the importance of diversity, that I truly reflected, and realized that discrimination and micro-aggressions occur very regularly, and I would brush it off as completely normal."*

Microaggressions also contribute to divisions within the department, as one participant pointed out: *"There seems to be a real disconnect between older male physicians and the daily micro aggressions, financial penalties and other challenges female physicians experience."*

Relationship with Allied Health & Support Staff

As noted above, the difficulty many women physicians experience in gaining professional respect extend beyond their fellow physicians into their relationships with support staff, allied health, patients and families:

"Sometimes, as a junior, small statured, and young-looking female staff, I feel that I am spoken to in a condescending manner by other staff and allied health. It sometimes even happens with residents (especially male residents, I sometimes feel that they question my decisions more than they do with male colleagues). I sometimes feel less respected than my male colleagues, and I assume that it is gender bias, because I try to conduct myself with the utmost professionalism and respect towards others."

"The different treatment of nursing staff towards male and female doctors alone is not at all subtle, neither is the treatment of female vs male physicians by patients and families."

Experiences of Discrimination

Survey respondents noted that they have faced discriminatory experiences based on aspects of their identity beyond gender, including age, ethnicity, religion, and being trained outside of Canada. Other respondents mentioned that they felt their LGBTQ+ colleagues may also face marginalization within the workplace.

Role of Leadership & Management

The strongest theme in respondents' comments about experiences of discrimination was the role of leadership and management in reinforcing or tacitly condoning an environment in which

discrimination, bullying and microaggressions are see as acceptable. While some respondents noted experiences of discrimination or bullying that came directly from leadership, many others wrote about how the lack of response from leadership to instances of discrimination contributed to an environment in which such behaviour is normalized. Respondents emphasized how this makes reporting incidents and improving equity in other domains increasingly difficult, and allows unaffected individuals to feel that there are no problems that warrant attention at a systemic level.

Interventions & Recommendations

Department Reviews

Respondents suggested that more data on several aspects of the department would help to clarify issues and paths forward. Specific reviews suggested included: a salary equity review, promotion review, leadership compensation review, hiring review, and workload equity review.

Mentorship Opportunities

Participants stressed that improving mentorship practices was critical for improving equity within the department. Suggestions included beginning mentorship earlier in women's careers; actively encouraging women to apply for leadership positions; career development guidance; and advisors to assist with academic processes.

Discrimination Reporting Procedures

Participants noted that trainees and early career physicians in particular need a safe, confidential mechanism to report issues or concerns, and assurance that action will be taken. Individuals who have been targets of discrimination also require adequate and safe support.

Training for Physicians & Faculty

Participants indicated that training around gender equity issues, and EDI more generally, would be beneficial for physicians, allied health, support staff, etc. Suggestions ranged from broad awareness-based training to very specific areas of concern, such as writing recommendation letters for women applying to academic opportunities (SSHRC or CIHR grants, etc).

Main Themes & Coding Frequency

Theme	References
Structural & Cultural Issues within the Department of Pediatrics	
Parental Leave	
Section Pressure	16
Letting Down Patients & Colleagues	13
Finding Coverage	10
Impact on Career Progression	8
Men taking Parental Leave	6
Financial Concerns	5
Working During Leave	3
Career Progression	
Accessibility of Opportunities	19
Promotion Practices	19
Mentorship	18
Balancing Family Concerns	13
Feedback, Evaluation & Recognition	9
Structural Factors	
Workload & Unpaid Labour	26
Women in Leadership Positions	19
Pay Equity	7
Accountability & Disciplinary Procedures	4
Informal or Opaque Decision-making Processes	2
Cultural & Interpersonal Environment	
"Demeanor" and being taken seriously	17
Microaggressions	7
Relationship with Allied Health & Support Staff	6
Experiences of Discrimination	
Role of Leadership & Management	11
Ethnicity-based Discrimination	9
Age-based Discrimination	5
Foreign Training-Based Discrimination	2
Religious-based Discrimination	2
Interventions & Recommendations	
Department Reviews	15
Salary Equity	4

Promotion Review	3
Composition of Leadership	3
Workload Distribution	1
Hiring	1
Mentorship Opportunities	6
Training Opportunities	6
Discrimination Reporting Procedures	3
Address full EDI Spectrum	3