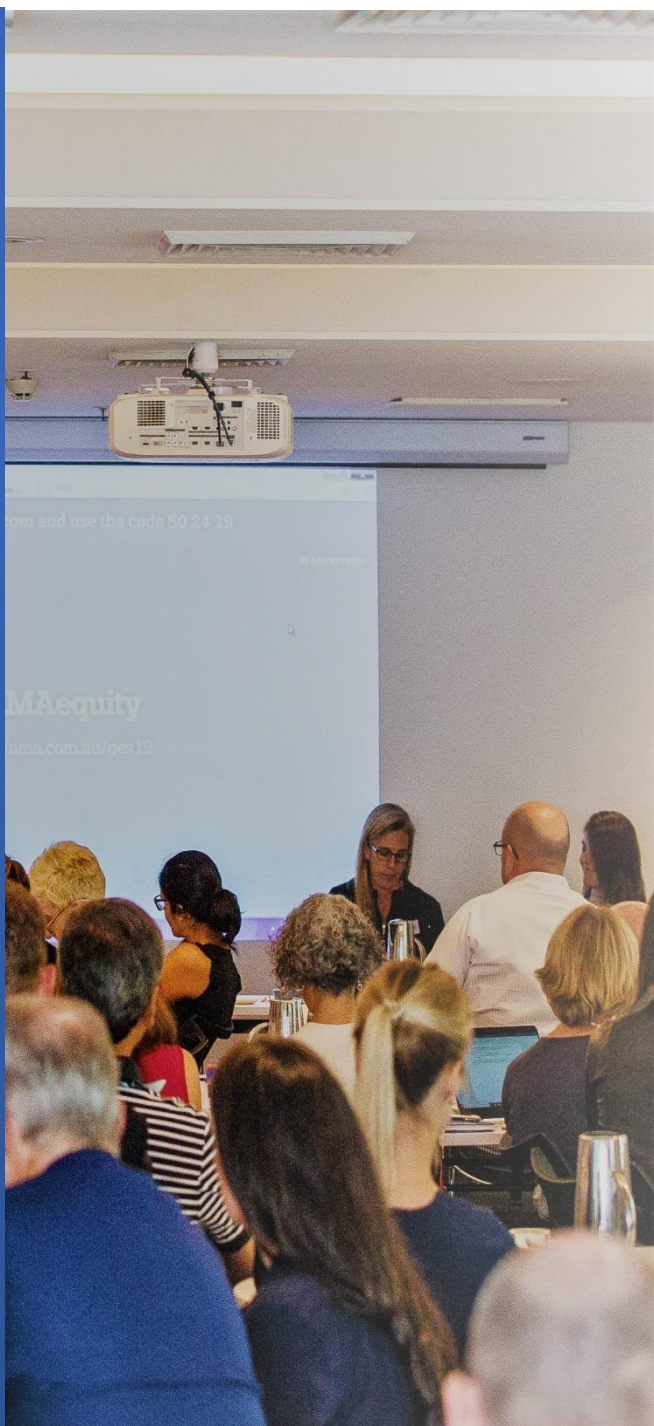




AMA

THE AMA GENDER EQUITY SUMMIT REPORT

23 MARCH 2019 | SYDNEY



INTRODUCTION

Three decades after achieving gender parity among medical graduates, the medical profession is still lagging behind in measures of equity and inclusion.

The pipeline theory hasn't worked, and women remain underrepresented in supervisory and leadership roles. There are large gender pay gaps for equally trained and skilled doctors in all craft groups. And even where women doctors are primary breadwinners for their families, they tend to shoulder a greater burden of childcare and domestic work.

Across Australia, State and Federal laws make it illegal to discriminate against any person based on characteristics such as sex, relationship status, family responsibilities, pregnancy or potential pregnancy, and breastfeeding. Yet doctors continue to report to the AMA that they are experiencing workplace gender, pregnancy, and carer-related discrimination.

Despite commitments from the medical profession and workplaces to remove discrimination, efforts have often focused on individual behaviours when, in practice, a range of practical, systemic, and cultural factors pose significant barriers to the equal consideration and treatment of all doctors. Many inequitable and discriminatory practices in medical workplaces stem from real or supposed differences associated with family responsibilities.

It is important that the medical profession and workplaces embrace the professional, economic, and social contribution of doctors from diverse backgrounds, and make the most of the extensive skills, perspectives, and networks that a diverse and inclusive medical workforce will bring to the medical work and training environment. This will lead to a more productive, responsive, and empathetic medical workforce, well equipped to deliver and advocate for the best health outcomes for patients and the broader community.

Gender inequity affects the wellbeing and productivity of all medical professionals and teams, not just women. To progress beyond achievement of gender diversity to gender equity and true inclusion in medicine, we need to take a systems-based approach, using available evidence to bring about "equity by design".

On 23 March 2019, the AMA hosted a Gender Equity Summit in Sydney with around 70 groups and leaders in health, business, and medicine discussing the cultural and systemic barriers to achieving gender equity in medicine, and practical actions to address them.

This report summarises the discussion and the priorities for action that were identified.



Dr Tony Bartone
AMA President

16 August 2019



Dr Tessa Kennedy
Chair, AMA Council of
Doctors in Training



Dr Helen McArdle
AMA Equity Inclusion &
Diversity Committee

THE GENDER EQUITY SUMMIT

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KEY RECOMMENDATIONS

1. Establish targets for gender diversity in representation and leadership.
2. Report and publish gender equity data.
3. Actively encourage women to apply for leadership roles.
4. Provide equitable access to leave entitlements for all genders.
5. Improve access and uptake of parental leave and flexible work and training arrangements for all genders.
6. Provide interstate portability of leave entitlements.
7. Implement transparent selection criteria and processes that disarm gender bias in entry into training and employment.
8. Provide access to breastfeeding facilities and childcare at exams, conferences, and work.
9. Identify gender equity champions (and celebrate women in medicine).

In 2019, the AMA has committed to:

1. Adopt a target of 40 per cent women, 40 per cent men, 20 per cent flexible for all AMA Councils, Committees, and Boards, with a gender diversity target of women holding 50 per cent of Federal AMA representative positions overall, by 2021.
2. Collate and report on gender data annually regarding composition of leadership positions within State and Federal AMA bodies, Councils, and Committees, speaker invitations at National Conference and Federal AMA recognition awards, and disseminating the findings to AMA Federal, State, and Territory Councils and Boards annually.
3. Develop an AMA Diversity and Inclusion Plan, including practical steps to improve diversity in membership and in the medical profession more broadly.
4. Provide funding for breastfeeding mothers in Federal AMA representative roles to bring a carer for their child to official representative activities.

NEXT STEPS

This report identifies key actions we can take to achieve gender equity in the medical profession and workplace.

The AMA is committed to working collaboratively with other organisations to tackle bias and achieve diversity, equity, and inclusion.

The AMA is asking all organisations who attended the Summit to adopt and report on three actions from the Summit with the goal of encouraging and supporting gender equity within their sphere of influence.

PARTICIPANTS

Included representatives from:

AMA Federal Council	Australian Society of Anaesthetists
AMA Council of Doctors in Training	Australian and New Zealand Association of Neurologists
AMA Council of General Practice	Australian and New Zealand College of Anaesthetists
AMA Council of Rural Doctors	Australian and New Zealand Society of Geriatric Medicine
AMA Council of Specialist Private Practice	Australian and New Zealand Society of Nephrology
AMA Equity, Inclusion and Diversity Committee	Chief Executive Women
AMA Australian Capital Territory	Cochlear
AMA New South Wales	College of Intensive Care Medicine of Australia and New Zealand
AMA Northern Territory	Council of Presidents of Medical Colleges
AMA Queensland	Doctors' Health Services
AMA South Australia	General Practice Registrars Australia
AMA Victoria	Healthscope
AMA Western Australia	Medical Deans Australia and New Zealand
Australasian College for Emergency Medicine	Medicine in Australia: Balancing Employment and Life Project
Australasian College of Sport and Exercise Physicians	Queensland Health
Australasian Junior Medical Officers Committee	Ramsay Health Care Australia
Australian College of Rural and Remote Medicine	Royal Australian and New Zealand College of Ophthalmologists
Australian Institute of Company Directors	Royal Australasian College of Physicians
Australian Medical Council	Royal Australasian College of Surgeons
Australian Medical Students' Association	Royal Australian College of General Practitioners
Australian Orthopaedic Association	

PROGRAM

10:00 – 10:10am Welcome & Summit overview

10:10 – 11:00am Keynote address

- Ms Libby Lyons, Director, Workplace Gender Equality Agency

11:00am-12:00pm Panel Session One: Lessons learnt from industries outside of medicine

- Ms Cecelia Herbert, Lead Employee Experience Scientist, Qualtrics
- Ms Janet Menzies, General Manager, Cochlear Australia and New Zealand
- Ms Rhian Richardson, Board Diversity Manager, Australian Institute of Company Director

12:00-1:00pm Panel Session Two: Making change in medicine

- Dr Cathy Ferguson, Royal Australasian College of Surgeons
- Dr David Martin, Australian Orthopaedic Association
- Dr Simon Judkins, Australasian College for Emergency Medicine
- Dr Victoria Atkinson, Healthscope

2:00-3:30pm Workshop Session Three: Translating intent into action

- Increased presence of women in academia, leadership and management roles
- Work-life balance
- Pregnancy and parenthood
- Changes in organisational culture
- Workforce planning and research

3:30 – 4:15pm Workshop Session Four: Identification of top priorities

4:15 – 4:45pm Post Summit Networking

WELCOME TO THE AMA GENDER EQUITY SUMMIT

AMA President, Dr Tony Bartone

The AMA wishes to acknowledge the traditional custodians of the land on which we meet and pays respects to their Elders past, present, and future, for they hold the memories, the tradition, and the culture of all Aboriginal and Torres Strait Islander people.

We wish to acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region. We would also like to acknowledge and welcome other Aboriginal and Torres Strait Islander people who may be attending today's event.

The AMA is delighted to be hosting today's event which has been coordinated by the AMA Council of Doctors in Training in collaboration with the AMA Equity, Inclusion, and Diversity Committee. I am also grateful to AMA NSW for supporting us this weekend.

Dr Tessa Kennedy is the Chair of the Council of Doctors in Training.

Dr Helen McArdle is the Chair of the Equity, Inclusion, and Diversity Committee.

I invite you to make yourself known to Tessa and Helen during the day.

This Summit is the first of its kind for the Federal AMA. It has the backing of the AMA leadership team and is evidence of our commitment to work towards achieving gender equity both within the AMA and more broadly.

At last year's AMA National Conference, the AMA supported a motion to develop strategies to drive cultural change within the profession and workplaces in support of equal participation across gender in the medical workforce.

This Summit actions that intent.

The AMA acknowledges that it has work to do in this area.

While the representation of women on the AMA's Board now sits at 36 per cent, it is much more variable among our Councils and Committees, with some doing well and others not so well.

We plan to do better.

That's why we have invited you here today to discuss how to address the cultural and practical barriers to achieving gender equity in medicine.

This morning I am looking forward to exploring how other industries have successfully shaped culture and systems to encourage gender equity in their workplaces and how might this translate to changing medical workplaces and culture.

And to hearing how our medical colleagues and health services are starting to do that also.

This afternoon our aim is to arrive at on some practical actions we can all take to help us work towards achieving gender equity in medicine.

I mentioned earlier that diversity, and gender diversity in particular, is a key focus area for the AMA.

Doctors from diverse backgrounds bring extensive skills and perspectives to enable the medical workforce to be more responsive and empathetic to individual patient needs and, importantly, broader community needs.

An improved gender, social, and cultural balance is essential for the whole profession.

Strong and enduring changes to values, culture, and decision-making must come from senior leadership and management, and flow down through the hierarchies.

We know that, despite the dramatic increase in female participation in the medical workforce in recent decades, under-representation of women in the upper tiers of the medical profession persists.

Australian Institute of Health and Welfare figures show that women make up 40 per cent of the medical workforce and 53 per cent of early-career practitioners, including just over half of all specialists-in-training.

But women are not progressing through to senior positions in representative numbers.

Cultural change is particularly important if we are to achieve a level playing field for both men and women in the medical workplace. Equal access to parental leave and flexible work arrangements should be available in all environments.

We want to ensure that all doctors can fully participate in the medical workforce and are guaranteed access to a range of flexible employment, return to work, and training opportunities.

The gender pay gap, gender-based workplace discrimination and bias are also significant issues for female doctors, impacting on many aspects from specialty selection to mental health and well-being and financial security.

That is why we are here today. To determine what barriers exist to creating equal partnerships from the beginning in the workplace and what we need to do to fix them.

Together I believe we can take significant, practical steps towards improving gender balance and equity in medicine.

I said before that the AMA has work to do to improve the representation of women on its councils and committees and to support more women to take on leadership roles, both within and external to the AMA.

We have developed a number of strong policy statements in support of anti-racism, equal opportunity in the medical workforce, flexibility in medical work and training practices, and sexual harassment in the workplace.

These are listed on the Summit website.

Our challenge is to translate policy and intent into practice, and that work has already started.

In 2017, the AMA established an Equity, Inclusion, and Diversity Committee.

This Committee provides the AMA with a forum for the identification and consideration of equity issues and will play an important role in actioning the outcomes from today to drive change both internally and externally.

I am also pleased to report that at our Federal Council meeting last weekend, the AMA supported the establishment of gender targets for our Councils and Committees.

The AMA Equity, Inclusion, and Diversity Committee will now develop recommendations on how to implement these.

Today we have a large and varied group of stakeholders in the room.

We are united in our shared goal to improve gender diversity in medicine.

We can set the scene for challenging the status quo.

We can and must think outside the box and share ideas.

Our target today is to discuss, develop, and agree on priorities for practical action for review in 12 months' time.



“Strong and enduring changes to values, culture, and decision-making must come from senior leadership and management, and flow down through the hierarchies.”

Dr Tony Bartone

SUMMIT OVERVIEW

Chair AMA Council of Doctors in Training, Dr Tessa Kennedy

Despite more than three decades of admirable gender diversity, with parity among medical graduates, we are lagging in measures of equity and inclusion. The trickle up approach hasn't worked: women are underrepresented in supervisory and leadership roles. There are large gender pay gaps for equally trained and skilled professionals in all craft groups.

No doubt there's been some cultural shift in recognising the importance of equitable and diverse participation and representation, as outlined in many organisational statements on the topic. But we've too often assumed that by saying gender equality *should* happen, that it will.

So why aren't best intentions enough?

This passive assumption ignores the context of the systems in which we work, which were built by medical men, for medical men, with women supporting them at home. Furthermore, the literature suggests that equitable expectations are derailed when they start to clash with workplace policies, which remain rooted in traditional gender norms.

Many current policies and practices ensure that the path of least resistance is the still the traditional one: for women to take the majority of responsibility for childbearing and rearing, while men remain fully engaged in the workforce.

To realise the full value of the equal participation of medical women in the workforce, and achieve work life balance in medicine for all, it's crucial that we confront and address the existing barriers in our systems as well as our culture. The two are inextricably linked.

The retrofitting required might feel like upgrading Sydney's public transport infrastructure: messy, delayed, and not always in the right place. But it's essential that it works.

In February, the *Lancet* dedicated an entire issue to women in medicine. An article by Kang and Kaplan (which you have all received) resonates wonderfully with the purpose of today, using a systems-based approach to explain the disconnect between gender diversity and inclusion in medicine, and make evidence-based solutions to "bring about equity by design".

The authors recommend viewing gender equality as an innovation challenge which, like any organisational initiative, should be approached with an open and scientific attitude, and the willingness to experiment and measure outcomes.

They assert that: "To make progress in achieving gender equality, we must declare the discussion on whether and why we should pursue equality to be over."

To be clear, this is not just a women's issue. Women feel the brunt of it professionally, but gender inequity sells all of us short on one side of the work-life equation or the other. And that is why it's so critical that we stand together to confront the barriers creating, exacerbating, and perpetuating gender bias, discrimination, and inequality in medicine.

Therefore, the purpose of today is to move beyond the whether and the why, to the how – to identify the barriers that remain and translate our best intentions into practical actions to overcome them.

Today we will be taking a deep dive into the data that describes gender equality or lack thereof in Australian workplaces and help explain why acting to improve gender equality at work is just so critical to the quality of the work being done.

We have brought together leaders in fields outside medicine to discuss how other industries have successfully shaped culture and systems to encourage gender equity in their workplaces, and how this might translate to changing medical workplaces and culture.

And closer to home, medical leader will highlight emerging best practice and remaining challenges to gender equity in medicine.

The Summit intends to arrive at practical actions to drive change internally at the AMA, and, more importantly for the profession at large.

We come from organisations and groups that are all at different stages of the gender equity journey. The important thing is by attending the Summit we have shown we are ready to translate our best intentions into action.

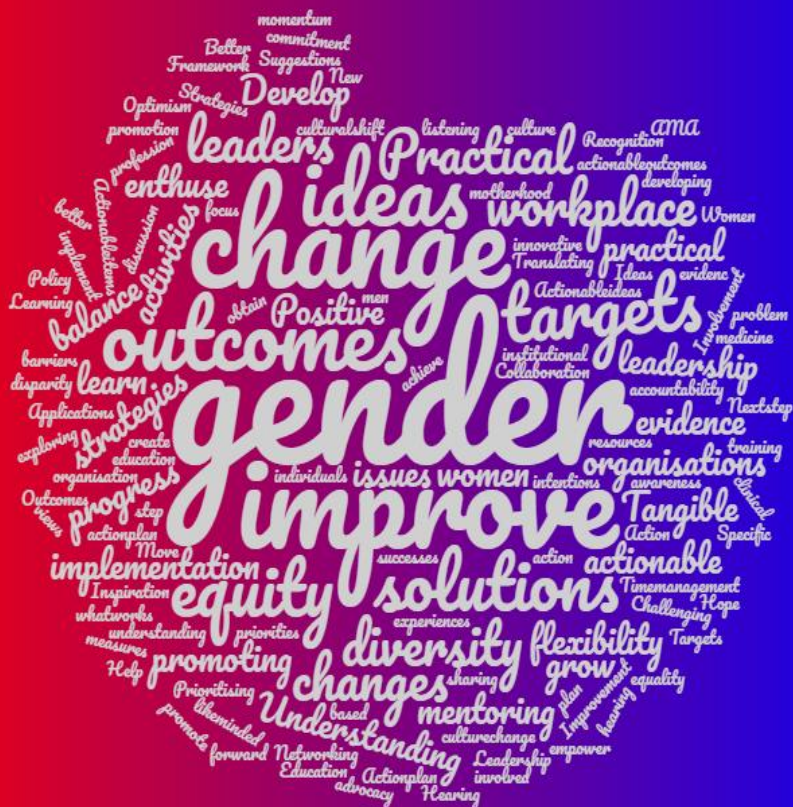


"To be clear, this is not just a women's issue. Women feel the brunt of it professionally, but gender inequity sells all of us short on one side of the work-life equation or the other."

Dr Tessa Kennedy

WHAT ARE YOUR EXPECTATIONS FROM TODAY'S SUMMIT?

Comments from participants collated into a word cloud



OPENING KEYNOTE

Ms Libby Lyons, Director, Workplace Gender Equality Agency

Ms Libby Lyons' keynote address focused on why achieving gender equity in the workplace is important, what is the evidence-base for change, and how we can address gender imbalance in the workplace. Her address was a reminder that there is more to be done to improve workplace diversity, in particular increasing the representation of women in senior ranks.

Ms Lyons referred to the growing body of evidence over the last decade that recognises harnessing the skills of women is a productivity and economic imperative, with strong evidence that gender diverse teams at all levels generate better decision making, foster innovation and creativity, and can improve the bottom line.

The main points Ms Lyons made were that:

1. Bias – both conscious and unconscious – is a major contributing factor influencing the participation and progression of women in the workplace.
2. Access to parental leave has stalled, with more than half of employers not providing primary carer's leave over and above the government scheme.
3. Data clearly shows there is an action gap. The best way to close action gaps is by being accountable.
4. Implementing formal flexible work arrangements and reporting this to an organisation's board has significantly increased the number of part-time female managers.

Opening keynote – questions and answers

Key points arising were:

- Collect and analyse your data to determine where problems lie.
- Encourage your board or College to conduct a gender pay gap analysis so everyone understands the real pay equity position of your specialty.
- Challenge stereotypes about the kinds of work women and men 'should do'.
- Promote flexibility. Support all your colleagues, particularly men, to embrace flexible work so their work and caring responsibilities are fulfilled,
- When your male colleagues become fathers, encourage them to take parental leave entitlements.
- Call out bad behaviour when you see it – the standard you walk past is the standard you accept.

“Whether it is taking action on closing pay gaps or setting targets for men’s engagement in flexible work or setting targets for recruiting women and men in non-traditional roles, I cannot stress just how important it is to analyse your own data – you don’t know what you don’t know.”

Libby Lyons

PANEL SESSION ONE: LESSONS LEARNT FROM INDUSTRIES OUTSIDE OF MEDICINE

In *Panel Session One: Lessons Learnt from Industries Outside of Medicine*, participants heard from three business leaders who discussed the diverse initiatives being pursued within their organisations to support gender equity, and how this might translate to changing medical workplaces and culture.

Dr Cecelia Herbert, Lead Employee Experience Scientist, Qualtrics, highlighted the significant gender gap when it comes to pay and role level, and the critical impact of parenthood and the segregation of professional and domestic work as a key driver of systemic gender inequality.

Dr Herbert encouraged participants to apply systems thinking to identify the levers to support change and drive action within their organisation and spheres of influence, and to ask:

1. Which parts of the system are you currently focusing on?
2. What are the highest impact leverage points?
3. What is within your sphere of influence to change?
4. How will you measure progress?

Ms Janet Menzies, General Manager, Cochlear Australia and New Zealand, and spokesperson for the Male Champions of Change, emphasised that gender inequality is an issue that affects all people – socially, economically, and politically. Ms Menzies described how the Male Champions group was motivated by the simple insight: to accelerate progress, powerful men need to step up beside women to drive change.

Ms Menzies identified four guiding principles as the basis for action to improve gender diversity, equity, and inclusion:

1. Men step up beside women to advocate for women's representation.
2. Prioritise achieving progress on women's representation and set targets that crystallise that intent.
3. Publish and share results, and act to remove obstacles to progress.
4. Shift the system by acknowledging and addressing systemic biases that act as barriers to women's advancement, instead of trying to 'fix women'.

Ms Rhian Richardson, Board Diversity Manager, Australian Institute of Company Directors, described the current campaign for 30 per cent female directors on ASX 200 boards, and discussed the launch of the 30% Club Australia, in May 2015, with the primary objective of campaigning for 30 per cent women on ASX 200 boards by the end of 2018. In March 2019, the 30% Club announced a new objective for 30 per cent women on ASX 300 boards by the end of 2021.

Ms Richardson reinforced six important elements of the campaign:

1. Data: collect it, analyse it and publish it.

2. Have a target and a timeframe that people can work towards – a national campaign and a way to effectively communicate your key message or mission is important.
3. Collaborate and work with other organisations.
4. Media and external influencers – ensure all the stakeholders that have influence are involved and get the media onside throughout the process.
5. Ensure buy in and continued support from key stakeholders and other organisations.
6. Find the touchpoints that work. Pressure is vital – the believers are already there or on their way, so you may have no choice but to “name and shame” to push forward the laggards.

Panel Session One: Lessons learnt from industries outside of medicine - questions and answers

Key points arising were:

- Identifying what improvement looks like, what actions will be taken to achieve it, and reporting on progress is critical to ensure progress towards gender diversity, equity, and inclusion in any environment.
- Talking to women about self-nominating and providing a welcoming, positive environment for women to apply for representative positions are important strategies to support women to nominate for representative roles.
- Traditionally, the route to senior leadership positions has not accommodated career breaks and visible caring responsibilities. Roles, career paths, policies, and processes need to be redesigned with consideration given to people at this stage in their life and career.
- We need to seek out innovative and effective approaches to disrupt the status quo.
- The objective of gender equality must be integrated across business processes with clear targets and accountability.



“The status quo on gender equality can lead to low expectations of women’s representation. At times, we assume obstacles to women’s advancement are inevitable or insurmountable. They are not, but standard approaches are not enough.”

Janet Menzies

PANEL SESSION TWO: MAKING CHANGE IN MEDICINE

Panel Session Two: Making Change in Medicine brought together four leaders from medical and health organisations who are working to make changes in medicine to achieve gender equity.

Dr Cathy Ferguson, Royal Australasian College of Surgeons (RACS), spoke to the events leading up to the development of the RACS Diversity and Inclusion Plan, released in late 2016. Dr Ferguson described the four pillars of the plan as:

- Inclusive culture and leadership excellence: Intentionally create a culture of inclusion amongst the surgical community through advocacy, championing, and communicating diversity.
- Gender equity: Increase the representation of women in the practice of surgery by removing barriers to participation and introducing flexible training models for any trainee or surgeon, irrespective of gender.
- Achieve greater diversity in participation and representation: Be transparent and accountable for implementing the Diversity and Inclusion Plan, by gathering data and reporting publicly on progress.
- Board & committee diversity: Increase diversity and in particular, the representation of women, on training boards and in all leadership roles within the College.

Dr David Martin, Australian Orthopaedic Association (AOA), outlined the vision for AOA to create a culture of inclusion within the profession of orthopaedic surgery to the benefit of the Australian people.

Dr Martin highlighted key achievements of the AOA to date:

- AOA Ethical Framework 2018.
- Workshops to encourage female medical students and junior doctors to consider an orthopaedic career.
- Orthopaedic Women's Link (OWL) Committee.
- AOA Champions of Change Group.
- Amended Selection Panels & Presenter Guidelines; improved inclusion and diversity of presenters and moderators.
- Flexible training and childcare at AOA Events.
- Revised hospital accreditation standards – to promote flexible/part-time training.

Dr Simon Judkins, Australasian College for Emergency Medicine (ACEM), spoke of the need to develop a range of strategies to support increasing the diversity of College entities and improve emergency department (ED) workplace culture more generally. He provided an overview of the initiatives being implemented by ACEM to promote and support female leaders within the College, in clinical practice, hospitals, and health systems.

These include the:

- ACEM Diversity and Inclusion Steering Group, created as the first step of the Discrimination, Bullying, and Sexual Harassment action plan.

- Advancing Women in Emergency Medicine Section (AWE).
- Development of a “Safe Emergency Department” document, which will be the standard-bearer for all EDs across Australasia, and include recommendations on safe rostering in pregnancy, family-friendly rostering and return to work supports post-maternity leave, and career progression.
- Changes to the ACEM constitution to reduce barriers to diversity in appointment to board positions.
- Skills and Updates for Parents in Emergency Medicine: a free simulation and skills-based day of education and conversation for parents returning to work in Emergency Medicine after a period of parental leave.

Dr Victoria Atkinson, Healthscope, outlined her experiences as a hospital administrator in creating a more gender diverse medical workforce by hospital and by specialty. She emphasised the need for workplaces to change to facilitate gender equity and described the implementation of the ETHOS program at St Vincent’s, Melbourne, in 2017, to address bullying and harassment, including the ongoing challenges inherent in confronting and changing the status quo.

Panel Session Two: Making change in medicine – questions and answers

Key points arising were:

- It is important that organisations commit to building a diverse membership that reflects and respects the community and recognises the inherent worth of all people and beliefs.
- Be transparent and accountable for increasing diversity and making progress in implementing change by gathering data and reporting publicly on progress.
- Collect data on representation of women on boards and committees, as well as creating and monitoring uptake of flexible training opportunities.
- Amend selection and interview panel guidelines to encourage diversity of individuals serving on interview panels to reduce the risk of unconscious bias and ‘groupthink’.
- Colleges have a role to play in taking action against gender inequality in selection and training, but workplaces also need to change so women feel welcome, valued, and safe.

“Gender-diverse institutions are more likely to outperform those that are not gender diverse. If productivity and innovation can be improved by increasing gender diversity, then there is an ethical imperative to do so. Any organisation that is not gender diverse is failing to access and leverage talent.”

Shannon G, Jansen M, Williams K, et al.

WORKSHOP SESSION THREE: TRANSLATING INTENT INTO ACTION

In [Workshop Session Three: Translating Intent into Action](#), participants discussed what practical recommendations could be implemented to address the underlying systemic and cultural barriers and contributors that impede progress towards achieving gender equity and inclusion in medicine.

Participants held roundtable discussions based on five categories for action, derived from the [World Medical Association Statement on Gender Equality In Medicine 2018](#). During discussion, participants were asked to identify practical measures that Colleges, jurisdictions, individuals, and professional bodies can take to achieve gender equity in medicine.

The five categories were:

1. Increased presence of women in academia, leadership, and management roles.
2. Work-life balance.
3. Pregnancy and parenthood.
4. Changes in organisational culture.
5. Workforce planning and research.

[Increased presence of women in academia, leadership, and management roles](#)

Despite gender parity among medical graduates since the 1990s, and approximately 40 per cent female doctors in the profession overall today, women remain underrepresented in medical leadership and management roles, as well as other positions of power and influence. From engagement and sponsorship to promotion and retention, participants explored practical actions to ensure more equitable representation of men and women in medicine.

[Key ideas discussed:](#)

1. Establish gender targets for representation.
2. Provide education about bias in selection.
3. Ensure conferences have gender balance among speakers.
4. Provide training in leadership and management skills to doctors.
5. Provide mentoring and sponsorship opportunities.
6. Shoulder tap women for leadership roles.
7. Provide detailed information about what leadership roles entail.
8. Provide flexible options to allow people with caring responsibilities to attend meetings and participate in leadership roles.
9. Include gender diversity targets among key performance indicators for organisational boards.
10. Report on and publish gender diversity and equity data.
11. Review recruitment and selection processes.
12. Celebrate and profile women as role models and leaders.

Work-life balance

Appropriate work life balance is beneficial to all medical professionals, though manifestations of imbalance are often gendered, as a result of stereotyped societal expectations of gender roles in the workplace (traditionally male dominated) and home (traditionally female dominated). Participants canvassed practical actions to promote balance between life at work, at home, and outside, for men and women alike.

Key ideas discussed:

1. Give merit to life outside work.
2. Improve access to flexible work arrangements in all medical work environments including training.
3. Shift to competency-based rather than time-based recognition of training.
4. Ensure access to all leave entitlements.
5. Provide portability of leave entitlements across State/Territory jurisdictions.
6. Provide better end-of-trip facilities at work e.g. showers, parking.
7. Provide childcare and breastfeeding facilities at work.
8. Improve rostering and provide adequate staffing to cover leave.
9. Pay un-rostered overtime.
10. Make organisations accountable for providing a safe work environment.
11. Provide wellbeing programs for staff.
12. Create a culture where it is ok for doctors to say 'no'.

Pregnancy and parenthood

Periods of pregnancy and parenthood are a common source of gender-based bias and discrimination. While there are some biologically imperative gender differences, gender inequity arises when these interact with medical workforce and training models that are not designed to accommodate them. An equitable rather than equal approach is required to acknowledge unavoidable gender differences without overstating them. Participants discussed practical actions that could be taken to address barriers to gender equity and inclusion associated with pregnancy and parenthood.

Key ideas discussed:

1. Provide equitable, paid parental leave entitlements (especially providing paid parental leave for men).
2. Shift to competency-based rather than time-based recognition of training.
3. Remove financial penalties for interrupted training.
4. Set targets for and report uptake of flexible work arrangements for men and women.
5. Provide breastfeeding facilities and childcare at exams, conferences, and work.
6. Have in place return to work programs following periods of extended leave.
7. Backfill potential leave.
8. Provide extra staff over school holidays.
9. Provide interstate portability of leave entitlements.
10. Celebrate children in the workplace.

Changes in organisational culture

Unfortunately, there are still unacceptable rates of sexual harassment, and gender and pregnancy discrimination in recruitment, selection, and the practice of medicine. While the underlying biases cannot all be eradicated, particularly unconscious biases, it is possible to create environments where they are less likely to result in discrimination. Participants discussed practical actions that could be taken to change the culture of medicine to encourage gender diversity and inclusion.

Key ideas discussed:

1. Ensure regular renewal of leaders.
2. Provide education about importance of gender equity, inclusion, and diversity.
3. Create a culture that allows for and encourages flexibility in work and training.
4. Increase accountability of positive cultures through accreditation and key performance indicators.
5. Effectively address discrimination, bullying, and harassment when they occur.
6. Call out bad behaviour.
7. Implement safe systems to report bad behaviour.
8. Create visibility of gender equity data.
9. Identify gender equity champions and celebrate achievements.
10. Leaders to engage in and support cultural change.

Workforce planning and research

The maxims “what is measured is valued” and “what is measured is what happens” describe the central importance of measurement and monitoring in achieving change of any kind. Participants discussed what practical actions would ensure systems are designed to foster gender equity, and what outcome measures would assist in monitoring progress towards achieving gender diversity, equity, and inclusion.

Key ideas discussed:

1. Fund workforce data collection on diversity and inclusion in the medical workforce.
2. Advocate for gender equity to be a workforce priority.
3. Design flexible work options for men and women and report on achievement.
4. Provide flexible work options as default in recruitment for all positions.
5. Implement transparent, unbiased selection criteria and recruitment processes.
6. Adopt a Science in Australia Gender Equity (SAGE) model gender equity award for health care.
7. Develop key performance indicators to describe achievement of gender equity, measure, and report.
8. Every College and health employer to develop a gender equity action plan.

The complete verbatim responses from participants for each category have been summarised and can be found in Appendix One of this report.

COMMON THEMES

	Increased presence of women in leadership roles and academia	Work life balance	Pregnancy and parenthood	Changes in organisational culture	Workforce planning and research
Set targets for representation of women in leadership/academic roles	X	X	X	X	X
Report on gender equity data	X	X	X	X	X
Set KPIs to achieve gender equity	X			X	
Provide flexible arrangements to allow women to participate in leadership roles	X			X	
Celebrate, profile and encourage diversity in leaders	X	X		X	
Provide opportunities for mentorship and sponsorship for women	X		X	X	
Provide information what leadership role entails	X				
Promote leadership renewal	X			X	
Provide leadership training for women	X				
Provide training for leaders in diversity/unconscious bias/bullying and harassment	X			X	
Require transparent selection and appointment processes	X			X	X
Invest in better staffing/rostering to improve access to all types of leave		X	X	X	
Provide equity of access to leave		X	X	X	
Provide portability of leave entitlements		X	X	X	
Provide access to part-time/job share roles/positions	X	X	X	X	X
Provide access to flexible work and training arrangements is an accreditation requirement		X	X		X
Implement return to work policies for employees returning from parental leave			X	X	
Shift to competency rather time-based training		X	X		
Mandate greater employer accountability for hours worked		X		X	
Implement policy, infrastructure and facilities to support child/family friendly training environments and workplaces	X	X	X	X	
Focus on wellbeing, doctor satisfaction and work life balance as a value of success		X		X	X
Provide opportunities for networking	X			X	
Improve communication and pathways for safe feedback				X	
Create a culture where saying no is ok		X		X	
Mandate zero tolerance for discrimination, bullying and harassment				X	

WORKSHOP SESSION FOUR: IDENTIFICATION OF TOP PRIORITIES

In Workshop Session Four: Identification of Top Priorities, participants prioritised areas for immediate action. Using [Mentimeter](#), participants evaluated the suggested actions within each category using a matrix of estimated impact versus effort.

The result was a list of nine priority actions to improve gender equity in medicine:

	Government	Employers	Specialty colleges	Peak bodies
1.Establish targets for gender diversity in representation	x	x	x	x
2.Report and publish gender equity data		x	x	x
3.Actively encourage women to apply for leadership roles	x	x	x	x
4.Provide equitable access to parental leave entitlements for all genders	x	x		
5.Improve access and uptake of parental leave and flexible work arrangements for all genders		x	x	x
6.Provide interstate portability of leave entitlements for doctors	x			
7.Implement transparent selection criteria and processes for entry into training and employment		x	x	
8.Provide access to breastfeeding facilities and childcare at exams, conferences and work		x	x	x
9.Identify gender equity champions (and celebrate women in medicine)			x	x

Further detail on the matrix outcomes can be found in Appendix Two of this report.

While the Summit priorities are not exhaustive or binding, they are a starting point, and will inform the development of an AMA Diversity and Inclusion Plan in 2019. We hope they will form the basis of practical actions and ongoing discussions that individuals, employers, and training and professional bodies can pursue to make a real difference to achieving gender diversity, equity, and inclusion in medicine.

WHAT'S ONE THING YOU'LL DO TO FURTHER GENDER EQUITY IN MEDICINE AFTER TODAY?

Tap shoulders	Tap a woman on the shoulder for my role	Tap shoulders and step aside soon
Advocate for flexible working targets in all aspects of medicine	Pursue and create more networking opportunities	Celebrate women as role models and leaders
Raise some of these action points with my college	Feedback to College. Continue to assist and sponsor potential registrars	Encourage another woman to take over my leadership post when I vacate
Push for greater renewal of management and broad positions	Data collaboration. Encourage some of my female colleagues into committee/ leadership roles	Be aware of my own unconscious biases and call myself out
Advocacy at College level to drive policy change that will result in meaningful impact	Support male colleagues to work flexibly and encourage my department to have sensible and safe rostering	Encourage female doctors to become involved in leadership
Make a genuine attempt at internal gender balance on the councils/ committees/ boards I'm on (whether or not a target is set)	Start the conversation that needs to be had with colleagues at work at opportune times	Implement some of the ideas of today into the Women in Ophthalmology activities. Lobby CEO for additional support for gender equity
Convey findings to medical executives	To return to my College to implement or advocate for some of these ideas that have come up today	Continue to try!
Engage actively	Advocate, and be aware of my own actions	Show off my shoulders!

RESOURCES

Selected reports, resources and initiatives

[ANZCA Gender Equity resource](#)

[Chief Executive Women A long way to the top February 2019](#)

[Queensland Health Gender Equity Strategies and Initiatives](#)

[RACGP Gender Equity report](#)

[RACS Diversity and Inclusion plan](#)

[RANZCO Gender Equity report](#)

[SCIENCE IN AUSTRALIA GENDER EQUITY \(SAGE\) Background Information](#)

[SAGE – A Pilot of Athena SWAN](#)

[Women in STEM Decadal Plan Submission](#)

[Workplace Gender Equality Agency Gender strategy toolkit](#)

[World Medical Association Statement on Gender Equality in Medicine](#)

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Selected research and reading

[Advancing women in science, medicine, and global health, The Lancet, 9-15 Feb 2019](#)

[Why do women leave surgical training? A qualitative and feminist study.](#) The Lancet, Feb 9 2019

Emma Watson [Gender equality is your issue too](#)

Male Champions of Change [Avoiding the merit trap](#)

Male Champions of Change [Backlash and Buy-in: Responding to the Challenges in Achieving Gender Equality](#)

[The problem with that equity vs. equality graphic you're using](#)

APPENDIX ONE

The complete verbatim responses from participants for each category appear below. They reflect the views of participants expressed on the day and should not be interpreted as AMA policy.

Increased presence of women in academia, leadership, and management roles: suggestions from summit participants

Increasing representation

- Create welcoming environment, where women feel included
- Ensuring taking on these roles isn't seen as a chore, e.g. presenting med student lectures, but rather a privilege and remunerate appropriately
- Really spell out what leadership role entails – number of hours required, what flexibility exists (i.e. baby change rooms) so women can figure out how it fits in their lives and make it work
- Encourage acting up in positions
- Apprenticeship models to shadow leaders
- Sponsorship of women to reach leadership roles
- Active sponsorship and direct nomination
- Tapping women on the shoulder for leadership positions
- Allow a woman who has never been on a board before – try it for a session just to see what is involved?
- Encouraging good female applicants to nominate/apply (or nominating them)
- Facilitating good collaboration so research projects don't have to be huge long-term commitment by individuals
- Provide opportunities for head authorship

Celebrating women as leaders

- I see therefore I can. Profile diverse leaders encourage women and empower applicants
- Celebration of female leaders

Report on data

- Encourage reporting of data, not to shame organisations but to identify areas of need

- Publish/report to members on gender balance of their groups. i.e. hospitals/colleges, report to their members annually

Mentoring and role models

- Mentors and role models – formal and informal
- Promoting organic mentorship to promote women in leadership positions
- Have a mentor train a person up a leadership ladder
- Apprenticeship models to shadow leaders
- Female mentoring, in leadership/academia
- Mentoring for new academics – how to write, grant and apply
- Mentoring programs for women
- Role models – visible, recognised, engaged

Culture

- Redefine the qualities of a leader “Harden up!”
- Female friendly networking events/activities i.e. not golf
- Need board/senior levels to demonstrate gender equity
- More widespread education on the nature of male bias
- Break down bias unconscious/conscious against females who display agentic guidance (vs authoritative)

Workforce policy and planning

- Built into workforce planning and business strategy
- Assess and modify the systemic barriers to advancement

Training and scholarships

- Provide training
- Incorporating nonclinical streams into medical training
- Training opportunities for mid-career women in leadership/managers
- Leadership training in medical schools and junior doctor years
- Run a short course to train what leading/being on a board/council would be like – time commitment, language, role, responsibilities
- AIDC scholarships for women in health care
- Scholarships for women e.g. MBA; to support training
- Paid research for PHD

Flexible arrangements

- Encourage leadership roles while part-time or on parental leave
- Flexibility of time commitment in those positions to allow for family emergencies etc
- Parenting supports at conferences/events/training (e.g. childcare)
- Allow part-time council/board positions or job shared positions
- Make leadership roles accessible to those on part time training with clearer requirements no 'all or nothing'
- Use of technology in boards/committees/leadership to make flexible or easier access i.e. virtual meetings, videoconferencing, employed feedback/discussion tools like slack/whats app
- Flexible and remote work options in academia
- Provide travel and childcare for parents of young children

Setting quotas/targets

- Should we have quotas?
- Quotas for board and management positions
- Gender quotas for leadership 40:40:20
- Medical organisations to agree on targets/quotas for – authorship in journals, speakers at conferences, board/committee membership
- Consider quotas for selection into specialist training to reflect graduates
- Quotas for research grants
- Need targets for leadership roles
- Agreed targets as a way of overcoming innate bias
- Targets or quotas in academic departments
- Built into workforce planning and business strategy

Selection and recruitment

- Involve women in recruitment and selection
- Make selection panels for appointments and research grants gender balanced
- Blinded applications for leadership roles (at written stage)
- Understand/identify what/if there are differences in recruitment policy, practice

Conferences and panels

- No more 'manels' representation in conference presenters
- Congress/conference equity for speakers and chairs
- 50% male – female conference presenters and lectures
- Abolishing male only panel [at] conferences, there are plenty of capable women
- Goals/quotas for equal representation in conferences (speakers and panellists) and publications
- Parenting supports at conference/events/training e.g. childcare

Work-life balance

Better access to leave entitlements

- Providing adequate staffing to cover sick leave and annual leave
- Ensure there is back fill for all doctors whilst on leave
- Ensuring sick leave is feasible without burdening already overworked staff
- Not having to find your own sick leave cover (sick leave rosters)
- Access to professional development leave, give adequate notice
- Portability of maternity/paternal leave [for GP registrars]
- Ensuring access to fatigue leave conditions as per enterprise agreements
- Ready granting of flex leave when requested/applied for with good notice
- All employees to take leave and ADOs;
- Regular rostering of ADOs (given to you rather than having to beg for them)
- Ability to take 'mid-week' day off – no judgement from seniors
- Not having to justify reason
- Being able to take your full leave quota

Better access to flexible training options

- Ability for men to feel comfortable to request flexible work (culture)
- Easier access to flexible work arrangements
- Innovative ways to train so “experience” is not the main teacher and tyrant of time
- Ability to work from home if the circumstances are mutually acceptable
- College support for part-time/leave
- All colleges to have the ability to job share
- Availability of part-time jobs

Changes to training programs

- Competency rather than time-based assessment/merit value
- Review requirements for “extracurricular” activities required for college selection
- Training more competency based, less time based
- Less focus on non-evidence-based selection into training that leads to less clinical experience but also hinders work-life balance

Better rostering and access to flexible rosters/roster hours

- Smarter rostering with consideration to the doctor as a person, rather than what just works [best] for admin
- Ensuring rosters and workload are regularly under review and changes made according to employee feedback
- Administration to be more proactive in matching staffing to work levels
- Supportive culture from admin e.g. limit excessive hours/runs of shifts, limit barriers to leave access
- Admin accountability for unsafe hours
- No admin staff on interview staff so juniors feel safe to report unsafe rosters
- Culture change, alter the notion of 'macho' hours
- Flexible rosters and roster hours
- Minimise un-rostered overtime
- Pay for work performed (including overtime/un-rostered overtime)
- Rosters coming out in a timely manner

Better workforce planning

- Consistency between states/health networks
- Workforce planning adequate to meet demand
- Update and modernise awards
- Culture change within health department hierarchy

Ongoing advocacy

- Advocacy by AMA
- Trainee reps on boards

Better access to non-clinical time at work for training

- Non-clinical time at work to meet training demands (logbooks, research) so we aren't taking work home
- Improve funding models to pay for non-face-to-face work

Giving merit to life outside work

- Promotion/celebration of unique hobbies within workplace
- Encourage sharing info re hobbies/interest
- Valuing experience outside of work – e.g. involvement with children at school when recruiting to work/college
- Recast as life-life choices
- Encourage/enforce limits to “on call” shifts
- Reduce amount of on-call after-hours shifts
- Enforce no rounds “after hours”
- 40-hour work week

Better facilities at work/hospital

- Shower facilities to encourage exercise/cycling to work
- Childcare and breastfeeding facilities at hospitals
- Appropriate parking facilities for staff to limit commute times/facilitate flexible start time

Provision of wellbeing programs

- Wellbeing programs at hospitals e.g. free exercise classes, meditation etc

Education on about self-monitoring

- Teach doctors to say “no”
- Encourage people to say “no” and value their time away from work
- Encourage managers/supervisors to tell their trainees it's OK to say “no”
- Provide access to upskilling opportunities

Pregnancy and Parenthood

Parental Leave

- Equitable access to parental leave for both men and women, and non-birth mothers
- Access to paid maternity and paternity leave.
- Provide backfilling for pregnancy leave so departments don't begrudge maternity leave.
- Maternity leave handbook – including ways to manage maternity leave during, pre and post leave. Should contain narratives and advice.

Language and Culture

- Removal of gendered language and assumptions of “traditional family structures” from hospital and college policies
- Abolish the term “maternity leave” and use “parental leave” instead
- Maternity leave being generalised to parental/carers leave
- Cultural acceptance of men taking long parental leave and other carers leave.
- Celebrate children in the workplace

Flexible Work

- Access to flexible training (prolonged/part time)
- Fostering part time training and flexible working conditions
- Requirement for colleges to make part-time arrangements a basic requirement
- Job-sharing made available
- Explore non-traditional job-sharing methods i.e. not “find your own colleague”
- Quotas or identified job-sharing positions – not left up to trainees to arrange
- Flexible working arrangements to allow for childcare limitations
- Create e-health/telehealth options for work from home
- Allow access to online/e health record to allow people to work from home more easily on administrative duties
- Enlist male medical leaders to champion flexible working arrangements as normal

- Not just making policy re flexible hours – action

Returning to Work

- Return to work courses and policies
- Reintroduction back to work after parental leave
- Opportunities to ease into work after parental leave

Breastfeeding

- Handbook on expressing at work
- Breastfeeding time in exams
- Supporting breastfeeding women
- Colleges to implement breastfeeding policies (RACP does this for exams)

Child-Friendly Workplaces

- Onsite staff childcare facilities at hospitals
- Access to childcare locally and subsidies
- Childcare – longer hours, more affordable, more access, less stigma
- Childcare availability at conferences and exams
- Arrange child-friendly days at the workplace
- Make workplaces “family friendly”
- Celebrate children in the workplace
- Children are a normal part of life they should be allowed in the workplace and in meetings.
- Support continuing through toddler years
- Extra staff provisioning over school holidays

Training

- Competency-based training curricula rather than time-based
- Training fees proportional to FTE
- Minimising impact of exams/training requirements either on ability to choose a specialty or delaying childbearing.
- Interrupted training recognition
- Remove financial penalties from colleges for interrupted training

- Breaks in training are not penalised by archaic ideas about a lack of clinical exposure
- Formal pathways for research, governance, other ways to continue to contribute to training/the workplace whilst on leave

Industrial Relations

- Mobilise industrially to change junior doctor/doctor in training public sector awards for flexible working and parental leave
- Accrual of long service leave/annual leave/seniority/superannuation for pay when on maternity leave
- Legislation to allow portability of leave and entitlements, especially for GP trainees
- Requirements to move employers to meet training requirements not impacting on access to maternity leave or long service leave

Workforce policy & planning

- Lobby politically at a state level to make gender equity on parental leave a key policy – if available for doctors, will need to be available for all health workers
- Need to link to how it will benefit availability of health workforce
- Research into barriers and supports

Mentoring

- Mentor program for mothers in medicine
- Mentors who have had babies

Working conditions for pregnant women

- Decreased physical work late in pregnancy
- Statement/policy on shift work in pregnancy
- Allow pregnant women to be pregnant – they can't do nights or operate late in pregnancy.
- Clear guidelines on acceptable work/rostering practices especially later in pregnancy

Changes in organisational culture

Regular renewal of leaders

- Time limits for unit heads
- Encourage turnover of leadership position – strict time limits
- Bring fresh leadership to the table
- Careful choice of who is given management positions
- Transparent appointment processes (not just who has been there longest) but support all who apply
- Changing T.O.R/job description for unit heads

Emphasis of communication & safe feedback

- Persistence
- Open communication; positive listening
- 360-degree feedback
- Be mindful of positive and negative influences of language (nuance)
- Be advocates for each other
- Building it into the 'DNA' of a college/organisation
- Engagement with allied health (not just doctors)
- Build trust
- Structured meeting processes to ensure all voices are heard
- Get to know your colleagues
- Stop doing things the same way just because that is how it has always worked – innovate
- Avoid triangular conversations
- Aware of competition and adverse effects and support
- Disseminating the evidence in support of gender equity in workplaces
- Express gratitude towards those that stand up to harassment. Celebrate the achievement
- Positive and regular stories on gender equity
- Tell the stories of bias – make the unconscious conscious

Working conditions

- Mandatory accountability for flexible hours, leave, equal representation across specialties and hospitals
- Create a culture that allows for and encourages flexibility and solutions to benefit trainees
- Have back up rosters in case people need leave e.g. spare pool of on-call staff
- Recognising doctors often work multiple P/T roles > fulltime
- Improve conditions in organisation that promote return to work or training after maternity leave
- Payment of un-rostered overtime
- Address gender equity pay gap now
- Expect changes and state if it is not happening
- Equal parental leave for all parents. Allow shared leave if both in one organisation
- Equal parental leave for males and females to change culture of females as primary care giver
- Mandatory reporting changes
- Day-care facilities at hospitals. Holiday programs/spaces for children of employees
- Make transferral between states more accessible to allow trainees to move as needed to where support networks/family are located
- Pay superannuation during parental leave
- Set flexible employment targets for men and women
- Ensure employment law is implemented
- Promote gender equity in selection panels
- Disallow "are you married" "are you pregnant" from interview questions
- Blinding in selection process; blind the selectors

Leadership

- College accreditation considers culture
- Deny accreditation to units with bad culture
- Expect change and state if it is not happening

- Support board decisions
- Medical superintends are powerful change agents
- Celebrating achievements/contributions of female leaders
- Need cultural change in medical workforce – be flexible – stop handing over to department heads – trainees fear this
- Develop policy that insists on a balanced (50:50) short-list for every job in organisation
- Good leaders – not department heads that just “fall” into position based on experience
- Have male champions in organisation to role model equitable leadership, flexible work, sponsorship of women
- Address sexual harassment and bullying transparently. Have training and policies clear for all. Champions essential
- Stop talking about “work life balance” work is part of life – make life better
- Recognition for positive leaders
- Once sponsor has been identified, actively accelerate careers of women in leadership
- Mentorship by leaders, especially for mid-career professionals. Mentorship is a door to sponsorship
- BDSH policies, regular reporting, positive and negative, actions to address and evaluation
- Take out bad behaviour
- Encourage participation in leadership
- Creation of opportunities for governance involvement for those working part-time and use this to keep these workers “visible” and recognised as a “merit”

Education

- Vanderbilt
- Training in education/colleges mentoring/leadership
- Mental health training. Develop groups to support and represent diversity
- Leadership training for all unit heads

- Bullying/harassment training for executives/head of department/supervisors of training
- Education in diversity/inclusion for leaders
- Unconscious bias training for all. Ongoing needs to be regular

Targets/measurement

- Starting with our leaders – colleges, committees, professional associations, board/council quotas
- Quotas in leadership positions
- 40:40:20 quota or target for every single board or committee, especially decision-making strategy, recruitment and promotion. Plus executive/board
- Report on gender balance in hospitals – set targets for numbers of women/men
- Set KPIs for achieving targets on equity, diversity and harassment
- Get the data. Use evidence not tradition to determine how training and workforce should be structured
- Visibility. Present data back to the organisation on its demographic breakdown
- Mechanisms to measure current state-of-play to benchmark for change
- Call it out – give it a name
- Walk the walk; actions speak louder than words
- Identify any harassment then ask if it is discriminatory
- Quiet tap on the shoulder “that is racist/sexist
- Harassment is named
- Clear pathway for reporting inequity and zero tolerance, promote reporting inequity
- Fire a M.A.W.G for bullying
- Call out bad behaviour
- Protecting reporters of bullying and misogyny from reprisal
- Discourage discussion about gender and pregnancy in workforce

System and workforce planning and research

Leadership

- Better workforce planning
- Career planning
- Stakeholders – there are too many who have their fingers in the pie and try to “own this space”
- Training that is matched to community need
- Having doctor/JMO satisfaction and work life balance as a value of success in the institution rather than patient outcomes only or finances
- At the end of the day this is about our patients, if leadership/workforce is not reflective of society it fails our patients
- Find the big stick (e.g. DoH, AHPRA, Colleges) to implement change
- Leadership by: academia, colleges, jurisdictions
- AMA and others advocacy to State Health and other employers to develop Gender Equity Strategies (measurable)
- Lobby AHMAC and COAG Health Ministers Council to make workforce data about training posts, flexibility, gender readily available to the profession and professional groups

Selection into training

- College/training selection panels being gender balanced
- Colleges standardising recruitment/application processes into a national standard rather than state based
- Time trainee selection to school year
- Transparency in training application processes and selection
- Review of college entrance and training requirements in view of modern workforce and need for work life balance

Recruitment and retention

- Diversity of intake market from beginning – university “x” should encourage diverse apps
- Encourage fractionated appointments between employers
- Explore innovative means of “add ons” for recruitment and retention

- Public – private working arrangements especially in rural
- (Geographic) increase time in each clinical rotation in same place
- Make hiring change over time a set date nationwide

Flexible training

- AMA and others advocacy to State Health (COAG) and other employers to develop measurable strategies to promote flexible employment opportunities – job sharing etc.
- Mandate colleges to accredit flexible training and mandate health services to fund and provide these services
- Opening hours of services
- Planning for flexible work options in all positions
- Trials of floating/flexible roles
- Flexible training pathways – rural and city part time
- Promoting part time/flexible jobs as an accreditation requirement by colleges
- Flexible specialised CMO positions to help fulfil roster shortfalls/leave
- Infrastructure to facilitate flexible work in metro and rural areas
- Holiday service provision
- Flexible training positions in rural areas – will also hopefully help retain people in these areas

Research

- Research linking workforce to health outcomes/quality
- Funding for research
- Audit of specialities and surveying/studying any gender disparity
- Survey across all colleges with data/results available to all for writing scientific research articles
- CPMC (Council of Presidents of Medical Colleges) and AMA to create questions for survey

- Data on number of trainees in each physician trainee specialty – including gender and identifying barriers where gender equity is not present
- Research on what clinical leadership means and how it is fostered
- Research opportunities for medical partners in rural areas
- Deep dive into data gender difference
- Evaluation of interventions

Data & reporting

- Link workforce planning to community needs data
- Data collection, sharing and analysis
- Data collection: workforce, college
- Census of trainees
- There is a lot of workforce data/planning at a Government level. Can we get the data and its implications translated for a wider audience?
- [Unclear] who is responsible for collating ALL data from all colleges and hospitals and what should they do with it
- Use of modelling and simulation in policy planning to reduce unintended consequences
- Gender equity data for rural areas
- Reporting on outcomes
- Setting targets and reporting streams to ensure accountability
- Include all parties in reporting: Government, colleges, organisations
- Publish the gender division for any survey
- Hospitals reporting on gender of staff – medical, non-medical and type of role/seniority
- Universities, colleges, etc. reporting on gender at intake and exit
- See tangible actions on surveys

APPENDIX TWO

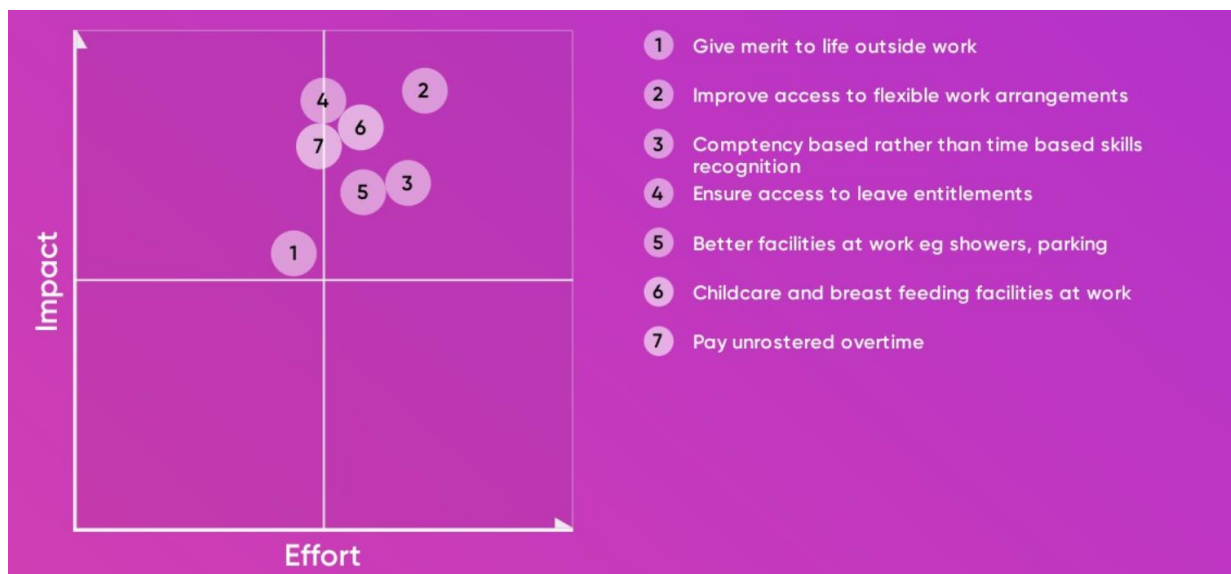
Gender equity summit: prioritisation of suggested actions by participants

(Rated on matrices of effort and impact)

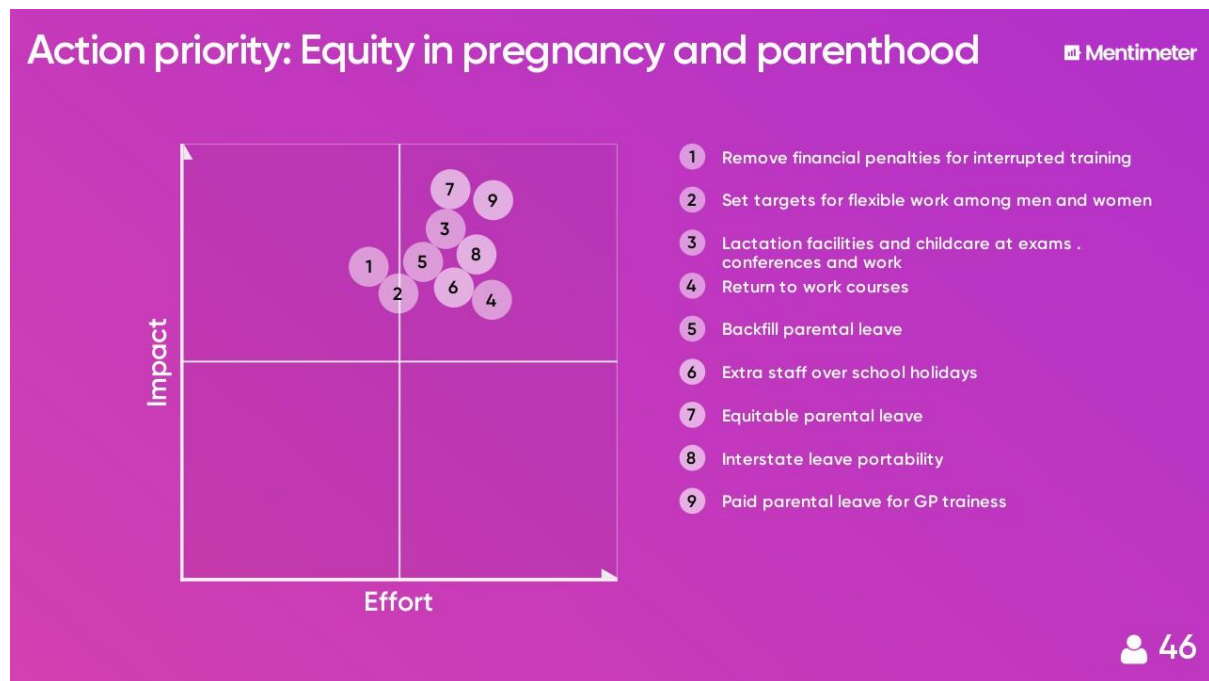
Increased presence of women in academia, leadership, and management roles



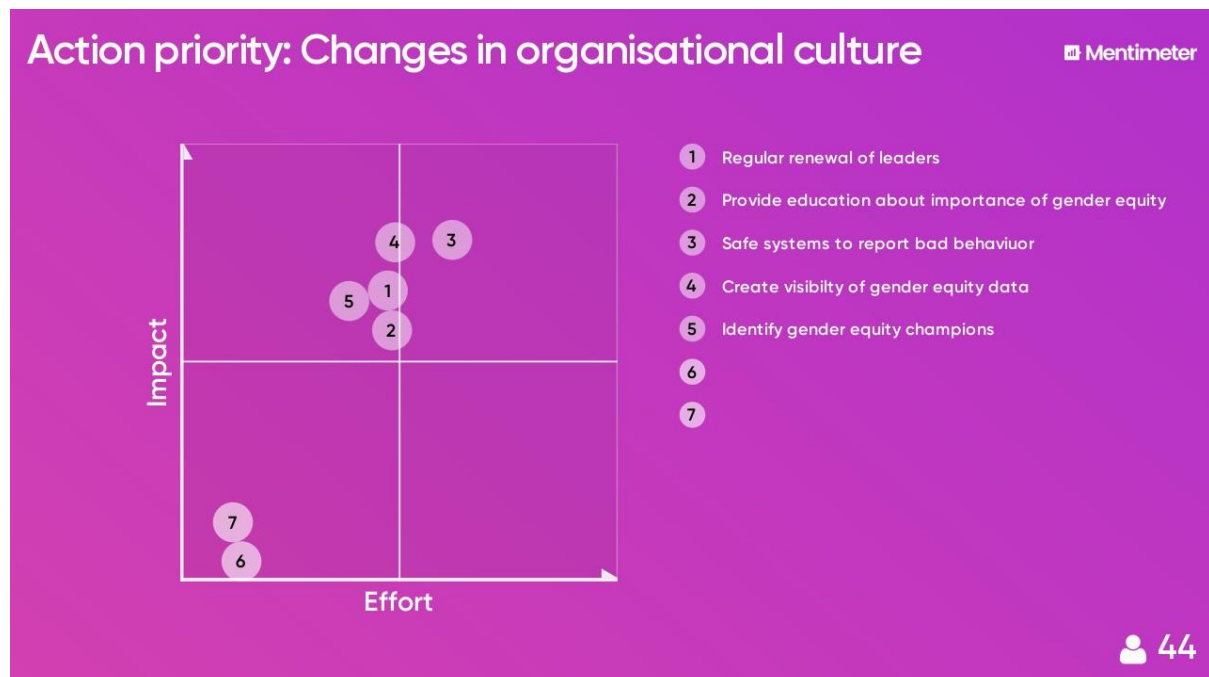
Work-life balance



Pregnancy and parenthood



Changes in organisational culture



Workforce planning and research

