

EDITORIAL

COVID-19: An Insult to Injury on EquityBiljana Parapid¹ and Rachel M. Bond^{2,3}*Belgrade University School of Medicine, Division of Cardiology University Clinical Center of Serbia,¹ Belgrade - Serbia**Dignity Health System, Division of Cardiology,² Chandler, AZ - USA**Creighton University School of Medicine, Division of Internal Medicine,³ Omaha, NE - USA*

SARS-CoV-2, which causes COVID-19, created a pandemic that not only overwhelmed the world in December 2019, but also challenged humanity in every way.

While a significant portion of the global population remained in a standstill, waiting for an end and adapting to limits of all sorts, including working from home, a new workforce category emerged: the “frontline” workers. Doctors, nurses, and all allied professions employed by the healthcare system were joined by a long line of diverse service providers. The latter faced different forms of discrimination from their surroundings, fearing the risk of infection based on high rates of medical misinformation; for the former group, Pandora’s box of bias was yet to be opened, in particular for women.

According to initial reports, women were less likely to develop severe or life-threatening forms of SARS-CoV-2 infection. With higher mortality rates seen in men, an assumption that frontline work was safer for women than men quickly emerged. As a result, although scarce, reports confirmed higher infection rates in women frontline healthcare workers, as was seen in Spain.¹

Globally, women occupy 70% of frontline positions in the healthcare sector. Despite this, they are paid 11% less than men.² This was reconfirmed during the pandemic, where women physicians and nurses in the United States were paid 12% and 8% less than men in the same positions.³ Yet, only 25% of healthcare leadership and decision-making positions have been held by women during the pandemic.⁴

The first warnings came from UN Women in early Spring 2020.⁵ With the significantly higher percentage of women frontline workers, an ongoing crisis will only deepen gaps on the road to achieving equity. This was best highlighted where, simultaneously, various international medical entities⁶ yielded additional attention to the world of academic medicine where tenure clocks were not stopped or even paused, further aggravating promotion pathways for women who had less time to publish. Additionally, while men were not participating in frontline work, they were afforded the opportunity to be lead authors of publications on frontline work and/or ongoing pandemic research.⁷

The existing unpaid workload at home was globally aggravated by the increased need for homeschooling, and, culturally, while dual physician households experienced additional challenges during pandemic work, the toll on women’s health were universally greater: from mental health issues to delayed family planning due to menstrual cycle disturbances,⁸⁻¹³ even in the absence of contracting the disease itself or while recovering from it.

Finally, as the pandemic has greatly changed our existence, lamenting and reporting well-known data should give way to implementation of actionable solutions.

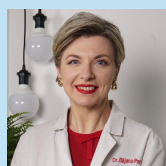
“*Primum non nocere.*” Medical academic institutions should start by practicing what they preach, beginning

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with their employees, the same way they do for their patients, regardless of gender, color, or creed. As women's healthcare policies vary globally,¹⁴ it is up to the leading medical and scientific authorities of each respective country – *regardless of local practice and of whether or not there is a Diversity-Equity-Inclusion officer/ vice-dean* – to protect their largest frontline workforce. Existing women's heart health programs, centers, and clinics should open their doors on a weekly basis to in-house staff, who most likely do not have time to schedule an appointment themselves. The potential budgeting issue could be overcome by the academic institution's dedicated burnout prevention program, and, in the event that there is no help from existing employee support models,¹⁵ there is no better moment in the history of modern medicine than now to start one. For what it is worth, as always and everywhere, a group of volunteers who are willing to see patients *pro bono* will quickly appear; so why not start with one's own colleagues?

As the face of education continues to change, with pressing needs to offer various forms of teaching to our

students, committees that handle academic promotions have had plenty of time to consider involvement in frontline work – *and more importantly lack thereof* – as well as existing engagement in virtual teaching.

One solution is the creation of a new category of achievement points for candidates, especially for those who have actively participated in all pandemic-related activities from the beginning, as well as for colleagues who suffered from workplace-acquired COVID-19.

Even in the setting where groups of junior or mid-career academics are promoted together, it may be best to delay the promotion of a pandemic bystander for the benefit of an active participant.

This logic can only promote a healthier work environment in the long run, where no one will feel that they are being "left behind" because they are "unworthy".

Most importantly, as doctors, we know that, as long as there is a will, we tend to find a way, and, finally, if not us, then who?

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