DIVERSITY IN GLOBAL HEALTH LEADERSHIP PANEL:
A CASE FOR CULTIVATING CULTURAL COMPETENCE AND DIVERSITY

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DISCLOSURES

• I have no financial or non-financial disclosures.
IDENTIFYING THE GAP
UNCONSCIOUS BIAS

• Our brains unconsciously make decisions on what feels safe, likeable, valuable, and competent.
• We make decisions largely in a way that is designed to confirm beliefs that we already have.
• Unconscious beliefs impact the way we perceive others, perceive ourselves, and as such, influence our organizations.
DEFINING CULTURAL COMPETENCE

• Cultural competence is a defined set of values and principles, and demonstrated behaviors, attitudes and structures that enable employees and leaders to work effectively cross-culturally.

• Cultural competency acknowledges that, while people develop a more or less automatic depth of understanding of the positions and cultures into which we are born and socialized, achieving that depth of understanding of other positions and other cultures is far more difficult, but not impossible.

• The process of gaining depth of understanding of subject positions and cultures other than your own is the process of gaining various degrees of cultural competency.
DIMENSIONS OF DIVERSITY

PRIMARY DIMENSIONS

SECONDARY DIMENSIONS
CULTURE, GENDER, AND LANGUAGE

- May influence:
  - Health, healing and wellness belief systems
  - Illness, disease and how causes are perceived
  - How health care treatment is sought and attitudes toward providers, impacting treatment
  - Delivery of health care services by providers who may compromise access for patients from other cultures due to a lack of diagnosis
Gender Inequality for Women in Plastic Surgery: A Systematic Scoping Review

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Background: Previous research has highlighted the gender-based disparities present throughout the field of surgery. This study aims to evaluate the breadth of the issues facing women in plastic surgery, worldwide.

Methods: A systematic scoping review was undertaken from October of 2016 to January of 2017, with no restrictions on date or language. A narrative synthesis of the literature according to themed issues was developed, together with a summary of relevant numeric data.

Results: From the 2247 articles identified, 55 articles were included in the analysis. The majority of articles were published from the United States. Eight themes were identified, as follows: (1) workforce figures; (2) gender bias and discrimination; (3) leadership and academia; (4) mentorship and role models; (5) pregnancy, parenting, and childcare; (6) relationships, work-life balance, and professional satisfaction; (7) patient/public preference; and (8) retirement and financial planning. Despite improvement in numbers over time, women plastic surgeons continue to be underrepresented in the United States, Canada, and Europe, with prevalence ranging from 14 to 25.7 percent. Academic plastic surgeons are less frequently female than male, and women academic plastic surgeons score less favorably when outcomes of academic success are evaluated. Finally, there has been a shift away from overt discrimination toward a more ingrained, implicit bias, and most published cases of bias and discrimination are in association with pregnancy.

Conclusions: The first step toward addressing the issues facing women plastic surgeons is recognition and articulation of the issues. Further research may focus on analyzing geographic variation in the issues and developing appropriate interventions. (Plast. Reconstr. Surg. 141: 1561, 2018.)
An Evaluation of Race Disparities in Academic Plastic Surgery

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Background: Academic plastic surgery has a history of underrepresentation of ethnic and racial minority groups. Recent policy shifts by national medical groups and plastic surgery societies have focused on reversing these inequalities. This study seeks to measure ethnic and racial representation at academic and leadership positions following recent changes.

Methods: A cross-sectional study was conducted in June of 2018, measuring ethnic and racial diversity of U.S. academic plastic surgery faculty. Among faculty, career qualifications, years of experience, faculty positions, and leadership ethnicity were compared.

Results: A total of 950 academic plastic surgeons were included in the study. Classified collectively as nonwhite, this group graduated more recently than other academic plastic surgeons (2006 versus 2001; \( p < 0.0001 \)) and had greater rates of clinical fellowship attainment (OR, 1.62; 95 percent CI, 1.16 to 2.20). Nonwhite individuals were less likely to be employed in the full professor position compared with their white colleagues (OR, 0.6; 95 percent CI, 0.32 to 0.88; \( p = 0.0077 \)). However, after adjustment for differences in years of postresidency experience, this disparity was no longer significant (OR, 1.06; 95 percent CI, 0.62 to 1.88; \( p = 0.82 \)), indicating the importance of current cohort experience differences. Assessment of program leadership found that nonwhite chairs employed significantly more nonwhite faculty (42.5 percent versus 20.9 percent; \( p < 0.0001 \)).

Conclusions: Academic plastic surgery continues to face disparities in representation of both ethnic and racial minorities. Current inequalities are most severe at senior academic positions and may be linked to cohort experience differences along with leadership and promotion biases. (Plast Reconstr Surg 145: 268, 2020.)
GLOBAL HEALTH IMPLICATIONS
ROLE OF PLASTIC SURGERY IN GLOBAL HEALTH

• Global health - an area for study, research, and practice that places a priority on improving health and achieving health equity for all people worldwide

• Surgical conditions constitute 11% of worldwide disability-adjusted life years (DALYs) with around five billion people lacking access to basic surgical services

• 66% of the measured surgical disease DALYs are due to injuries, malignancy, or congenital anomalies, the three categories most frequently treated by plastic surgical intervention.

• Plastic and reconstructive surgery has a long tradition of international service and strong history of innovation
GENDER INEQUALITY IN GLOBAL HEALTH

- Gender inequality drives large-scale excesses in mortality and morbidity globally
- Health risk increases through discriminatory values, norms, beliefs, differential exposures to disease, disability and injuries, biases in health systems, and biases in health research
MISMATCH IN HEALTHCARE DELIVERY

- Demographic changes and rising health care demands will drive the creation of 40 million new jobs by 2030 in the global health and social sector.

- There is an estimated shortfall of 18 million healthcare workers, primarily in low- and middle-income countries, required to achieve universal health coverage.

- Women account for 70% of the health and social care workforce, and face significantly different barriers at work not faced by their male colleagues.

  - Yet women only hold 25% of the senior roles.
PROMOTING GENDER EQUALITY IN GLOBAL HEALTH

- Gender equality is one of the most important determinants of health and economic development, but remains a complex issue to address

- Focus areas to improve gender equality:
  - Occupational segregation
  - Decent work free from bias, discrimination and harassment, including sexual harassment
  - Gender pay gap
  - Gender parity in leadership
OCCUPATIONAL SEGREGATION

- Occupational segregation impacts service delivery and the health system by limiting full participation of all genders in all aspects of the health workforce, fostering greater gender inequities.

- Occupational segregation has its roots in two cultural ideologies: gender essentialism and male primacy.

- This is driven by long-standing gender norms that define caring as female work and portray men as more suited to technical specialisms in medicine.

- Horizontal and vertical dimensions of occupational segregation combine to cluster women into lower-paid and lower-status work, with a lifelong impact on their earnings and economic security in old age.
SAFE WORK ENVIRONMENT

• Women are more likely to face sexual harassment in the workplace than men.
  • In the United States 30% of female medical academics reported accounts of sexual harassment compared to 4% of men.

• Many countries, particularly low- and middle-income countries, do not have a legislative framework to support gender equality at work, including laws to prohibit sexual discrimination and sexual harassment at work.

• Female health workers in conflicts or emergencies or working in remote areas can face violence in the course of their work, with a number of female health workers severely injured or killed every year.
GENDER PAY GAP

- Limited data from low- and middle-income countries, but estimates of the average gender pay gap are between 16% and 21%.
- In the United States, the health care industry has one of the largest gender pay gaps for any sector, with pay differences reaching 25% for physicians.
- The gender pay gap is directly linked to poverty, as it has implications for lifelong financial stability. Poverty affects women at disproportionately higher rates compared to men, and eliminating the gender pay gap could halve poverty levels for women.
- Wage differences lead to lower morale and motivation to work longer hours, or may cause women to quit the health workforce altogether.
GENDER PARITY IN LEADERSHIP

- Current gender gaps in leadership due to power imbalances, gender stereotyping, and structures that segregate women into subordinate roles.
- Women who deliver global health do not have an equal say in its design and delivery.
- Women in leadership positions in health expand the agenda, giving greater priority to rights—such as sexual and reproductive health and rights—that apply to all genders but, where absent, can have the most negative impacts on women’s health.
HOW DO WE GET THERE?

- Manage the dynamics of difference
- Make your leadership style based on the situation and people involved
- Acquire/institutionalize cultural knowledge
- Adapt to the cultural contexts of the internal and external communities they serve
- Be aware that diversity and inclusion must be reinforced and measured
FIVE ESSENTIAL ELEMENTS

• Valuing diversity and understanding what cultural diversity truly represents
• Having the capacity for cultural self-assessment
• Being conscious of the dynamics inherent when cultures interact with patient-centered care
• Acquiring institutionalized culture knowledge through cross-cultural encounters
• Develop adaptations to global health service delivery reflecting an understanding of cultural diversity
ENCOURAGING DIVERSITY IN SCIENCE

THE NIH DIRECTOR

The NIH Director

June 12, 2019

Time to End the Manel Tradition

The National Institutes of Health is committed to changing the culture and climate of biomedical research to create an inclusive and diverse workforce. The recent report by the National Academy of Sciences, Engineering, and Medicine, “Sexual Harassment of Women: Climate, Culture, and Consequence in Academic Science, Engineering, and Medicine,” identified the critical role that scientific leaders must play to combat cultural forces that tolerate gender harassment and limit the advancement of women. These concerns also are highly relevant to other groups underrepresented in science. It is not enough to give lip service to equality; leaders must demonstrate their commitment through their actions.

Toward that end, I want to send a clear message of concern: it is time to end the tradition in science of all-male speaking panels—sometimes, jokingly referred to as “manels.” Too often, women and members of other groups underrepresented in science are conspicuously missing in the marquee speaking slots at scientific meetings and other high-level conferences. Starting now, when I consider speaking invitations, I will expect a level playing field, where scientists of all backgrounds are evaluated fairly for speaking opportunities. If that attention to inclusiveness is not evident in the agenda, I will decline to take part. I challenge other scientific leaders across the biomedical enterprise to do the same.

The diversity of bright and talented minds engaged in biomedical research has come a long way—and our public engagements need to catch up. Breaking up the subtle (and sometimes not so subtle) bias that is preventing women and other groups underrepresented in science from achieving their rightful place in scientific leadership must begin at the top.

Francis S. Collins, M.D., Ph.D.
Director, National Institutes of Health
Maximize women’s economic participation and foster their empowerment through institutionalizing their leadership, addressing gender biases and inequities in education and the health labour market, and tackling gender concerns in health reform processes.

Deliverables:

- Increase opportunities for formal education
- Transforming unpaid care and informal work into decent jobs
- Equal pay for work of equal value
- Decent working conditions
- Equal representation in management and leadership positions
FOR MORE INFORMATION

https://www.thelancet.com/journals/lancet/issue/vol393no10171/PIIS0140-6736(19)X0006-9
THANK YOU!

• Questions?
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REFERENCES

- Managing Diversity At Duke University: A Toolkit for Managers: Cultural Competency
- https://www.nih.gov/about-nih/who-we-are/nih-director/statements/time-end-manel-tradition
- https://www.thelancet.com/journals/lancet/issue/vol393no10171/PIIS0140-6736(19)X0006-9
- Delivered by Women, Led by Men: A Gender and Equity Analysis of the Global Health and Social Workforce
- Shannon G, Jansen M, et. al. Gender equality in science, medicine, and global health: where are we at and why does it matter?
INDIVIDUAL STEPS

• Do recognize that cultural competence is a developmental process for both individuals and organizations.

• Do commit to building awareness, knowledge and skills related to cross cultural teamwork and communication over an extended period of time. This is not a one day workshop.

• Do remember that people and work systems develop the capacity for being reflective and adapting new work styles.

• Do know that both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum.

• Do not assume that only employees with direct patient care benefit from cultural competency skills and awareness. All employees would benefit from better understanding the diverse students, faculty, patients, staff, visitors, and researchers who make up the community.

• Do not try to evolve a formula for working with different groups. Although you can develop awareness about ethnic or religious or gendered or generational groups, do not assume that everyone within that group will fit into a formula. People are ultimately individuals and appreciate being treated that way.

• Do not forget about elements of diversity that can be overlooked: sexual orientation, region, country of origin, and generation are also elements that impact communication, marketing, educational styles, and safety for some of the different groups you come into contact with.