Gender Disparities in Oncology: A Report From Four Countries in Latin America

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ABSTRACT

PURPOSE Women represent a growing force in oncology but remain underrepresented in high-level positions. Gender-related challenges affect academic progression, research, and clinical practice. This manuscript aims to describes gender-based professional development challenges faced by women in oncology in Latin America (LATAM).

MATERIALS AND METHODS We conducted a multicenter, cross-sectional study among LATAM oncologists using a 27-item questionnaire on the basis of the European Society for Medical Oncology Women for Oncology Survey. Our analysis focused on male-female disparities, excluding other gender identities. Logistic regression models were used to calculated odds ratios (ORs) for gender inequity, wage disparity, workplace and sexual harassment, and family development. Statistical analyses were performed using SPSS version 26, with the significance set at $P < .05$.

RESULTS We analyzed 254 participants from Argentina, Chile, Mexico, and Peru, mostly females (88%) and based in Mexico (55%). Most were attending physicians (68%), 51.5% worked 41-60 hours, and 33.4% reported gender equity initiatives. Gender inequity was significantly higher among women (83%) than among men (37%), with the female gender identified as a risk factor (OR, 15.67; $P < .001$). Workplace harassment was reported by 60% of women and 19% of men, whereas sexual harassment was experienced by 34% of women and 16% of men (OR, 2.78; $P < .05$). Sixty-five percent reported that men had the highest salaries. Logistic regression indicated that working 20-40 hours per week was associated with the likelihood of women having children (OR, 3.0; $P < .01$), as was working 41-60 hours (OR, 1.97; $P < .01$). However, holding an attending or resident position was associated with significantly lower childbearing rates

CONCLUSION Our findings indicate that Women oncologists in LATAM report experiencing higher rates of gender-based inequity and harassment and remain underrepresented in leadership and high-earning roles.

ACCOMPANYING CONTENT

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INTRODUCTION

Women are increasingly becoming a significant force in medicine, with their proportion rising from 26% in 2004 to 38% in 2022.[1] This trend extends across all medical subspecialties, with female faculty members increasing from 38% to 45%.[2] This upward trajectory is expected to continue, as women now constitute the majority of applicants and graduates at medical schools.[3] The proportion of female professionals in oncology is also on the rise. In the United States, women represented 22% of oncology/hematology specialists, increasing to 36% by 2022.[2] Similarly, European data show a greater annual increase in female oncologists compared with their male counterparts, with membership of the European Society for Medical Oncology (ESMO) among women growing from 24.9% in 2004 to 47.5% in 2019.[4,5]

However, gender-related challenges persist in oncology, mirroring the broader issues in the medical field. Women often face significant disparities in their employment opportunities, remuneration, and leadership roles. The gender wage gap in health care is substantial, with women earning 26% less than men, and this difference is even more significant (35%) among women from racial or ethnic minorities. These gender-related challenges affect academic progression, professional careers, research, publication, clinical practice, and health. In oncology, gender discrepancies are evident in authorship of scientific publications, with women being less likely to be senior authors, invited as

CONTEXT

Key Objective

Are there gender disparities regarding professional development, workplace harassment, and work-life balance in the field of oncology across Argentina, Chile, Mexico, and Peru?

Knowledge Generated

To our knowledge, this is the first study to highlight these disparities in Latin America. Our findings show that women are significantly more likely than men to report gender inequity, with up to 83% compared with 37%, as well as workplace harassment, with 60% of women experiencing harassment and 34% reporting sexual harassment, versus only 19% of male participants. Furthermore, women face challenges in family planning, with longer work hours negatively affecting the likelihood of having children, especially among attending physicians, residents, and fellows.

Relevance

This study provides valuable insights into the gender gap in Latin American oncology, emphasizing the need for policies that address gender inequities and support a better work-life balance for female oncologists.

peer reviewers, full professors, or board members of international and national oncology societies.[5,6] Gender biases also affect the presentation of research findings at international conferences, where women are underrepresented in both presenting studies and invited talks.[7] Additionally, workplace violence, including physical aggression, harassment, bullying, and mobbing, remains a significant issue.[8]

Wage disparities and the underrepresentation of women in leadership roles are prominent issues in Latin America (LATAM), where women represent only 26.32% of oncology societies' board members.[9] The Women for Oncology (W4O) Latin America (LA) group was created to address these issues, inspired by ESMO's W4O initiative.[10] This regional intergroup aims to promote equal professional development opportunities for female oncologists and raise awareness of gender inequity in LATAM.

This study focuses on male-female disparities, a decision informed by the composition of our sample and the design of our survey instrument. Although we acknowledge the existence of other gender identities, our analysis was limited to male and female respondents because of their predominance in the data and specific objectives of our research.

In this manuscript, we aim to describe gender-based professional development challenges in Oncology in LATAM. Addressing these issues is crucial for advancing gender equity in the medical field and ensuring that all health care professionals can fully realize their potential.

MATERIALS AND METHODS

We conducted a multicenter, cross-sectional predictive correlational study and developed a 27-item questionnaire on the basis of the ESMO W4O Committee survey.[10] The questionnaire comprises six sections: demographic characteristics, workplace environment, gender inequity, wage disparity, workplace and sexual harassment, and family development (Data Supplement, Fig S1). We distributed the survey online between March 1, 2022, and May 31, 2022, using a nonprobabilistic convenience sampling method. Recruitment was conducted by professional oncology societies, research networks, and direct outreach.

The methodology adopted in this study was tailored to examine the disparities between male and female respondents. Given the sample composition and constraints of the survey instrument, the analysis exclusively compared the two groups. We recognize other gender identities and appreciate their importance; however, they were not included in the statistical analysis to maintain the clarity and robustness of our findings.

To ensure clarity in the assessment of workplace and sexual harassment, we adopted definitions on the basis of established frameworks.[11] Workplace harassment refer to any unwelcome conduct, whether verbal, physical, or psychological, that creates a hostile or intimidating work environment. This includes behaviors such as bullying, exclusion, intimidation, or undermining professional credibility. Meanwhile, sexual harassment was defined as unwanted sexual comments, advances, or coercion, which may include inappropriate remarks, physical advances, or quid pro quo situations where professional opportunities are contingent on compliance with inappropriate requests. These definitions were explicitly included in the survey to ensure the participants' understanding and consistency in their responses.

The participants were oncology health care professionals from Argentina, Chile, Mexico, and Peru, covering all sex and age groups. The countries were chosen on the basis of existing research collaborations and the feasibility of the

data collection. Because of the minimal risk of the study and anonymity of the participants, IRB approval was deemed unnecessary.

Demographic data were analyzed using descriptive statistics including ranges and percentages. Logistic regression models were used to calculate the odds ratios (ORs) for sex-related analysis. The predictors included gender inequity, number of offspring, perception of the pay gap, and workplace and sexual harassment. A separate model used "having offspring" as the dependent variable for women, with predictors being weekly work hours and job position. We presented the ORs to aid in the interpretation of the results, with a significance level of $P < .05$. All statistical analyses were performed using the SPSS software version 26.

RESULTS

Demographic Characteristics

The estimated response rate was approximately 30% on the basis of the total number of invitations sent. Our analysis included 254 participants from Argentina, Chile, Mexico, and Peru. The majority were female (88%), based in Mexico (55%), age between 30 and 39 years (49%), and 82% (209) were medical oncologists.

Furthermore, 44% were single and 136 participants had offspring (53%). As per their current academic position, 174 held an attending position (68%), 40 were residents/fellows (15.7%) at the time of the survey, and the remaining participants were primarily involved in research roles. The majority (51.5%) worked between 41 and 60 hours per week. Finally, when assessing the availability of initiatives that support gender equity in the workplace, only 85 (33.4%) reported having any available. Table 1 presents the baseline characteristics of the study. We observed differences in the baseline characteristics of the cohort. Peru had the highest proportion of male participants, with 16 of 48 responders from that country. Additionally, we noted that the proportion of male participants with offspring was significantly higher than that of female, with 22 (72%) male and 113 (51%) female responders. Furthermore, the number of children differed between male and female participants, with women having an OR of 0.09 and 0.088 for having three or four or more children, respectively ($P < .05$).

Gender Inequity

Among participants, women were more likely to report any form of gender inequity, with 83% having experienced it throughout their academic career, and 62% of cases reporting the source of bias being either male or female. Contrastingly, only 37% of male participants agreed to have experienced with some form of gender-based inequity. Table 2 displays the rate of gender-based inequity among the male and female participants. Among the 186 female participants who reported having experienced gender-based inequity, 36 (26%) said it came from patients (26%), while 29 (21%) reported it came from coworkers, subordinates, and superiors (Table 3). Furthermore, female gender was identified as a risk factor for experiencing any gender-based inequity (OR, 15.67; $P < .001$).

Workplace and Sexual Harassment

One hundred and thirty-four women (60%) reported experiencing some form of workplace harassment, whereas

TABLE 1. Demographic Characteristics of the Cohort

Variable Assessed	Female (n = 224), No. (%)	Male (n = 30), No. (%)
Country of origin		
Argentina	24 (11)	5 (17)
Chile	29 (13)	7 (23)
Peru	32 (14)	16 (53)
Mexico	139 (62)	2 (7)
Marital status		
Single	103 (45)	9 (30)
Married	98 (44)	14 (47)
Divorced	17 (8)	5 (17)
Widowed	1 (1)	1 (3)
Number of hours worked per week		
From 20 to 40	45 (20)	7 (23)
From 41 to 60	117 (52)	14 (47)
Over 60	62 (28)	9 (30)
Has any offspring		
Yes	114 (51)	22 (72)
No	110 (49)	8 (28)

TABLE 2. Workplace and Gender-Based Violence

Variable Assessed	Female (n = 224), No. (%)	Male (n = 30), No. (%)
Have you ever been affected by gender inequity?		
Yes	127 (57)	3 (10)
No	56 (25)	23 (77)
Maybe	41 (18)	4 (13)
Have you ever faced difficulties due to your gender or any type of gender-based discrimination?		
Yes	186 (83)	11 (37)
No	38 (17)	19 (63)
Which gender is the aggressor of the gender-based discrimination?		
Male	56 (25)	3 (10)
Female	7 (3)	5 (17)
Both	149 (67)	8 (27)
None	12 (5)	13 (43)
Not available	0	1 (3)

only 19% of their male counterparts reported it (Table 2). When specifically assessing for sexual harassment, 76 women (34%) and five men (16%) reported incidents of sexual harassment (OR, 2.78; $P < .05$). Among all participants, only 85 (33%) were based in an institution where specific efforts to aid gender equity were made.

Wage Disparity

Notably, only 32% of respondents reported having a female leader at their institution, while 68% had a male superior. Furthermore, only 8% of participants identified a woman as the highest earner in their institution compared with 92% who reported that a man held the top salary position. Table 4 provides a breakdown of participants' responses regarding wage disparity and female participation in upper-level positions. Additionally, we found no significant statistical differences in the way male and female participants perceived the gender of the highest-earning person.

Family Life

Finally, we conducted two logistic regression models, where the dependent variable had offspring as a woman and the predictor variables were the range of hours per week dedicated to work and the job position held (Table 5). Our analysis revealed that working 20-40 hours per week was significantly associated with a higher likelihood of having children (OR, 3.0; $P < .01$), as was working 41-60 hours per week, although to a lesser extent (OR, 1.97; $P < .01$). By contrast, occupying a position as an attending physician was associated with a 59.7% lower likelihood of having children ($P < .01$), whereas being a resident or fellow was associated with a 97.5% lower likelihood among women ($P < .01$).

DISCUSSION

Gender equity is a critical indicator of health and health disparities in the current era. Achieving gender equality in

TABLE 3. Source of Bias of Violence and Gender-Based Discrimination

Source of Gender-Based Discrimination	Female (n = 186), No. (%)	Male (n = 11), No. (%)
Who has perpetrated gender-based discrimination?		
Patients	36 (19)	4 (37)
Coworkers	9 (5)	2 (18)
Superiors	24 (13)	2 (18)
Subordinates	2 (1)	0
Patients and superiors	27 (14)	1 (9)
Patients and subordinates	1 (0.5)	1 (9)
Patients and coworkers	7 (4)	0
Coworkers and superiors	12 (6)	1 (9)
Patients, coworkers, and superiors	27 (15)	0
Patients, subordinates, and superiors	7 (4)	0
Patients, coworkers, and subordinates	1 (0.5)	0
Coworkers, subordinates, and superiors	4 (2)	0
Patients, coworkers, subordinates, and superiors	29 (16)	0

TABLE 4. Wedge Disparity

Workplace Indicators of Gender Disparity	Yes, No. (%)	No, No. (%)
Are there any efforts to specifically address gender-based discrimination at your current institution?	85 (33)	169 (67)
Is your boss at your current institution a woman?	81 (32)	173 (68)
In your opinion, is a woman the highest earner at your institution?	20 (8)	234 (92)

science, medicine, and global health can significantly improve health outcomes, social well-being, and economic growth.

We report the results of the first international, multi-institutional survey of oncology health care providers based in LATAM. Our study observed that among the participants, women were more likely to experience any form of gender-based inequity from both male and female colleagues. Women were more than twice as likely to report sexual harassment. Additionally, females were less likely to hold a leadership position within their institution or to be the highest-paid personnel. We also observed an association between lower working hours and having more children as well as a negative association between having children and holding an academic position.

Consistent with previous reports, a significantly higher percentage of female health care providers have reported experiencing some form of gender inequity. In the field of emergency medicine, up to 68% of female physicians and over 40% of female anesthesiologists reported having encountered a form of gender inequity.[12,13] Furthermore, according to data from the Association of Women Surgeons, as many as 91% of practicing female surgeons have encountered gender-based inequity.[14] Additionally, specifically within the field of Oncology, gender harassment was indicated by 79% of women in a survey from ASCO.[11] This finding is highly relevant, as other authors have pointed out that gender remains the main obstacle to career development.[4] Historically, there has not been a clear difference in gender among aggressors, with a proportion between 40% and 60% of female-to-male source of bias.[13]

In our study, 34% of women and 16% of men reported having experienced some form of sexual harassment in their workplace. This is higher than the results from a survey conducted by the American Society of Oncology, where 22% of women indicated having experienced unwanted sexual attention within their institutions during the past year.[11] Sexual misconduct is not exclusive to the oncology field, as there have been several reports from clinical and surgical specialties that from 30 to over 50% of female specialists have been subject to some form of sexual misbehavior.[15-17] Collecting data on gender-based violence in health care workplaces remains challenging, possibly because of the stigma associated with reporting such incidents,[8] as well as an overall lack of accountability among aggressors,[18] and we recognize that it is likely that these rates underreport the

TABLE 5. Logistic Regression Model Displaying the Odds Ratio on the Basis of the Questionnaire Between Male and Female Participants With Woman Coded as Class 1

					Wald Test		
Questionnaire Variables	Estimate	SE	OR	*z*	Wald Statistic	*df*	*P*
(Intercept)	2.715	0.344	15.111	7.889	62.244	1	<.001
How many children do you have? (1)	0.263	0.685	1.301	0.385	0.148	1	.700
How many children do you have? (2)	−0.708	0.494	0.493	−1.432	2.050	1	.152
How many children do you have? (3)	−2.310	0.572	**0.099**	−4.041	16.328	1	<.001
How many children do you have? (more than 3)	−2.428	0.838	**0.088**	−2.898	8.398	1	.004
(Intercept)	2.219	0.235	9.200	9.426	88.859	1	<.001
Does a woman earn the highest salary at your institution? (yes)	−0.273	0.661	0.761	−0.414	0.171	1	.679
Does a man earn the highest salary at your institution? (yes)	0.025	0.462	1.025	0.053	0.003	1	.958
(Intercept)	1.914	0.206	6.778	9.282	86.163	1	<.001
Have you ever experienced sexual harassment in the workplace environment? (yes)	1.020	0.503	**2.774**	2.028	4.112	1	.043
(Intercept)	−0.565	0.250	0.568	−2.257	5.095	1	.024
On average, how many hours do you spend working per week? (41-60 hours)	0.678	0.302	**1.970**	2.248	5.054	1	.025
On average, how many hours do you spend working per week? (20-40 hours)	1.101	0.359	**3.007**	3.068	9.410	1	.002
On average, how many hours do you spend working per week? (<20 hours)	0.565	1.436	1.760	0.394	0.155	1	.694
(Intercept)	1.126	0.235	3.083	4.793	22.977	1	<.001
Have you ever been affected by gender inequity? (yes)	2.752	0.629	**15.676**	4.377	19.157	1	<.001
Have you ever been affected by gender inequity? (maybe)	1.342	0.522	**3.827**	2.573	6.619	1	.010

NOTE. Bold indicates significant values.
Abbreviation: OR, odds ratio.

actual rates. Furthermore, it is important to note that less than half of the participants have access to any initiatives aimed at addressing gender-based challenges in the workplace. This lack of initiative hinders both men and women from receiving timely support in cases of violent workplace interactions.[19,20] Additionally, there is a significant gap in information regarding the current state of gender equity programs in medical training, including residency and fellowship. A survey of hematology-oncology fellowship programs in the United States found that over 78% did not provide gender equity training for the physician workforce, primarily because of a lack of resources, potentially perpetuating the problem in the future workforce.[21]

The underrepresentation of women in leadership roles in oncology is a critical issue that has significant implications for the field. Our data align with previous studies, revealing that only 32% of participants reported having a female leader. This finding is consistent with a survey conducted within the institutions accredited by the Accreditation Council for Graduate Medical Education, which found that women occupied only 31.4% of program director positions in medical oncology, 17.4% in radiation oncology, and a mere 11.1% in surgical oncology.[22] Similarly, in India, one third of oncology medical teams are managed by a woman.[23] These disparities are concerning, as diverse leadership has been shown to improve organizational performance, innovation, and patient outcomes. Moreover, this gender imbalance may also contribute to disparity in the highest-paid positions within institutions, further perpetuating inequities. The wage gap among physicians has discretely improved over the past two decades, mostly among women with higher education levels. Nevertheless, the improvement has not been proportional in comparison with other economic areas, especially among health care workers with lower educational levels.[24] Addressing these gender imbalances is essential for fostering a more inclusive and effective health care environment.

Finally, we observed a significant difference between female and male participants who had three or more children, with a negative association among women attending full-time positions or training because of demanding workloads. Our results suggest that the observed link between reduced work hours and having children reflects broader structural and cultural constraints, rather than a simple causal relationship. This finding highlights the unique challenges that women face in balancing their professional and personal responsibilities. A survey based in India reported work-life balance as the most frequent perceived obstacle to the career advancement of women oncologists.[23] During the COVID-19 pandemic, the percentage of female physicians with children significantly declined compared with male physicians, indicating disproportionate childcare responsibilities for women.[25] This underscores the need for supportive policies and flexible work arrangements to help women in oncology manage their careers and family lives effectively. Addressing these challenges is essential for promoting gender equity and ensuring that female oncologists can thrive professionally and personally.

One limitation of this study is that it used convenience sampling, which may have introduced a selection bias. This method might not accurately represent the broader population of oncology health care professionals in LATAM, thereby limiting the generalizability of the findings. Additionally, the sample size was relatively small and disproportionate between genders, with a significantly higher number of female participants than male participants. The cross-sectional nature of the study also precludes any assessment of causality, and the reliance on self-reported data can introduce response bias, as participants may underreport or overreport their experiences because of social desirability or recall bias.

On the other hand, to our knowledge, this is the first international, multi-institutional survey specifically targeting gender-related issues among oncology health care providers in LATAM, providing valuable insights into a previously underexplored region. The questionnaire covered a broad range of relevant topics, including demographic characteristics, workplace environment, gender inequity, wage disparity, and family development, allowing for a comprehensive analysis of the factors influencing professional development. Using logistic regression models to analyze gender-related disparities provides a robust statistical framework for identifying significant predictors and associations. Additionally, the findings highlight critical areas for intervention and advocacy, underscoring the importance of initiatives such as the W4O LA group in addressing gender inequity and promoting equal professional development opportunities in oncology.

The inequalities do not result directly from gender differences, but rather from the way these differences are turned into power imbalances that favor a specific gender. Our study focused on the widespread gender disparities in oncology in LATAM, highlighting the considerable obstacles female oncology health care providers encounter in their careers. According to data from oncology societies, approximately 65%-70% of oncology professionals in LATAM are male, which may partly account for the gender disparities observed in the region. Our findings indicate that women experience a disproportionate gender inequity and sexual harassment, and they are underrepresented in leadership positions and the highest-paid roles. In many Latin American countries, hierarchical workplace cultures create significant barriers to reporting discrimination and harassment. Employees, particularly women, may fear retaliation, professional repercussions, or even job loss if they report incidents involving their superiors. Rigid authority structures often discourage open dialogue and perpetuate a culture of silence, making it difficult to hold accountable those who commit acts of violence. Additionally, the lack of transparent and independent reporting mechanisms further exacerbates this issue, preventing effective institutional responses to workplace

harassment and discrimination. These inequities not only hinder women's career advancement but also have an impact on overall effectiveness and innovation within the health care sector. However, the connection between working fewer hours and an increased probability of having children as well as the negative link between clinical roles and having offspring further underscores the unique challenges faced by women in juggling professional and personal obligations.

It is essential to address gender-related issues to create a fair and supportive work environment in oncology. Initiatives such as the W4O LA group, inspired by the ESMO's W4O initiative, are crucial for promoting equal professional development opportunities and raising awareness of gender inequity in the field. Professional development programs, including support for childcare services, flexible scheduling, and mentorship opportunities, as well explicit mechanisms against harassment are essential to promoting gender equity in the workplace. By promoting diverse leadership and ensuring fair treatment and opportunities for all health care professionals, the oncology field can improve not only in terms of gender equity but also in terms of patient outcomes, organizational performance, and overall health care innovation. The lack of gender equity programs in medical training continues to perpetuate disparities in the physician workforce. Addressing this issue requires a structured, institutionalized approach that integrates gender equity education into residency and fellowship curricula, expands mentorship opportunities for underrepresented groups, and enforces policies that ensure equitable career advancement. Targeted initiatives are essential for breaking systemic barriers, fostering an inclusive professional environment, and ultimately strengthening the effectiveness and diversity of the health care system.

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