Gender inequity and sexual harassment in the pharmacy profession: Evidence and call to action

Am J Health-Syst Pharm. 2021;78:2059-2076

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Keywords: bias, equity, equality, gender, harassment, pharmacy profession

https://doi.org/10.1093/ajhp/zxab275

All members of the pharmacy profession should have equal opportunity and sponsorship to reach their highest potential. Significant gaps in support of the diverse membership of the pharmacy profession have highlighted a lack of awareness of harassment on the basis of gender and gender inequity issues. Fostering a more diverse workforce improves communication, healthcare access, patient satisfaction, and problem solving for complex challenges; cultivates innovation; and decreases health disparities.[1]

In order to act to achieve gender equity and equality and prevent sexual harassment and discrimination, it is important for pharmacists and pharmacy leaders to be aware of these definitions. Gender equality is defined as "having the same rights, status, and opportunities as others, regardless of one's gender."[2] However, this is distinct from gender equity, which is defined as "fairness of treatment for women and men, according to their respective needs. This may include equal treatment or treatment that is different but which is considered equivalent in terms of rights, benefits, obligations and opportunities."[3] Therefore, different needs of women and men should be considered and favored equally, and equity is seen as a path to equality.[3,4] Sex discrimination is defined as treating someone unfavorably based on their sex.[5] Sexual harassment is considered a type of sex discrimination and is defined as "unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment when this conduct explicitly or implicitly affects an individual's employment, unreasonably interferes with an individual's work performance, or creates an intimidating, hostile, or offensive work environment."[6] *Unwanted sexual attention* is verbal or physical advances that can include assault. *Sexual coercion* is when favorable professional or educational treatment is conditioned on sexual activity (also known as quid pro quo). *Harassing behavior* can be targeted at an individual or be ambient in the local environment and involve a pattern of behavior over time toward multiple targets.[7]

Social media platforms, online petitions, anonymous surveys, and organizational investigations have brought to the forefront significant gender inequity and sexual harassment claims in the pharmacy profession. These highly visible discussions garnered national attention within pharmacy leaderships, and in September 2020 three national pharmacy organizations put forward

statements in response to the public reports of sexual harassment and gender inequality, reemphasizing the current policies in place and ongoing support for this movement.[8-10] Specifically, the American College of Clinical Pharmacy (ACCP) encouraged "education of all stakeholders regarding the implications, detection, and management of sexual harassment, bullying, and similar unacceptable behaviors."[8] The American Society of Health-System Pharmacists (ASHP) encouraged pharmacists to serve as "mentors to students, residents, and colleagues in a manner of high personal standards of personal integrity" and "set expectations for standards of conduct, and discourage intimidating or disruptive behaviors" while also supporting the adoption of zero-tolerance policies system-wide. A report of the ASHP Task Force on Racial Diversity, Equity, and Inclusion was recently published.[11,12] Finally, the American Pharmacists Association (APhA) remarked that discrimination, harassment, and intimidation behaviors are "a very real threat to pharmacy and the patients we serve" and highlighted that the current movement has "motivated pharmacy groups . . . to reevaluate their actions to support women in the profession and recommit to living their principles," calling on all individuals to fight sexism, racism, discrimination, harassment, and intimidation.[10]

These organizational statements of support have served to both denounce inappropriate behaviors and unite our profession in reflection of professional values and codes of conduct. However, the work has truly just begun: Tangible strategies to foster systemic change to advance a culture of growth and diversity are paramount and are in their infancy, and significant gaps exist, such as wage disparity, hiring and promotional biases, and lack of gender equality in scientific panels, leadership positions, publications, and editorial boards. In addition, much of the data regarding these gaps are from outdated studies conducted prior to recent social movements and changes in laws that affect higher education; therefore, contemporary evaluations regarding practices across health disciplines are needed. The purpose of this commentary is to summarize the current evidence surrounding gender inequity and sexual harassment within the pharmacy profession. This review seeks to summarize the current evidence surrounding gender inequity within the pharmacy profession, highlight current gaps, and chart the necessary steps to create a profession that equally nurtures all of its members.

Women in pharmacy. *Recognition and promotion of women.* Approximately 60% of pharmacists identify as women.[13,14] The pharmacy profession has been listed as the number one position for working mothers given the potential for work-life balance and benefits, and the US Bureau of Labor Statistics ranks pharmacy as the second highest-paying job for women overall.[15,16] When considering the statistically greater number of pharmacists who are women, the field may continue to attract more female than male trainees. In 2013, 60.7% of pharmacy school applicants were women.[17] Among a surveyed sample of prospective pharmacy students, 62% indicated they knew a current or past pharmacist who influenced their decision to pursue pharmacy and were more likely to do so if that individual was perceived as similar to themselves.[18]

Despite more than half of the profession identifying as female, there is a notable lack of women in top leadership roles in pharmacy across the professional spectrum: academia, hospital pharmacy, pharmaceutical companies, and other areas of pharmacy practice.[19] The 2019 National Pharmacy Workforce Study found that discrimination by gender is much more likely to affect women (74.7%) than men (25.3%).[20] In a survey of career satisfaction in academic medicine, women reported lower mean career satisfaction scores than their male counterparts.[21] Additionally, female faculty who reported experiencing gender bias had lower mean career satisfaction scores than those who had not (3.2 and 3.7, respectively; $P = 0.001$).[21]

From 2015 to 2020, women pharmacists represented about 60% of all assistant professors but only about 35% of full professors and 23% of deans (Table 1). In the reported data from the 2020-2021 academic year, 31 of 119 deans (26%) were women, and the majority of professor positions were still held by men (36% were held by women).[22] A similar theme has been noted at colleges of medicine. Abdellatif and colleagues[23] evaluated leadership positions at the top 25 medical schools on 4 continents (a total of 100 schools) and found that males held the majority of leadership roles: 87.2% of the highest-tier positions (including dean or equivalent rank), 64.6% of deans working under the highest-ranked dean (assistant/associate deans), 82.3% of department chairs or equivalent positions, and 77.8% of directors of research and/or similar operating units. All colleges of pharmacy have the opportunity to evaluate gender parity (ie, numerical equality) and the potential sources of explicit and implicit bias and inequity that may hinder female faculty.[24-26] In order to identify problems, systematic data collection and assessment regarding compensation, promotion, and leadership opportunities should be standardized. Additionally, candidates for promotion and tenure-eligibility require comprehensive peer evaluation; however, evaluators must be at an equal or higher academic level than the candidate. Because men dominate upper-level positions, as well as outnumber women in tenure track positions, blinded review (as possible) for faculty promotion and compensation may alleviate potential bias.

Women are recognized less often than men with national pharmacy achievement awards, with one study determining that 90% of awards bestowed from 1981 to 2014 were given to male recipients.[27] Although the number of women leaders is increasing, women are making slower strides than men towards becoming major award recipients.[28] Table 2 is a summary of what we consider to be top awards and recognition (eg, election into the role of president) granted in each organization; the gender data for recipients was obtained via review of publicly available information

Table 1. Distribution of Full-time US Pharmacy School Faculty by Rank and Gender, 2015-2020

	2020-2021[a]		2019-2020		2018-2019		2017-2018		2016-2017		2015-2016	
Faculty Rank	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Provost	5 (55.6)	4 (44.4)	7 (58.3)	5 (41.7)	5 (71.4)	2 (28.6)	7 (77.8)	2 (22.2)	9 (81.8)	2 (18.2)	10 (90.9)	1 (9.1)
Dean	88 (73.9)	31 (26.1)	92 (76.7)	28 (23.3)	93 (77.5)	27 (22.5)	95 (77.9)	27 (22.1)	94 (76.4)	29 (23.6)	86 (74.1)	30 (25.9)
Associate dean	176 (50.7)	171 (49.3)	181 (52.5)	164 (47.5)	192 (54.7)	159 (45.3)	185 (56.7)	141 (43.3)	197 (59.9)	132 (40.1)	205 (61.9)	126 (38.1)
Assistant dean	87 (36.3)	153 (63.7)	63 (29.4)	151 (70.6)	73 (33.8)	143 (66.2)	78 (35.3)	143 (64.7)	80 (37.2)	135 (62.8)	90 (42.1)	124 (57.9)
Professor	937 (63.4)	541 (36.6)	907 (64.6)	496 (35.4)	890 (65.3)	472 (34.7)	860 (67.0)	423 (33.0)	857 (68.3)	397 (31.7)	846 (70.4)	355 (29.6)
Associate professor	901 (88.7)	1,016 (11.3)	909 (47.3)	1,011 (52.7)	928 (48.7)	977 (51.3)	937 (50.3)	925 (49.7)	954 (51.5)	898 (48.5)	928 (52.1)	853 (47.9)
Assistant professor	826 (40.6)	1,207 (59.4)	889 (40.9)	1,287 (59.1)	929 (40.8)	1,346 (59.2)	903 (39.4)	1,390 (60.6)	911 (38.7)	1,443 (61.3)	921 (38.5)	1,471 (61.5)
Instructor	30 (37.9)	49 (62.1)	41 (41.4)	58 (58.6)	40 (39.6)	61 (60.4)	41 (40.2)	61 (59.8)	45 (40.9)	65 (59.1)	43 (38.1)	70 (61.9)
Lecturer	13 (22.8)	44 (77.2)	14 (26.4)	39 (73.6)	11 (22.0)	39 (78.0)	13 (28.3)	33 (71.7)	11 (27.5)	29 (72.5)	8 (22.9)	27 (77.1)
Librarian	4 (22.2)	14 (77.8)	3 (15.0)	17 (85.0)	4 (17.4)	19 (82,6)	4 (16.7)	20 (83.3)	4 (14.8)	23 (85.2)	6 (20.0)	24 (80.0)
Total	3,067 (48.7)	3,230 (51.3)	3,106 (48.8)	3,256 (51.2)	3,165 (49.4)	3,248 (50.6)	3,123 (49.7)	3,165 (50.3)	3,162 (50.1)	3,153 (49.9)	3,143 (50.5)	3,081 (49.5)

Source: American Association of Colleges of Pharmacy (AACP) Profile of Pharmacy Faculty Survey.
[a]In the 2020-2021 AACP survey, the response rate for demographic data was 94.9%; therefore, not all colleges and schools of pharmacy provided demographic data for all faculty members.

on professional organization websites. A review in the *Journal of the American College of Clinical Pharmacy* highlights the gender distribution among men and women on editorial boards of pharmacy journals. Of the 813 editors identified, 40% were women, and only 4 journals out of 20 had a female editor-in-chief.[29] These data highlight the pervasive theme that women are not equally represented across a myriad of organizations, from promotion and tenure to service on editorial boards of prestigious journals.

Notably, these trends are not isolated to pharmacy or academia. While diverse leadership teams are known to enhance morale, motivation, and performance, similar trends of predominant male occupancy of senior roles exist among all healthcare disciplines as well as in the public sector. While women deliver the majority of healthcare in general, men tend to lead it.[30,31] The World Health Organization (WHO) reports that women account for 70% of the health and social care workforce worldwide but hold just 25% of leadership roles.[32,33] Women represent only 23.7% of executives at Fortune 500 healthcare companies and 37.1% of executives at the top 100 largest hospitals.[34] A 2018 analysis found that women make only 85% of the salary of their male counterparts, while data within the profession of pharmacy demonstrate a gap of 5%.[31,35,36]

Work-life balance. Women spend disproportionally more time on child and domestic responsibilities compared to their male counterparts, often with larger opportunity costs associated with decisions relating to career and family.[31,37,38,39] An observational study among high-achieving physician-scientists found that women with children spend 8.5 hours per week more than men on parenting or other domestic activities.[40] In another survey, two-thirds of the 13% of practicing cardiologists who were female reported workplace discrimination related to gender and childbearing.[41]

Of the 140,000 jobs (including healthcare and nonhealthcare jobs) that were lost due to the coronavirus disease 2019 (COVID-19) pandemic in December 2020, the net loss affected

Table 2 . Awards and Recognition: Recipients of Major Pharmacy Organization Honors by Gender[a]

Organization	Male	Female	% Female
American Society of Health-System Pharmacists			
President	15	15	50
Harvey A.K. Whitney Lecture Award	23	7	23
John W. Webb Lecture Award	26	5	16
Distinguished Leadership Award	15	7	32
William A. Zellmer Lecture Award	7	3	30
American Pharmacists Association			
President	26	7	21
Remington Honor Medal Award	26	6	19
Hugo H. Schaefer Award	28	3	10
Hubert H. Humphrey Award	26	3	10
Gloria Niemeyer Francke Leadership Mentor Award	12	14	54
Daniel B. Smith Practice Excellence Award	19	11	37
American Association of Colleges of Pharmacy			
President	17	12	41
Lifetime Achievement Award	2	1	33
Distinguished Teaching Scholar Award	5	5	50
Robert K. Chalmers Distinguished Pharmacy Educator Award	5	7	58
American College of Clinical Pharmacy			
President	20	10	33
Paul F. Parker Medal for Distinguished Service to the Profession of Pharmacy	15	3	17
Robert M. Elenbaas Service Award	11	1	8
Russell R. Miller Award	22	7	24
Clinical Practice Award	22	9	29
Education Award	20	11	35
New Clinical Practitioner Award	6	6	50
New Educator Award	4	8	67

[a]Based on currently available reported data on honors bestowed.

women exclusively; specifically, women lost 156,000 jobs while men gained 16,000.[42] As of September 2020, a staggering 865,000 women versus 216,000 men had left the workforce due to the COVID-19 pandemic.[42] The disproportionate impact on women, including working mothers, is highly visible. These numbers are expected to increase further as 1 in 4 women consider "downshifting" or leaving their career in light of new challenges brought forward by the pandemic.[43]

Further, funding mechanisms can dictate women having to choose between having a family and disadvantaging their career (eg, salary reductions, reduced productivity).[39] While inevitable that having new obligations (eg, children) would have some effect on productivity (even as transient as productivity loss during maternity leave), a workplace can enact policies that mitigate these effects, including (1) adequate parental leave for birth, (2) centralized or supported childcare systems, (3) dedicated time and space for breastfeeding and/or pumping during the workday, and (4) caregiver support for aging parents or other family members.[13] In the United States, 40% of the workforce, including both men and women, are not eligible for time off under the federal Family and Medical Leave Act (FMLA). Of additional concern is the impact on students and trainees, who may not be eligible for FMLA benefits. Notably, the FMLA does not provide paid leave.[44] In fact, the FMLA entitles eligible employees the opportunity to

take unpaid but job-protected leave for specified medical reasons, with continuation of group health insurance coverage. The employer must return the employee to the same job or one that is nearly identical/equivalent. Despite national legislation, discriminatory attitudes persist in healthcare: In one survey of orthopedic surgeons, 21% believed a woman's family responsibilities should not be accommodated in the surgical profession.[45] When flexible institutional policies for employees with children do exist, they are rarely utilized due to negative perceptions of personal or professional repercussions (eg, women's fear of being perceived as less committed to their career or concern over slowing career progression).[46] This perception differs from that in other developed countries such as Denmark and Sweden, which not only have guaranteed time off for birth but also often provide paid parental leave, shared between parents, reducing the bias against women as primary childcare providers.[44] Even within companies that do provide a physical location and resources for breastfeeding, discriminatory behaviors from colleagues can reduce willingness to breastfeed upon returning to work. In some states, companies with fewer than 10 employees are not required to provide a private space for lactation.

Subtle workplace behaviors such as scheduling work-related meetings or educational events after an assigned shift may intentionally or unintentionally exclude a primary caregiver. In the era of virtual professional meetings, the careful evaluation of scheduling for overall inclusiveness is warranted. For example, scheduling a virtual meeting after working hours, when caregivers are usually tending to the needs of the household, dinner time, and bedtime, will disadvantage the working caregiver. This type of scheduling was common in the last year as national and international organizations' meetings went virtual, spacing out the meeting over weeks instead of days. For many working moms, it is easier to take time off work and be present at home during the day than to extend the workday via meeting or conferencing into the evening hours, when childcare activities take priority.

Discrimination and harassment. *Discrimination and harassment in the workplace.* Settings where men dominate in leadership or other roles over subordinate women have a high rate of sexual harassment.[7] The greatest predictor of sexual harassment is the organizational culture. Contributors to a culture with harassment include a permissive climate, risks to those who may report the behavior, a lack of sanctions or repercussions against offenders, and a sense that such behavior will not be dealt with seriously. Options to influence the behavior of individuals and the culture begin with an awareness of local data and risk to vulnerable persons. Pharmacy settings where males are in leadership or other roles that involve supervision of women coworkers, employees, or students create a potential environment for harassment.

Women experience significantly higher rates of workplace harassment, including verbal and nonverbal behaviors that convey hostility and objectification.[47] The Physician Sexual Harassment Survey in 2017 found an incidence of workplace sexual harassment as high as 12% for females, compared to 4% for males.[48] Gender harassment is one type of many forms of harassment that exist within the healthcare profession and is reportedly the most frequent form of harassing behavior and may be sexual or nonsexual.[7] Examples would be a patient asking to talk to a male pharmacist who is working along with a female pharmacist instead of recognizing the woman as the person in charge. However, nonsexual gender harassment among coworkers also occurs not only when inappropriate comments about women are made, but also when it is assumed that the female employee will be responsible for coffee, parties, meals, or cleaning up a break area. It is notable that nonsexual harassment is the most common form, and many women try to ignore it or attempt to "laugh it off" to defuse the impact.

Unwanted sexual advances and sexual coercion/harassment are far more well publicized and reported to human resources personnel.[49,50] There are examples from medicine, surgery, and pharmacy. A 2020 systematic review and meta-analysis of orthopedic practices in the United Kingdom cited data indicating that 53% of female surgeons believed their chosen specialty to be sexist and discriminatory towards women.[45] Shillingburg and colleagues[51] reported that 52% of Hematology/Oncology Pharmacy Association members believed sexual harassment and its downstream effects of diminishing self-worth and confidence to be barriers to leadership development for women. Seventy percent of respondents experienced harassment themselves, and 31% identified other discriminatory behaviors (eg, work-life imbalance, women bullying other women) during pharmacy school, residency, or fellowship. Other data suggest that 50% of female pharmacists have experienced sexual harassment by patients, providers, or pharmacy colleagues.[52] Similarly, up to 81% of female medical students have experienced sexual harassment by patients.[52,53] A recent Pharmacy Podcast Network series entitled "Ending Sexual Harassment in Pharmacy" addressed the severity and timing of sexual harassment in pharmacy and illustrated that sexual harassment may occur at any point in a career.[54] Sexual harassment can occur at the student level, during postgraduate training, or even during an established leadership role.[54]

Rates of sexual harassment may be significantly underestimated due to lack of awareness, underreporting, or fear of retaliation.[20,55,56] In a survey of physicians, 15.2% of women reported filing a discrimination complaint, but of those individuals, 27.6% perceived worsened workplace conditions/retribution after filing the complaint.[57,58]

While much of the literature surrounding sexual and gender-based harassment has focused on female experiences, men also experience discrimination, especially in settings with high female-to-male ratios, such as a hospital.[59] According to recent literature, 9.8% of male faculty members reported having experienced gender bias;

however, this rate was nearly 6-fold lower than that for female faculty, who reported experiencing gender bias at a rate of 66.3%.[60] However, in one report, 41.9% of a sample of male medical residents (n = 92) reported that they had experienced some form of sexual harassment in the workplace.[61] Male physicians and trainees report comments on their physical appearance, relationship status, and being asked out on dates as the most common harassing behaviors encountered. Overt sexual behaviors or physical advances are less common.[59] In contrast to reports from women, sexual harassment or discrimination appeared to result in less emotional distress in men and were viewed mostly as unprofessional behavior.[59] Men who experienced sexual harassment often utilized humor, redirection, or enlistment of a chaperone as coping strategies to mitigate and respond to such behaviors.

It is important to recognize that coworkers may avoid speaking up to interrupt inappropriate behaviors as a component of the harassment culture. However, men were more likely to speak up against observed sexual harassment if it involved a trainee (eg, student or resident) as opposed to a colleague or staff member; in that latter case, escalation of the issue or defense of the harassed individual was more likely to be deferred.[62] Within the pharmacy profession, exploration of reasons why men are reluctant to defend an individual who encounters sexual harassment is warranted (eg, Are reporting mechanisms in our professional networks adequate? Is fear of personal repercussion more concerning?). Inaction may be viewed as condoning these inappropriate acts despite efforts of organizations to establish a zero-tolerance culture against sexual harassment.

Harassment of trainees. Given studies from other healthcare professions, harassment of trainees is likely present in pharmacy as well, as a recent report has indicated.[54] However, limited data are available regarding gender discrimination and sexual harassment in pharmacy education and training versus other healthcare disciplines. At the time of writing, when using the search terms *gender discrimination* and *medical education, surgical education*, or *nursing education*, a PubMed search returned 665, 140, and 148 results, respectively. When the term *nursing education* was replaced with *pharmacy education*, only 17 results were found. In medicine, female medical students perceive a high rate of gender mistreatment.[62] Responses to the Association of American Medical Colleges (AAMC) Graduation Questionnaire showed a higher prevalence of perceived unwanted sexual advances (6.8% vs 1.3%), sexist remarks (24.3% vs 3.4%), and lower evaluations or grades based on gender rather than performance (6.8% vs 4.6%) in women versus men.[63] A study conducted in 1997 by Nora and colleagues[64] found that 69% of a sample of women at 14 US medical schools (n = 512) had experienced sexual harassment and/or gender discrimination in an academic context. In a report on how harassment influenced medical students' choice of residency programs, almost 3 times as many women than men reported that these experiences influenced their choice of specialty (45.3% vs 16.4%).[65] In a 2018 survey of over 7,400 surgical residents, 19.9% of female respondents reported experiencing sexual harassment, while only 3.9% of male respondents reported similar experiences.[69] Both men and women are victims of gender harassment perpetrated by patients and their families, with women perceiving slightly higher rates of this mistreatment.[66] Compared to male medical trainees, female medical trainees have reported a higher prevalence of sexual harassment by attending physicians, ranging from 33% to 80%.[6,76,70] Although avenues for reporting exist, many trainees do not report inappropriate behaviors due to perceived lack of importance, perception that nothing will be done, or fear of reprisal.[69] This harassment has been correlated with more disruptions in coursework completion, greater reduction in overall health, and increased risk of substance abuse. This finding is supported by the strong negative relationship between female well-being and the occurrence of sexual harassment, as opposed to other stressors.[7,56]

In workplace settings, the usual avenue for reporting harassment lies with a human resources department or personel, confidential phone reporting mechanisms, and through trusted supervisors. Occasionally, the victim of harassment will need to seek assistance of equal-employment support groups in the government or locally. For students and employees involved with educational programs, there is protection against sexual discrimination and harassment through the Education Amendments of 1972 (Title IX).[70] Every US college and university is required to have Title IX policies and procedures in place in addition to a dedicated Title IX coordinator to investigate allegations of misconduct. Because policies are institution-specific, it is not within the scope of this review to evaluate specific Title IX policies; however, there exists a large gap in the process for handling interinstitutional Title IX violations, since most processes only address harassment or intimidation within a specific institution. There is a gap for reporting occurrences of external online harassment because Title IX only protects students and employees of educational programs. For example, a resident who is being harassed by a preceptor at another hospital would not have clear direction for a chain of reporting. For those unprotected by Title IX, a potential reporting mechanism is through the harasser's specific state board. Each field of healthcare (eg, medicine, pharmacy, nursing) has a state board responsible for maintaining documentation of licensure, continuing education requirements, and any disciplinary action. Other methods of redress include the local institution's human resources department, the federal Equal Employment Opportunity Commission, and relevant state and local agencies. However, as with Title IX, each state board has its own set of rules and regulations, including policies governing what types of complaints can be made and what actions can be taken. There is currently no database listing each state

board's stance on harassment or if action by a licensing board can be taken against a perpetrator of sexual harassment. Additionally, there is currently no guidance on how to file a complaint against an individual from another state.

Between 2016 and 2020, the pharmacy profession observed a 24.8% increase in pharmacy residency positions and a 28.5% increase in pharmacy residency applications.[74] Surveys of medical trainees reveal that women perceive an alarmingly higher rate of gender discrimination and sexual harassment than their male counterparts.[66,72,73] However, no such granular detail is available for postgraduate pharmacy education. The paucity of data is unlikely to be related to an absence of issues; rather, it is more likely to be related to underreporting or failure to collect the data. Trends in gender inequity and harassment in medical education are easily tracked due to the multiple national surveys conducted by medical organizations and accrediting bodies, such as AAMC. Although the American Association of Colleges of Pharmacy (AACP) does administer a survey to graduating students, this survey asks only whether pharmacy students know how to utilize policies related to harassment and discrimination.[74] In contrast, the AAMC survey explicitly asks how *often* medical students experienced instances of discrimination based on gender, race, sexual orientation, or other personal traits and beliefs.[78] As the accrediting organization for pharmacy residencies, ASHP created an annual survey for pharmacy residents in 2020, but the survey does not directly ask about harassment. The lack of data on frequency, location, and power dynamics of gender discrimination and sexual harassment in pharmacy training has created a foundational gap in our understanding of this potentially widespread issue and presents an opportunity for pharmacy organizations to routinely obtain these data from our trainees.

Interinstitutional harassment. Social media has become an invaluable networking tool in pharmacy, providing the ability to create and maintain relationships and collaborations beyond a local institution, and use of social media has increased over the last decade.[76] Social media platforms beneficially increase networking, education, and mentorship but also raise the risk of cyber harassment.[77] Most notably, the potential for anonymity and hidden personal characteristics may further increase bullying or harassment potential.[78] Winkleman and colleagues[79] found that among 293 women who used social media, approximately 20% repeatedly received unsolicited sexually obscene messages and/or sexual advances. Interestingly, 70% of women see online harassment as a major problem, as compared to just 54% of men.[80] Results of a 2020 Pew Research Center survey suggested that approximately 41% of adults in the United States have encountered some type of online harassment. Of those, 11% experienced online sexual harassment, an increase of 5 percentage points from 2017 data.[81] Women were more likely than men to experience more severe forms of online harassment, including sexual harassment (16% vs 5%) and even stalking (13% vs 9%), while more men reported name-calling (35% vs 26%) and physical threats (16% vs 11%). Even though women experience more concerning forms of online harassment, men are more likely to report an incident (43% vs 38%).[81] One of the first studies addressing online harassment of healthcare workers demonstrated that nearly a quarter of US physicians have experienced some form of online harassment, with 17% of female physicians experiencing sexual harassment.[82] Data on the prevalence of online harassment in other healthcare disciplines are needed.

In addition to online harassment via social media, another potential avenue for interinstitutional sexual harassment is through professional society meetings and committee involvement. Local, state, and/or national meetings allow members to connect with others who have similar career and research interests. Frequently, this networking leads to mentorship, collaboration on projects and manuscripts, and potential employment opportunities, but it can also lead to power imbalance, intimidation, and harassment. Although most professional organizations have sexual harassment policies, they often require the recipient to initiate a complaint with the Title IX coordinator of their specific institution. This action may not be feasible if the harasser is employed by a different institution. Additionally, each organization's policies and procedures differ. Collaborating with other victims and producing tangible evidence can be challenging. Unless there is a witness, verbal and physical harassment often leave no tangible evidence. Moreover, some social media platforms do not archive messages, so any allegations of harassment on those platforms become hearsay unless the recipient captures screen images. Another challenge is that most professional organizations do not have defined mechanisms to report and share harassment allegations or convictions. The implication is that the process would need to be repeated with every organization where harassment occurred. The current process inadvertently protects the harasser while placing high workload and stress on the victim.

Although data regarding the exact incidence of interinstitutional harassment are lacking, the previously mentioned Pharmacy Podcast Network series included an episode in which 4 female pharmacists described their personal experiences with interinstitutional online and social media sexual harassment.[54] In this episode, all the women emphasized the difficulty and lack of means of reporting an individual from another institution. This type of scenario emphasizes a gap in information sharing known as "passing the trash."[83] The phrase "passing the trash" refers specifically to enabling elementary school teachers to pursue another job after being fired for sexual abuse allegations but is oftentimes what happens to college or postgraduate professors who are accused or found guilty of sexual harassment.[83] Administrations may fear legal liability and ruined reputations if they were to reveal the truth surrounding the termination. This allows sexual predators to pursue positions in other school districts with no

public record of the sexual abuse or misconduct. The Every Student Succeeds Act, signed by President Obama in 2015, requires school personnel to report any incidents of sexual misconduct. Despite this, lack of widespread implementation, plans for evaluation, and actual liability for schools who fail to comply have led to the continued practice of passing the trash.[83] Similarly, for various reasons, institutions of higher education rarely disclose information surrounding issues of sexual misconduct following termination, which permits the terminated harasser to obtain employment opportunities at other institutions.

Female bullying. The role of woman-on-woman bullying is also noteworthy. In a 2018 report, the ACCP president described a theme in member stories of workplace discrimination whereby "some women discriminate against women more often and with more impact than their male counterparts."[84] In a recent study of science, technology, engineering, and math graduates, working in a sector in which women were negatively stereotyped (even if the sector was female dominated) was recognized as one of the strongest predictors of gender identity threat. This threat was negatively associated with work engagement and career confidence.[85]

Intersectionality of harassment. Intersectional harassment is defined as harassment that is committed on the basis of multiple factors. Research has shown that African American or Hispanic women, for instance, are subject to a greater rate of sexual harassment (62%) than Caucasian (56%) or Asian/East Indian (46%) women, presumably due to their marginalized racial and gender identities.[86-88] These results were consistent with reports that women of ethnic minority groups experience sexual harassment more often than White women.[89] While we consider the intersectionality of race and other variables that influence the incidence of harassment, we must also consider the influence of the victims' perceptions. Among a group of 105 Black women who reported sexual harassment, cross-racial harassment was perceived more negatively than intraracial harassment, despite no differences in the likelihood of harassment, unwanted sexual attention, or coercion.[90] Furthermore, cross-racial harassment is more likely to include racialized sexual harassment and to be perpetrated by individuals with a higher professional status.

Other challenges for minority professionals also exist. At present, the majority of first professional degrees conferred in 2019 were to White Americans (55.6%), followed by Asian Americans (28.6%), but only 9.4% of such degrees went to African Americans and 6.4% to Hispanic Americans.[14] Among working women in the United States, 42% report having faced gender discrimination on the job, with a higher reported prevalence among minority or ethnic groups (54% of African American women vs 40% of White women).[35]

Harassment of sexual and gender minorities. Added considerations in gauging the scope of harassment beyond biological or assigned sex are those of sexual orientation and gender identity. According to the Joint Commission, challenges reported by LGBTQ+ (lesbian, gay, bisexual, transgender, queer or questioning) employees include pressure to conceal LGBTQ+ status, harassment, ostracism, lack of mentors and role models, denial of promotions and pay raises, use of incorrect pronouns, and restrictions on bathroom use.[91] Challenges are compounded for LGBTQ+ workers of color, who experience lack of mentorship, hiring bias, and on-the-job discrimination.[92] Pursuant to a landmark US Supreme Court ruling in 2020, Title VII prohibits discrimination by employers based on sexual orientation or gender identity; however, inequity regarding availability of bathrooms for transgender people and restrictive employee benefits.[93] The Joint Commission recommends hospitals create robust LGBTQ-inclusive nondiscrimination policies; however, in 2020 the Human Rights Campaign (HRC) determined only 63% of hospitals incorporated LGBTQ-inclusive language within published employment nondiscrimination statements.[91,94]

A 2018 study by HRC reported that 46% of LGBTQ employees conceal their LGBTQ status at work, primarily due to concerns for being stereotyped, making others uncomfortable, or losing connections with coworkers.[94] That figure represents only an 8% improvement from an incidence of 50% in 2008, indicating the workplace environment has not significantly improved for LGBTQ individuals.[95] More than half of LGBTQ workers reported hearing jokes about sexual orientation at work, and 18% reported receiving sexually inappropriate comments; however, the top reasons LGBTQ workers do not report negative comments in the workplace is that they believe nothing would be done and it would damage relationships with coworkers.[94]

There are limited published data on the prevalence of LGBTQ+ individuals within the profession of pharmacy; however, some extrapolation can be made from data from our colleagues in medicine. In a recent publication, 5.4% of surveyed medical students were self-designated as lesbian, gay, or bisexual (LGB). A greater proportion of LGB students experience humiliation, mistreatment specific to identity, and mistreatment not specific to identity (27%, 17%, and 11%, respectively). LGB students had an 8-fold higher predicted probability of burnout when compared to their heterosexual colleagues.[96] In a separate survey of medical students, 15.8% identified as members of a sexual and gender minority. Of these minorities, 60% reported concealing their gender identity. The fear of discrimination in medical school and lack of support were common rationales for concealment (42.9% each).[97] In a survey of transgender women, men, and nonbinary participants, 78% reported censoring their speech and mannerisms at least half of the time they were at work or school, and 69% reported hearing derogatory comments about transgender and gender nonbinary individuals in medical school or in residency.[98]

Steps to equity. *The role of mentors and sponsors.* Mentorship should be prominent in a strategy to foster

professional advancement of women in pharmacy and a deliberate purview on behalf of all individuals.[99] Development and maximization of both formal and informal mentorship programs can support women in professional advancement. Further, the term *sponsorship* (ie, advocacy on behalf of a high-potential junior person by senior leaders that is critical for the career advancement of young professionals) is vital.[100] Sponsorship goes beyond the traditional bounds of a mentor's advisory role and involves recommendations of protégés for high-profile opportunities. While there is little published data describing a sponsorship role in pharmacy practice, studies of mentorship in pharmacy have demonstrated mentor influence on personal development, career guidance, career choice, and research productivity.[101]

Consistent data support the absence of female mentors as a negative factor for trainee entry into and retention within a profession.[102] A study evaluating positive effects of female mentors early in college demonstrated that female students with female mentors maintained a feeling of belonging in the profession, self-efficacy, motivation, and retention, while male mentorship of female students or no mentorship had the opposite or no effect.[103] Notably, 100% of female trainees with a female mentor remained in engineering, compared to just 82% with a male mentor and 89% without a mentor. Benefits of female mentorship in health academics include career and personal development as well as job proficiency and satisfaction. Women prefer mentors within the same department, with similar interests and backgrounds. While findings on women's mentor gender preferences have varied among studies, several studies have indicated the benefit of female mentors in providing guidance on work-life balance.[104]

As the number of women in pharmacy increases and the role of pharmacists evolves, there is a need for strong mentorship throughout a career. A lack of role models may negatively impact leadership mentality among women.[34] Several pharmacy organizations have mentor-mentee programs, but there are limited published data on the objective value and impact of these programs. Men can also advocate for the advancement of women into pharmacy leadership roles. Given the disproportionate apportionment of leadership roles favoring men in pharmacy, they may frequently serve as mentors for female trainees and junior practitioners. Like female mentors, male mentors can be supportive simply by establishing a safe environment and identifying opportunities for sponsorship.[105]

Role of healthcare organizations. While powerful statements by pharmacy organizations decrying sexual harassment have been released and educational programs have been launched, it will take a consistent focus to curb discriminatory behaviors.[7-10] WHO established the Gender Equity Hub (GEH) in 2017 with the goal to strengthen gender-transformative policy guidance and implementation capacity for overcoming gender biases and inequalities in the global health and social workforce.[106] Key findings were grouped into 4 themes: occupational segregation, leadership, decent work (including discrimination, sexual harassment, and bias), and gender pay gap. The GEH literature review of gender and equity in the global health workforce is greatly generalizable to pharmacy practice. The key recommendations that must be considered by future pharmacy organizational efforts include (1) change of the narrative to include women as drivers of global health, (2) adoption of gender-transformative policies to challenge the underlying causes of inequity, and (3) refocusing research to include a gender and intersectionality lens.[106]

The US National Academy of Sciences, Engineering and Medicine recently published a report entitled "Sexual Harassment of Women: Climate, Culture, and Consequence in Academic Science, Engineering, and Medicine," which provides recommendations for system-wide changes to the culture and climate of higher education to prevent and effectively address all forms of sexual harassment.[107] This report, citing male-dominated gender ratios in leadership and an organizational climate that communicates tolerance of sexual harassment as the characteristics most closely associated with harassment, contains recommendations directly applicable to pharmacy practice. We encourage national pharmacy organizations, hospital administrators, and pharmacy leaders in academia to evaluate their own organizational diversity, equity, and inclusion (DEI) climate and use the recommendations outlined by the aforementioned authors and organizations to advocate for gender-affirming policy and action.

A call to action in recent years has minimized the frequency of all-male scientific panels, sardonically referred to as "manels." The National Institutes of Health director, Francis S. Collins, MD, PhD, recently released a communication entitled "Time to End the Manel Tradition" that challenges scientific leaders to refuse to participate in manels and encourages recusal to allow the addition of women and other underrepresented groups.[108] These actions force reconciliation with biases and provide a more even playing field across gender and racial/ethnic groups.

The role of pharmacy organizations. Progress in gender equity is evident within some aspects of clinical pharmacy, with several organizations making progressive strides towards impartiality. For example, within ACCP women currently hold 56% of positions at the director level or higher and 65% of all chair positions and have held 55% of all ACCP committee chair positions over the past 5 years.[109] ACCP has purposed a plan that will promote the advancement of women in leadership positions across the profession. Likewise, 10 (71%) of the 14 members of the ASHP board of directors are female, and 60% of ASHP presidents over the last decade have been female, while the recently formed ASHP Task Force on Racial Diversity, Equity, and Inclusion aims to take inventory and enhance diversity and inclusion across governance and committees; education and training, research, and publications; and advocacy, marketing,

and communications.[11] The first task force report provides specific recommendations and deliberate actions not only for ASHP but also for residency programs, colleges of pharmacy, health systems, and hospitals. Additionally, ASHP's Women in Pharmacy Leadership initiative recognizes the unique barriers and challenges facing women and aims to enhance women leaders within the profession. Similarly, the International Pharmaceutical Federation has formed a Women in Science and Education initiative focused on raising awareness and building a community for gender equity and empowerment of women.[110]

One opportunity for national pharmacy organizations is to force member accountability for inappropriate behaviors. While a professional organization may have its leadership or members sign a statement pledging to maintain professional behavior, accountability and monitoring of these behaviors is an ongoing challenge. In the case of a pharmacist exhibiting unprofessional behavior within the realm of organizational activities, a victim would have little recourse and likely no existing mechanism to lodge a complaint or express concerns.[111] Pharmacy organizations have an unmet opportunity to give a voice to members who feel they have been victimized in some way during a professional meeting or participation in organizational activities. Recently approved ASHP policies, including a "Zero Tolerance of Harassment, Discrimination, and Malicious Behaviors" statement and ASHP Participant Code of Conduct are examples of initiatives dedicated to these efforts.[112] Organizations now must provide recourse or penalties for unacceptable actions or behavior of members.

While federal, state, and local employment-related antidiscrimination laws are the primary legal means of protection from harassment and discrimination for individuals, pharmacy residency policies are a structural tool to provide protections from issues of harassment and discrimination for individuals in postgraduate training. All residents should be oriented to the process of filing a complaint within their site. However, residents are in a position of significant dependence and would understandably hesitate to initiate an action against a preceptor or program director upon whom they may depend for a future recommendation. Thus, residents may be unlikely to report specific issues, especially during their training period. Since a program director is generally appointed by the director of pharmacy, that individual is responsible for the character of their residency program directors, coordinators, and other preceptors. While accreditation requests list scholarly contributions and accomplishments, consideration could be given to adding a signed statement of character and an affidavit affirming the professionalism of the program director. Issues of harassment and well-being of the resident(s) are discussed during pharmacy residency accreditation visits, but visits are too infrequent to detect a systemic and persistent issue. Further, the accreditation standards do not currently include a requirement for specific training in DEI.[113] A survey of residents regarding their current awareness of DEI issues, whether they have received specific education, and whether they have been the victim of discrimination or harassment of any kind could be revealing.

The pharmacy residency accrediting body, ASHP, has a mechanism for residents to report noncompliance with an accreditation requirement if they have been unable to resolve it with their program director and/or through filing a formal grievance at the next level (eg, director of pharmacy, school administrator, or human resources department). There is an opportunity here for residency program accreditors to identify any episodes of bias and harassment as an unbiased governing body of residency programs during the residency program evaluation process. While we acknowledge that ASHP is not an investigatory body and does not have the legal authority to investigate or prosecute allegations of sexual harassment, a statement condemning harassment in residency standards would be a powerful action towards progress in the protection of pharmacy residents.[114] Similarly, ACPE and AACP should be called upon to address and condemn sexual harassment occurrences involving pharmacy students.

There are other opportunities for professional organizations to address gender inequity and enhance DEI, including the process for appointments to committees and choice of speakers for major meetings. A proactive effort to identify and engage participation from a diverse group of members will enhance leadership development and promote a pathway to greater involvement. This effort can start with ensuring the membership database is robust enough to include vital information on gender as well as race and ethnicity. Beyond that, the culture in the organization must adapt to be more inclusive and recognize failure in that effort.[115,116] Organizations can set objective goals for participation of women and underrepresented groups in committees and programming and hold themselves accountable to improve. Transparent reporting of these statistics will also indicate the level of commitment to diversity goals.

Call to action. Gender inequity and sexual harassment are pervasive across institutions and organizations in pharmacy.[117] While early strides have been made, rectifying this deficiency requires widespread awareness, thoughtful planning, and deliberate action.[7-10] Here, we outline concrete steps as part of a comprehensive plan that can bring this issue to the forefront and improve our profession for the generations to come.

Organizational actions. Recommendations are developed around 3 core areas: (1) building national infrastructure that promotes diversity and gender equity, (2) scoping the problem and establishing a baseline with plans for improvement, (3) developing organizational initiatives to promote diversity in leadership and recognition. Further, supporting education initiatives and ongoing process improvement will be instrumental to effect change.

The first step is the creation of a national pharmacy "Diversity Taskforce"

with a focus on gender equity, comprised of key stakeholders from multiple organizations (similar to the Joint Commission of Pharmacy Practitioners), to oversee the realization of these initiatives. This taskforce would be responsible for the publication and subsequent enactment of an action plan to address equity within the profession. This plan would include recommendations for colleges of pharmacy, postgraduate training programs, and professional societies. To support this action plan, complete characterization of the scope of gender inequity and sexual harassment in the profession is recommended. These data would be foundational to ensuring a comprehensive action plan and will provide a metrics-oriented baseline for future comparison of initiatives.

Within this published action plan, the creation of a national resource center specific to gender bias and sexual harassment by the proposed Diversity Taskforce is recommended. The resource center, such as a website, would house items such as publications, archived webinars, surveys, case studies, sample policies, and guidance on how to report a grievance, serving as the central repository of tools and resources for the pharmacy community. Organizations are encouraged to develop their own transparent reporting system and grievance processes. This type of reporting would transcend institutional barriers and foster professional accountability. The aim of this process is to inform organizational leaderships of potentially problematic behaviors that jeopardize an organization's ability to fulfill its mission (due to the mistreatment of its members) and the creation of a structured investigation and disciplinary process. Proposed considerations for an organizational reporting system and grievance process are provided in Table 3.

At its core, this action plan will be aimed at the development of an organization's individual members. Within professional societies, specific initiatives aimed at the advancement and recognition of a diverse membership are recommended. Two primary focuses will be fostering diversity in leadership positions and national recognitions (eg, awards, speaking opportunities, committee leadership service). The first step will be an inventory of the organization's current membership to create thoughtful goals and associated development plans for improving representation and engagement of women, with additional consideration for inclusion of women of color and LGBTQ representation. This information should be shared with the Diversity Taskforce to foster information sharing across organizations. Next, designing proactive strategies to identify potential female leaders starting early in their careers and cultivate them through purposeful committee appointments is recommended. These processes would support female membership through diverse mentorship and sponsorship to create avenues for advancement. These strategies should also address specific barriers faced by female members, such as maternity leave and childcare, and ensure that these barriers are sufficiently mitigated within requirements for leadership opportunities. Performance of a gap analysis and evaluation of award descriptions and criteria for national honors, invitations for national conference speaking engagements, and grant awards can ensure transparency and lack of gender or other bias. Notably, processes dedicated to thoroughly reviewing candidates nominated for national awards can ensure that character evaluations are involved in the nomination and selection processes. The review and recall of awards granted to those individuals who have engaged in reproachful behavior (eg, sexual harassment) may be advisable. Table 4 provides further details.

Local actions. In academia, verbalization from leadership members should aim to undo misconceptions on flexible policy use and promote employee well-being. Additionally, promotion and tenure should be approached in a similar fashion irrespective of leave utilization. Healthcare organizations should aspire to be more progressive in offering benefits that resonate with caregivers, such as extended maternity or paternity leave, childcare credits, and telework, to allow more flexibility and enable sustainability with family and other personal commitments. Similarly, colleges of pharmacy should be considerate of familial obligations of student pharmacists by offering flexibility in coursework and rotation selection. Students supporting families may benefit if they can attend class virtually so that they can simultaneously help with childcare, if meetings are restricted to traditional business hours, and if they have the option to select rotation sites closer to home. Mitigation strategies should be developed to identify both conscious and unconscious biases within the workplace and seek to avoid the downstream impact of a woman's absence from key events, which can potentially preclude future opportunities or promotion. For student pharmacists, mitigation strategies may involve colleges of pharmacy actively soliciting information to assess discriminatory experiences among learners via anonymous or optional-disclosure surveys or rotation evaluations. Colleges of pharmacy can support student pharmacists by designating faculty or staff members to provide Title IX resources upon request and at regular, unsolicited intervals to ensure availability of the information. Importantly, understanding the full scope of the problem will require critical observation and self-reflection regarding the institutional norms and culture it has created. Only then can targeted steps be implemented to drive sustainable progress on a local level.

This call to action is summarized in Figure 1. A commitment by organizational leaderships to provide sustainable oversight to address gender inequity and sexual harassment is essential to effect real change, and this commitment should start immediately. Notably, once an organization implements these initiatives, a comprehensive commitment is needed for continuous improvement. Data-driven evaluations of initiatives, with transparent reporting, should be routine. Educational programs provided by experts on gender inequity and sexual harassment should be included as required components of professional development.

Table 3. Recommendations for Developing an Organizational Reporting System and Grievance Process Related to Gender Bias and Sexual Harassment

Step	Questions to Ask and Items to Consider
Define the intent and scope of the grievance process	• Who is able to utilize the grievance process (eg, certain membership categories, organization employees, vendors, donors, etc)? • How will your organization define (and illustrate with examples) gender bias and sexual harassment? • Will your process pertain solely to issues arising within the immediate context of your organization's business (eg, harassing behavior that occurs during a conference hosted by your organization), or will you consider conduct that occurs outside of the organization but is still relevant to your organization's business (eg, harassing behavior in the context of a person's professional work related to candidacy as a member of your organization's board of directors)? • What are the things that fall outside of the scope of the process?
Structure the grievance process	• How will your organization receive the grievance (eg, in writing, via a third-party website, etc)? • What are all of the points of information you will require a person(s) provide in their report before the process can be initiated? • Once received, who is to be notified of the grievance within your organization? • Who within your organization will be responsible for reviewing and deliberating on the grievance, and how will you ensure both their subject matter competency and independence from all involved parties as well as the organization's leadership? • Who will be involved in the review process from outside of your organization (eg, legal counsel, etc) • What tool(s) will your organization utilize to review grievances (eg, a rubric the organization develops, an external evaluation, etc)? • What disciplinary actions (give examples) will the organization consider/render if a party is deemed to have exhibited conduct that constitutes bias or is harassing? • How will you notify all of the parties once a determination is made, and how will you follow through on recommendations and subsequent actions? • How will you afford the person(s) named in the grievance adequate opportunity to respond to allegations as well as any disciplinary action? • What timeframe will you establish to complete each step of the grievance process once initiated? • How will you ensure that the rights of all parties are maintained (eg, confidentiality, fairness, etc)? • How will you ensure a zero-tolerance policy for retaliation towards all parties involved? • What resources, including money and personnel, will be necessary for your organization to implement and support a grievance process that is timely, rigorous, and fair?
Develop a statement of rights as part of the grievance process	• How will you define the environment members and stakeholders can expect within your organization? • Are there any other rights a person should expect (eg, right to due process and fair procedures, zero tolerance for retaliation, etc)? • Who is entitled to these rights (eg, only members, vendors, sponsors, etc)? • How often will you review your statement? • How will you ensure the statement is easily and widely available to members and stakeholders? • Who will be listed as the contact person (including contact information) for questions or comments?
Commit to continuous quality improvement	• Solicit feedback on the grievance process from all parties involved, including the targeted person(s), alleged harasser(s), named witnesses, and process reviewers. • At regularly scheduled times (consider after every grievance is completed), make necessary changes within the organization to strengthen the grievance process, update general operations across the organization, and revise all associated materials (eg, policies and procedures, statement of rights, member code of conduct, etc) to mitigate future risks. • Allot time, resources, and money to educating and training volunteer leadership members (eg, board members, committee chairs, etc) and organization employees on the grievance process at regular intervals (eg, during orientation programs, etc).

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Table 3. Recommendations for Developing an Organizational Reporting System and Grievance Process Related to Gender Bias and Sexual Harassment

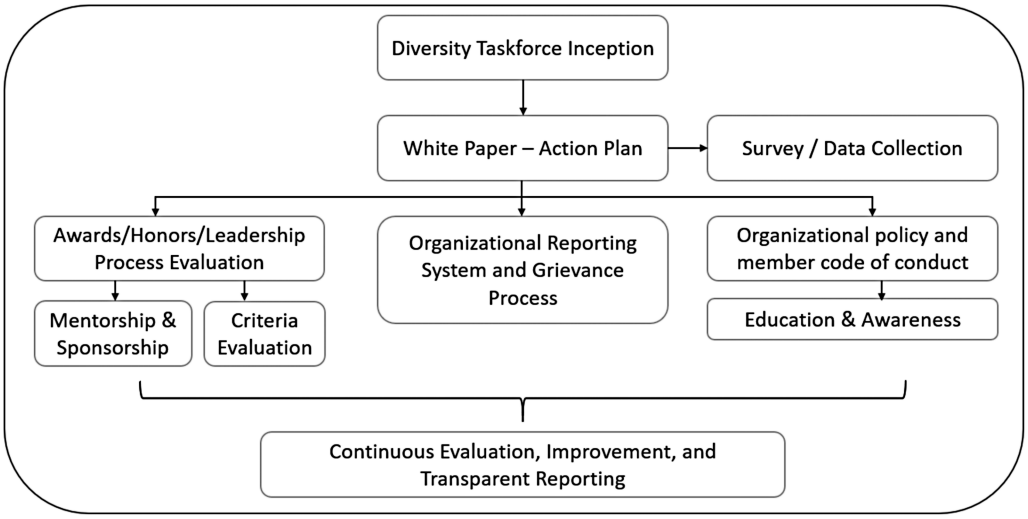
Step	Questions to Ask and Items to Consider
	• Communicate the availability of your organization's grievance process to all stakeholders routinely (eg, at the time of membership renewals, at the time vendor contracts are signed, etc). • Develop a method to educate members and stakeholders on the grievance process (eg, on-demand webinar available on your organization's publicly accessible website, etc). • Designate someone responsible for remaining up-to-date in current trends, best practices, and legalities related to gender bias and sexual harassment.
Explore and evaluate future considerations	• Can information be shared across professional organizations (eg, development of a national reporting system), and if so, how? • Can information be shared with or by employers, and if so, how? • What role, if any, do state boards of pharmacy and credentialing boards have? • What role, if any, does restorative justice have in rebuilding a community of trust among victims, bystanders, and stakeholders?

Table 4. Recommended Actionable Organizational Changes to Increase Gender Equity in Pharmacy

Action	Steps for Completion
Acknowledge and rectify the lack of gender equity in leadership and create processes to support female membership through diverse mentorship, with the inclusion of senior male and female mentors, and sponsorship.	a. Inventory the current membership of professional organizations and ensure that the leadership roles held by women are proportionate to the number of women members. Furthermore, these data should be made publicly available to the organization's membership in the context of annual yearly reports or published in the organization's journal. b. Enable content sharing among organizations that have developed successful mentorship programs, with an emphasis on the development of transparent criteria for the selection of mentors and the extensive character vetting of interested mentors. c. Advocate for female leadership advancement opportunities for faculty, practitioners, residents, etc. d. Provide specific training for women that addresses barriers commonly encountered in leadership opportunities.
Develop equitable, transparent, and just criteria to increase the number of women pharmacists who receive national honors, invitations for national conference speaking engagements, and award grants.	a. Review current organizational nomination criteria and ensure that the requirements are clearly stated and provide women with both a viable and equal opportunity to attain the pursued honor. b. Perform a gap analysis of current presenter nominations, grantsmanship, and promotion processes as they pertain to equity matters. c. Enact formal and transparent action to rectify identified inequities.
Form specific task forces dedicated to extensively reviewing those individuals who are nominated for national honors/awards.	a. Select and appoint awards committee leaders to make sure they represent equity, ensuring that character evaluations and character attestation is provided in the awardee nomination and selection processes. b. Implement formal policy and procedure development with competency training and processes for executive committee, awards committee, and board committee appointments. c. Create protocols, such as those supported by ASHP and ACCP, that call for the review and/or recall of awards to individuals formally found to have engaged in illegal behavior (eg, sexual harassment).
Provide best practice statements for pharmacy schools to address gender inequalities.	a. Review recruitment, promotion criteria, and compensation scales periodically, with monitoring to ensure fairness. b. Require training courses in explicit and implicit gender bias. c. Provide symposiums and workshops to (1) include special interest groups and sections dedicated to women's issues within the pharmacy profession; (2) offer mentorship, sponsorship, and other career development programs; and (3) promote policies supporting work-life balance.

Abbreviation: ACCP, American College of Clinical Pharmacy.

Figure 1. Steps toward gender equity.



Conclusion. Major groundwork is needed to promote gender equity more effectively within pharmacy, but this work is essential to ensuring future sustained infrastructure. Gender inequity and sexual harassment are pervasive in our society, in the medical community, and in the pharmacy profession. The potential benefits of gender equity are vast, including patient satisfaction, economic benefit, and the cultivation of innovation, diversity, and a unified profession.[1] Women in pharmacy have started the discussion using online platforms and professional networks, but the drivers of continued change will be through organizational leadership and awareness and advocacy of individual pharmacists.

Disclosures

Dr. Newsome has received research funding through the National Center for Advancing Translational Sciences (NCATS) of the National Institutes of Health (NIH) under award numbers UL1TR002378 and KL2TR002381. Dr. Jacobi is a consultant for Pfizer Hospital Products Division and La Jolla Pharmaceuticals. Dr. Koontz has served on a speakers bureau of Servier Pharmaceuticals LLC and received consulting fees from Accord Healthcare and Servier Pharmaceuticals LLC. The other authors have declared no potential conflicts of interest.

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