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COVID-19, LEADERSHIP AND GENDER EQUALITY: PREPARING FOR THE CHALLENGES AHEAD

Introduction

The COVID-19 pandemic has presented one of the greatest challenges of our generation, with a wide-reaching global impact which has affected all aspects of society. The UK has been particularly badly affected, with over 127,000 deaths reported as COVID related,[1] the NHS placed under considerable strain, massive disruption to normal life and long-lasting damage to the economy and the health and well-being of so many.

The media have been consumed by the pandemic, and a recurring theme has been 'what could and should have been done differently?'[2] Sadly, this has tended to focus on blame,[3] rather than adopting a reflexive approach where we could perhaps reflect, learn and improve.[4] The UK Government and the Prime Minister have been held to account throughout the pandemic, and at times widely criticised for decisions which have been made.[5] Critics have been quick to cite a lack of leadership by the Prime Minister, and have often compared the UK response with that of other countries.[6]

Leading through COVID-19

This comparison may be unfair on many levels, but it has certainly stimulated debate on how other countries have responded to the pandemic, and how other national leaders have reacted to the unfolding crisis. An intriguing point of discussion has been around the performance of women leaders in comparison to men, where it has been reported that countries with female leaders tend to have lower COVID-19 death rates and better economic performance.[7] Evidence has been put forward to support this analysis,[8] while others refute the suggestion and believe the situation is more complex than simply concluding that women are better leaders in a crisis.[9] Irrespective of the evidence underpinning the theory, it has stimulated discussion around women in leadership. This is to be welcomed and will resonate for many within dentistry, where the lack of women in leadership roles has been highlighted recently.[10]

The World Health Organization officially declared a global pandemic on 11 March 2020,[11] and since then the world's healthcare systems have been trying to respond to unprecedented demands and challenges. In this crisis management mode 'the tyranny of the urgent'[12] takes over, with health leaders scrambling to manage finite resources despite surging demand for medical intervention. While this modus operandi is understandable, some commentators are critical of the fact that the gender dimension of the pandemic is being forgotten.[13]

Women in healthcare

Research by the World Health Organization[14] confirms that 70% of the world's health and social care workforce is now female. Here in the UK, 77% of all NHS staff are female.[15] Since women make up most of the health workforce, it is logical that female healthcare workers are at the sharp end of the pandemic, being most at risk of infection through their frontline worker status and left to

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juggle the emotional, psychological and social cost of their demanding work.[16]

Despite the predominance of women within the health and social care sectors, there is a significant disparity in the number of women occupying leadership roles. The WHO report indicates that women account for only 25% of global health leadership positions.[14] As a result, the female health workforce often feel they do not have a voice and have little opportunity to influence the decision-making processes that shape their professional lives.

Women in dentistry

Gender intersects with the dental profession in a similar pattern. A process of feminisation, namely the increased numerical presence of women in a profession,[17,18] can also be found in dentistry. In 2013, 63% of dental students and 49% of registered dentists in the EU/EEA were female.[19] In 2015, 50% of US dental students were female.[20] It is now estimated that 50% of the global dental workforce under the age of 35 are female.[21] In the UK this feminising trend was first observed in 2004. Since then, the net number of female registrants to the GDC has increased.[22] In 1968, 10% of GDC registrants were female; this rose to 30% in 2000.[23] By 2020, 51% of GDC registrants were female.[24]

Despite relative parity within the numbers of dentist registrants, there are specific differences between the two sexes in terms of work patterns and career choices:

- Female dentists are more likely to work part-time,[25,26] as associates or in hospitals[25]
- Female dentists are less likely to own their own dental practices[27]
- Female dentists are more likely to be 'performer-only' dentists (90%) than their male colleagues (72%)[28]

Access to specialism is a mixed story: The GDC records that women account for 51% of the specialist list.[24] However, the spread of women is not evenly distributed across the specialisms. Women are over-represented in special care dentistry, paediatric dentistry, dental public health and dental education and under-represented in oral maxillofacial surgery and endodontics.[24,26,27,29,30] This mirrors a trend observed in medicine where there are fewer women in the surgical and more prestigious specialisms.[30]

Despite the steady increase in women entering the dental profession over the last 40 years, the numbers of women in positions of leadership in dentistry are still limited. In dental academia, females continue to be poorly represented in senior roles, with only 22% of professorial chairs held by women.[29] There does appear to be progress, although there is still a significant imbalance across many levels within academic dental institutions. The membership of the Dental Schools Council consists of the heads / deans of the 20 dental schools within UK and Ireland. Seventeen of the representatives are men, with only 15% of the heads of the dental schools within the UK and Ireland being women. The deans of the dental faculties of the various Royal Colleges fair even worse in terms of gender balance, with all five Deans being male.

Why is there a difference?

A gender imbalance within certain specialities or in particular job roles may be due to a number of factors, including life choices or career decisions. However, there is growing concern that a level playing field does not exist, and women face many challenges within their career which men do not. There may be challenges with career breaks due to maternity, reports of prejudice and bias in appointments, and societal pressures to conform to traditional family roles, which often includes taking primary responsibility for childcare. While working mothers and fathers face obstacles trying to fulfil their childcare responsibilities alongside work responsibilities, 56.2% of working mothers made changes to their working arrangements (i.e. reduced their hours, job-share) compared to 22.4% of working fathers.[31] The situation appears to be gradually improving, with more men sharing childcare responsibilities, introduction of flexible training and working patterns, and a greater focus on EDI in terms of training and selection of appointments/interview panels. This may be seen as progress, but there would still appear to be significant barriers which account for a recalcitrant gender imbalance within academia or within many dental organisational boards.

The COVID pandemic may have led, albeit inadvertently, to a positive change for equality. Our new enthusiasm for remote meetings has undoubtedly been a significant step forwards in terms of communication, but this has allowed many of our dental boards and committees to conduct business efficiently and effectively, without the need to take a whole day out of work to travel to a distant venue. This is good for efficiency, financial prudence and the environment. It also supports a level of flexibility, which has not previously been available, which could perhaps remove one of the many barriers to women applying for leadership and committee roles.

Balancing the boards

O'Brien[10] highlighted concerns that despite the feminisation of the dental workforce, women were still under-represented on the boards of many dental organisations and societies. O'Brien et al[10] undertook a survey of various dental organisations to ascertain the gender balance which existed within each board or executive committee. The reported findings indicated a significant gender imbalance on many boards, including the British Dental Association (BDA), The Association of Dental Implantology (ADI), British Association of Oral and Maxillofacial Surgeons (BAOMS) and the Faculty of Dental Surgery of Edinburgh (FDS Edin). Interestingly, similar issues were reported to exist within most of the dental care professional societies, although the issue was primarily a lack of men, with some having no male representation on their boards. This would appear to be a reflection of the workforce demographics and the gender imbalance of their membership. This should not simply be dismissed as acceptable or reasonable and the importance and value of diversity should still be acknowledged and embraced.

The 'Balancing the Boards' campaign was established in 2020, in response to the O'Brien report, and has helped shine a light on the issues of gender imbalance on committees and boards within dentistry. The lack of female

representation on dental boards has been recognised as an issue for some time, and although progress has been made, the recent focus on gender inequality will undoubtedly provide greater impetus for organisations to undertake a review and implement change, where appropriate.

Addressing the challenges

There are specific challenges to achieving diversity within open elections, compared to appointments, but there are ways of ensuring equality of opportunity if we are committed enough to deliver change. We need to create an inclusive environment within our organisations, promote role models within the profession, encourage women to stand for election and persuade the electorate to vote for the best candidate.

Appointment to boards and committee, may not be democratic, but they allow a level of control in terms of diversity. This can clearly be a positive and a negative, depending on the approach and attitude of the appointments panel. An organisation should have a clear EDI policy in place and consideration needs to be given to equality at every stage of the appointments process. Consideration should be given to the language used in the job specification, the way the role is advertised and the selection of an appointments panel which has a reasonable level of diversity.

Appointments should be based on merit, but as reported by Roger Kline,[32] merit can often be subjective and tainted by bias. Mackenzie et al.[33] suggest a different approach based on identifying the best candidate who will contribute most effectively for the development of the team. This perhaps requires a shift in mindset as well as in the appointment process for non-elected positions.

Why is this important?

The demographic nature of our boards and committees ought to reflect the diversity of our profession, and there are a number of reasons why this is important:

- First, we have a moral obligation to ensure that our profession supports social justice through a culture and environment of inclusivity. In the past, some dental societies and organisations were considered to be elitist, misogynistic and populated by a homogenous group of individuals – mostly men. That is changing, but perhaps not at the rate which many desire. As the composition of boards change, it is also important to change the attitude, the environment and the structures which exist in order to promote inclusiveness and actively embrace diversity.
- The second important factor is the beneficial impact diversity has on the function of a board. Diversity within a board modulates attitudes and behaviours, undermines groupthink, and delivers improved performance within an organisation. Social and professional diversity reflects the diversity within our profession and can provide insight into the different views, attitudes and beliefs which may exist. This is a healthy environment which can stimulate discussion, debate and reflection, and in turn, provides a degree of internal accountability.
- Third, many societies and institutions are membership organisations which are dependent on recruiting and retaining members. The stark reality is that if they are not seen to be representative of the profession, why would anyone choose to be a member? Diversity is critical in understanding the changing needs of the dental profession, to connect with new members and ensure that organisations continue to be relevant.

Reasons to be positive

Many dental organisations have acknowledged the shortcomings within our profession and wider society, and have committed to work together to influence change and ensure that dentistry embraces equality, diversity and inclusiveness at every level. The Faculty of General Dental Practice (UK) and the British Dental Association (BDA) are working closely together to promote EDI in dentistry, with the two organisations establishing a programme board which advocates equal opportunity for all and is working to ensure that barriers are identified and removed, with women afforded the same opportunities as men. This is part of a wider piece of work on EDI which encompasses all aspects of diversity, not simply gender.

The Office of the Chief Dental Officer for England is also playing an active role in promoting EDI through the Diversity in Dentistry Action Group (DDAG) which includes representation from a wide and disparate group of organisations and individuals. The DDAG is committed to removing barriers to ensure that all members of the dental team are able to progress and fulfil their potential, irrespective of their background, colour, gender, sexuality or disability. It is also important to recognise that gender is considered fluid, and although we have referred to male and female, men and women, throughout this text, consideration must be given to transgender and gender diverse individuals and ensure that they are not discriminated against in any way.

Role models are highly important within our profession and we need to highlight diversity within our current organisations and provide mentorship to support colleagues in setting out their ambitions, and then provide enablement in order that their aspirations can be met.[34] There is considered to be a lack of positive role models for women in positions of leadership and authority in dentistry, however this assessment would appear to be based on quantity rather than quality. There is currently a significant number of inspirational women within the dental profession, but we perhaps need to promote this more widely and work harder to ensure that their voices are heard.

Discussions around gender equality can provoke strong reactions, and some individuals wrongly assume that attempts to address any imbalance are based on a resentment of men, and driven by a desire to promote the rights of one sex over another. This is an inappropriate depiction of feminism and does not reflect what those campaigning for equality strive for. Gender equality campaign groups want fairness, a level playing field and equality of opportunity.

The future

The EDI agenda has gathered significant momentum over the last 18 months and it is encouraging to see so many members of the dental community working together to influence change. Working together is key to success, and it is so important that we maintain the ability and desire to see the world through another's eyes. It is all

too easy to have an overly narrow perspective on life, and simply base our views, attitudes and beliefs on our own world experience.

Consideration and acknowledgement of the life experience of others will allow us to appreciate the challenges which many colleagues have faced, and instil a greater degree of empathy, understanding and compassion than perhaps currently exists. A series of webinars has been produced by ProDental in conjunction with FGDP(UK) to promote EDI within dentistry, and this has provided a platform for colleagues to share real life experiences of bias, prejudice and discrimination.[35,36] This is a valuable resource which powerfully illustrates some of the issues which continue to exist within our profession, and amply underpins the need for change.

Conclusion

As we gradually emerge from the pandemic, there will undoubtedly be a period of reflection, various inquiries into management of the crisis and recommendations as to how we should respond in the future if faced with a similar situation. There is no doubt that the UK Government, and other agencies, will be held to account and questions will be asked about decision making and leadership. Comparisons are likely to be drawn with other countries and it will be interesting to observe whether the suggestion that 'women are better leaders in a crisis' will be revisited and debated once again.

Views on the relative importance of gender in leadership will differ, but what is clearly important, is that we recognise and celebrate the contribution which women leaders have made around the globe during this pandemic. Leaders such as Prime Minister Jacinda Arden of New Zealand have become role models for many, and will no doubt have inspired women across the world. We have many inspirational women in dentistry and there is no doubt they could, and should, be enabled to provide leadership for the dental profession in the future.

UK dentistry will face many challenges in the years ahead, and representative leadership will be vitally important as we seek to adapt and transform in the wake of the pandemic. Our leaders will need to have the skills, attributes and experience to guide the dental profession, and we must take advantage of the breadth of knowledge, expertise and diversity at our disposal. The dental profession has a diverse workforce, which is to our great credit and benefit, and we must embrace this and use it our advantage. The lack of diversity within our boards, committees and leadership groups has the potential to weaken the dental profession, and this must be addressed if we are to prepare ourselves for the challenges ahead.

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