**'Women in medical leadership: having a quota makes for better representation'**

Quotas are believed to be the peak of representation. They are perceived as elevating groups and individuals, allowing their voices to be heard, and encouraging greater societal progress. Quotas and affirmative action have been used in political parties, corporate boards, hiring policies. However, there is little research into their effectiveness, and whether they truly catalyse social change, and promote equality and equity or empowerment of these communities within society. This essay argues that quotas for women in medical leadership do little for improving representation, as the systemic problems are not fully addressed. Instead, a combination of methods which address underlying gender inequalities and norms should be attempted.

Background:

Representation is acting on behalf of a group or individuals.(1) Equality or having the same status, rights, or opportunities is linked to representation.(2) Systems such as quotas and affirmative action are often used to increase representation and equality. Affirmative action involves steps taken to increase representation of women and minorities in areas they have historically been excluded from such as education and employment.(3) The argument for such action is that both can act as redress for past exclusion from these environments, and help to provide justice or social good.(3–5)

Despite gender parity in medical schools, there are inequalities within specialties and medical leadership.(6,7) Research shows how experiences during clinical training can affect students' sense of belonging, their choice of specialty and career expectations.(6) During clinical training, students learn a hidden gendered curriculum where standards conform to traditional masculine ideals of objectivity, detachment, authority, and competition.(6,8) The cumulative effect of overt and covert forms of sexism in the learning environment creates an adverse climate for female students reducing their confidence, participation, and aspirations.(9,10)

This translates into the workforce. Across multiple countries and contexts horizontal and vertical segregation of women occurs and is not unique to medicine. Common explanations for this include women being more likely to work part-time and take career breaks, often due to practical difficulties with childcare.(11–13) Therefore, medicine still has rigid structural inequalities, maintaining male privilege within medicine.(14)

Strategies to reduce inequality:

Gender inequity in medical leadership is mainly due to socially constructed gender norms and roles.(15) Different methods can be used to counteract this. Examples include equal opportunity recruitment, anti-discrimination policies, flexible working arrangements, mentoring and networking for women, and diversity training for staff.(14–16) However, methods like diversity and unconscious bias training raise awareness but have a short-lived effect without addressing underlying systemic issues. Instead, structural and individual interventions are more effective.(15)

To counteract gender inequality, levels of gender inequality in funding, publications, promotion and pay should be quantified and communicated publicly. This should be followed by annual reporting of any impact from action plans and interventions. Both methods provide accountability and incentivise change.(15)

Recognising the systemic nature of gender inequality requires solutions addressing this system, incorporating principals of equality, diversity, and inclusion as the foundation of all policies. This underpins behavioural change. Further solutions include career flexibility – allowing for non-gendered parental, childcare, family and career leave with financial support.(15) All of these tools have been used in different combinations and levels of success in four European countries – Germany, Sweden, Austria and the United Kingdom.(16)

In the Berlin University of Medicine (Charité) there are voluntary targets for increasing gender balance at different levels. Mandatory biannual gender equality reports are sent to the Berlin senate to ensure accountability and progress.(16) In Sweden's Karolinska Institute there is a Council for Equal Treatment with representatives at each department with action plans regularly revised. There are no quotas, but there are clear targets for women in leadership positions. These are regularly revised with close monitoring and

supported with performance incentives or monetary incentives when female professors are appointed.(16) Finally, in the Vienna Medical University there are compulsory quotas on university boards and decision-making committees. There must be a minimum of 40% women which is annually monitored and enforced by the Federal Ministry for Science, Research and Economy. Additionally, Vienna Medical University has implemented new entrance exams which minimise gender-discrimination.(16)

Reverse quotas:

Reverse quotas focus on rectifying overrepresentation, rather than underrepresentation. Many gender quotas are framed explicitly or implicitly as quotas for women, unintentionally framing men as the norm and women as “the other”. Maintaining men as the status quo, shifts the burden of proof to outsiders, namely, women. While men are not required to prove competence or justify their inclusion, women must show that they deserve a greater presence. This leads the perception that quota candidates are selected purely due to their gender, with lesser qualifications and without competing for their position. Men have escaped these criticisms despite benefiting from preferential gendered selection. By shifting to an explicit quota requiring men to not be overrepresented, the onus is shifted to men to prove their worth and justify their presence, therefore, removing male privilege.(15,17) This must be done with transparent, objective criteria. Furthermore, overrepresentation of any group restricts representation across all of society as candidates are selected from a small pool. This highlights the lack of a meritocracy underpinning such practices. Such reverse quotas exist in Spain where there is a minimum of 40% and maximum of 60% for either sex for political candidature.(17)

Weakness of quotas:

Norway is one of the most gender-equal countries worldwide.(18) In 2005 it passed legislation requiring public limited company (PLC) boards to have minimum 40% women representation on boards. Quotas were seen as a solution to gender inequality.(18,19) Due to strict monitoring, Norway is an appropriate case study for long term effects of quotas.

Despite research showing compliance with this quota, there was only a modest increase in equality for positions in different influence and power, and even less in broader areas such as economic participation by women.(20–22) For women who did obtain positions following the quota introduction, many were faced with key gatekeepers, minimising possibilities for culture change on these boards.(18)

Furthermore, many eligible PLCs became limited companies to avoid penalties for non-compliance. Of those eligible to change status, 57% did. There was no evidence of improvements or increased opportunities for women working in PLCs who were affected by this reform, suggesting that this quota has limited effect in addressing the underlying problems present in company cultures.(23)

In conclusion, quotas fail to address underlying structural problems present within medicine, medical leadership and continue to perpetuate the status of women as “the other”. From medical school curricula and into the workforce, emphasis should be on rectifying overrepresentation of men and incentivising change at all levels. Regular and open reporting can enforce accountability and progress and encourage structural and cultural changes. Tailoring methods to suit the workplace landscape will the provide the best method of increasing female representation at all levels.

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