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Mini Review

Gender-Based Discrimination as a Behavioural Stressor in Clinical Practice

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Introduction: Incidence as Clinical Context

Gender-based harassment and microaggressions remain pervasive within medical training and clinical practice, functioning as chronic occupational stressors for women physicians with cumulative psychological and professional consequences [1]. Contemporary data indicate that up to half of female physician's report experiencing sexual harassment from coworkers, supervisors, or patients, and gender-based microaggressions occur frequently enough to shape daily professional interactions and workplace climate [2]. Women physicians report higher rates of anxiety, depressive symptoms, posttraumatic stress, and burnout, alongside persistent underrepresentation in institutional and thought leadership roles. This opinion piece examines how the literature characterizes gender-based discrimination in medicine, with particular attention to the cumulative impact of microaggressions on physician well-being and workforce sustainability, and concludes with practical multilevel strategies to promote gender equity through provider support, institutional accountability, and national policy reform.

Provider-Level Behavioural Consequences

Chronic exposure to gender-based bias may promote maladaptive cognitive and behavioural adaptations at the individual level, including heightened self-monitoring, anticipatory threat appraisal, and internalized self-doubt, consistent with chronic psychosocial stress exposure in stigmatized professional environments [3]. These responses can erode psychological safety and contribute to disengagement, particularly in high-stakes clinical environments where credibility and authority are continually contested. Such effects may be especially pronounced during training. Trainees report higher rates of microaggressions and sexual harassment compared with attending physicians, suggesting that early-career exposure to discrimination may shape professional identity formation and coping patterns in ways that persist over time. Women physicians experience disproportionately higher rates of burnout, depression, and diminished well-being compared with their male counterparts.

Burnout in this context extends beyond transient fatigue; it manifests as depersonalization, reduced sense of professional efficacy, and emotional withdrawal from clinical work. These responses reflect that what is often dismissed as individual fragility is a product of sustained psychological threat [4]. Recent evidence published in The New England Journal of Medicine underscores the scope of this problem, demonstrating strong associations between workplace discrimination, emotional exhaustion, and depressive symptoms among physicians. This research highlights how discriminatory workplace interactions can function as chronic behavioural stressors in clinical practice [5]. Clinically, these outcomes are accompanied by observable behavioural changes

that affect the professional performance and personal well-being of women healthcare workers. Nearly three-quarters of women physician's report reducing work hours or considering part-time practice within six years of completing training, primarily citing work–family conflict and unsupportive workplace cultures cited as drivers [6].

For those that choose to remain in the workforce, many report reduced engagement in professional activities, reluctance to seek leadership roles, and intentional narrowing of clinical scope as protective strategies. While often characterized as personal lifestyle choices, these decisions occur within environments marked by unequal expectations, biased evaluations, and limited institutional support [7]. Thereby creating an unsustainable workforce model in which many of its trainees have exited the field just as they are reaching early professional milestones.

Microaggressions as Repetitive Behavioural Conditioning

Microaggressions– subtle, intentional, or unintentional verbal, behavioural, or environmental actions that communicate hostile, derogatory, or negative slights toward marginalized groups– in healthcare are not episodic occurrences; they are sustained patterns of behaviour among colleagues and administration that contribute to the culture of the workplace [8]. Gender-based microaggressions function as repetitive behavioural conditioning within clinical environments. Women faculty describe at least 21 commonly recurring microaggressions, clustered into themes including sexism, pregnancy- and caregiving-related bias, underestimation of competence, sexually inappropriate remarks, assignment to low-status tasks, and professional exclusion. Gender-based behavioural conditioning may occur as reinforcement or punishment of particular behaviours by healthcare workers who identify as women [9]. Recurrent microaggressions in the workplace have been shown to elicit negative emotional states and diminish engagement [10]. Repeated exposure during training may substantially impact professional identity formation of women healthcare workers [11]. These adaptations in the behaviours of women physicians may be maladaptive and could limit the career progression of this group.

Systemic Consequences: Attrition as a Behavioural Outcome

When examined collectively, the behavioural adaptations adopted by women physicians in response to discriminatory work environments produce substantial downstream effects on workforce stability and institutional capacity. Persistent structural barriers, including sexual harassment, inequitable compensation, and constrained promotion pathways, are associated with workforce attrition; thereby reducing time at work and leaving the workforce all together and contribute directly to staffing shortages, loss of institutional expertise, and weakened leadership pipelines, with microaggressions conditioning women to pre-emptively remove themselves from the workforce or advancement opportunities to mitigate harm [12,13].

From a systems perspective, harassment and discrimination operate as inefficiencies that undermine workforce sustainability and organizational performance. The normalization of gender-based mistreatment further obscures institutional accountability by reframing women's career modifications as personal lifestyle decisions, despite evidence that disparities in burnout and retention attenuate after adjusting for professional and environmental factors [14-16]. Reframing discrimination as an occupational behavioural health exposure clarifies that observed workforce losses represent predictable responses to chronic workplace stressors, underscoring the need for institutional interventions that prioritize environmental modification, accountability, and retention rather than individual resilience alone [17].

Clinical and Institutional Implications

Addressing the behavioural consequences of gender-based harassment in medicine requires a deliberate shift in how responsibility is assigned and harm is understood. In our view, continued emphasis on individual coping and resilience misidentifies the locus of the problem and risks perpetuating preventable workforce losses. Gender-based discrimination functions as an occupational exposure that predictably alters behaviour, engagement, and career trajectories; therefore, interventions must be structured to reduce exposure rather than to train individuals to endure it. At the clinical and supervisory level, behavioural withdrawal, reduced participation, and emotional exhaustion should be interpreted as potential indicators of workplace harm rather than deficits in professionalism or commitment. Failure to recognize these patterns reinforces stigmatization and delays intervention. Normalizing explicit discussion of microaggressions and validating their cumulative impact are essential to restoring psychological safety.

These interventions are particularly important in training environments where individuals have increased reluctance to report for fear of repercussions, as well as the time in which professional identity is actively forming and vulnerability to disengagement is highest. Institutional responsibility is paramount. Effective responses extend beyond formal reporting pathways to include transparent promotion and compensation structures, recognition of community-oriented labour, and leadership accountability tied to measurable outcomes in retention, well-being, and advancement. We believe that resilience-based programming targeted at building resilience in individual physicians, when implemented in isolation, is insufficient and may inadvertently exacerbate these issues by shifting blame onto those experiencing harm. Meaningful progress requires environmental modification, clear consequences for misconduct, proactive enforcement of professional standards, and leadership evaluation metrics that prioritize workforce sustainability.

At the national level, clinician retention and well-being should be treated as core quality indicators rather than secondary workforce concerns. Accreditation bodies, specialty boards, and funding agencies have a critical role in establishing enforceable equity benchmarks and mandating institutional transparency around harassment, attrition, and advancement. Without coordinated

accountability across systems, gender-based discrimination will continue to function as a hidden driver of workforce instability. Reframing this issue as a behavioural and organizational imperative, rather than an individual challenge, is necessary to preserve both the integrity and longevity of the medical profession.

Conclusion: Clinical Takeaway

Gender-based harassment and microaggressions in medicine represent clinically significant occupational exposures with measurable behavioural and workforce consequences. Beyond individual distress, these experiences shape professional behaviour, career decision-making, and long-term retention, contributing to systemic inefficiencies within healthcare systems. Recognizing discrimination as a chronic behavioural stressor allows clinicians and institutions to move beyond resilience narratives toward prevention and accountability. Addressing these patterns is essential not only for equity, but also for sustaining a healthy, effective medical workforce.

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Conflict of Interest

No Conflict of Interest.

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