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Original Contribution

Standing out or fitting in: A latent projective content analysis of discrimination of women and 2SLGBTQ+ anesthesiologists and providers

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ABSTRACT

Introduction: Discrimination toward sex and gender minority anesthesiologists and anesthesia trainees exists. Potential reasons for this discrimination are unclear and incompletely characterized. This study sought to better understand what discrimination looks like for sex and gender minorities in anesthesiology and the culture within anesthesiology that allows this discrimination to occur.

Materials and methods: With institutional research ethics board approval and informed consent, we performed a qualitative analysis of free-text responses from a previously-published internet-based cross-sectional survey distributed to Canadian anesthesiology residents, fellows, and staff. The purpose of this survey was to characterize intersections between respondent gender or sexuality with experiences of discrimination in the workplace. Separate analysis of qualitative and quantitative components of this survey was planned *a priori,* and the quantitative component was published elsewhere. Free-text responses were independently coded by two researchers and subsequently synthesized into emerging themes using latent projective content analysis sensitized by Butler's theory of performativity.

Results: Out of 490 free-text responses from 171 respondents [140 (81.9%) identifying as heterosexual], two themes emerged: i) fitting in: performativity reinforcing the status quo, and ii) standing out: performativity as a means of disruptive social change. Power structures were observed to favour individuals who "fit in" with the normative performances of gender and/or sexuality.

Discussion: Our study illuminates how individuals whose performances of gender and sexuality "fit in" with those expected normative performances reinforce a workplace culture that advantages them, whereas individuals whose performances of gender and sexuality "stand out" disproportionately experience discrimination. The dismantling of bias and discrimination in the anesthesiology workplace requires individuals (a) who are empowered within their workplace because they "fit in" with the majority; (b) who recognize discrimination toward communities of their peers and/or colleagues; and (c) who actively choose to "stand out".

1. Introduction

Women and two-spirited, lesbian, gay, bisexual, transgender, queer, plus (2SLGBTQ+) physicians disproportionately experience discrimination, broadly defined as "any behaviour or language toward another [individual] that serve[s] to alienate, belittle, humiliate, or trouble" in academic medicine [1–6]. Gender bias persists despite increasing awareness and active responses to this issue [6–15]. Anesthesiology is no exception, as a growing body of evidence illuminates the existing biases against women and 2SLGBTQ+ anesthesiologists [1,2,7,16–21]. Women in anesthesiology are less frequently published [17,18,20] and receive fewer career awards and leadership positions [1,2,17,19] – discrepancies largely attributed to organizational practices and policies which enable unfair and/or inequitable treatment. Harassment,

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bullying, humiliation, and other forms of individual discrimination of 2SLGBTQ+ anesthesiologists have also been recently explored: women and non-heterosexual anesthesiologists were more likely to report experiencing individual discrimination and gender- or sexuality-based barriers to carrier advancement [15].

We have previously noted a discrepancy between anesthesiologists' reported experiences of discrimination and their reported comfort with patients and colleagues who are sex and/or gender minorities [15]. In our quantitative analysis of a cross-sectional national survey on this topic, we observed that women, compared to men, were more likely to experience and/or witness discrimination, barriers to career advancement, and made more uncomfortable due to gender or sexuality within the workplace [15]; except for career advancement, similar results were found for anesthesiologists and anesthesia providers who identify as non-heterosexual [15]. However, disclosure of one's sexuality or gender identity in anesthesiology was perceived to not affect workplace dynamics, nor was "coming out" reported to be discouraged. It is yet unknown how or why gender and sexuality-based discrimination can be commonly experienced but rarely recognized within the anesthesiology workplace; these are questions better addressed by qualitative analyses rather than quantitative approaches.

We aimed to address this knowledge gap and better understand the experiences of discrimination attributed to gender and/or sexuality among Canadian anesthesiologists and anesthesia providers using a latent projective content analysis of comments collected from our previously administered survey [15]. Specifically, we sought to better understand: i) what discrimination looks like for sex and gender minorities in anesthesiology; and ii) the culture within the anesthesiology workplace that allows this discrimination to occur.

2. Materials and methods

We performed a qualitative analysis of narrative, "free-text" survey responses using a latent projective content analysis. The questions from which the "free-text" responses were analyzed asked about experiences of discrimination, harassment, derogatory comments, and bullying toward patients and their partners who identify as 2SLGBTQ+, women, men as well as healthcare providers who identify as 2SLGBTQ+, women, and men. Quantitative analysis of data from this survey has been previously published by our group [15]; herein we present the qualitative aspect of this project.

Separate analysis of the qualitative and quantitative components of this survey was planned *a priori*; the quantitative analysis adopts a postpositivist framework *(i.e.,* researchers seek objectivity while considering the risk of bias) [22] whereas the qualitative analysis relies on a constructivist paradigm *(i.e.,* researchers seek to understand the meaning constructed around experiences) [22]. Classically, metrics of quantitative research such as response rate, validity, bias, and generalizability - to name a few - are not presented as there is epistemological-methodological misalignment. Rather, in qualitative research, markers of trustworthiness (namely credibility, dependability, confirmability, and transferability) are included [23,24]. While there is long-standing debate around whether the different epistemological and ontological assumptions underpinning qualitative and quantitative methods can be synthesized, simple quantitative techniques, such as frequency counts of responses and themes, may be used in qualitative research for select purposes [24,25]. In this article, we present select quantitative metrics for context and encourage that our quantitative analysis be read as a companion to the present article [15]. It is worth noting that the number or length of responses in qualitative research are not necessarily markers of high-quality research, whereas the depth and richness of responses relative to what is known about the topic are stronger indicators of credibility in qualitative research [24].

2.1. Survey design and data collection

With approval of the University Health Network Research Ethics Board (19–5087; 18 April 2019), in accordance with Checklist for Reporting Results of Internet *E*-Surveys, and following the modified Dillman approach [26], we distributed an internet-based cross-sectional survey to Canadian anesthesiology residents, fellows, and staff. The survey link was accessible to all members of the Canadian Anesthesiologists' Society and to all members of the University of Toronto Department of Anesthesiology and Pain Medicine between June 3, 2019 and December 4, 2019 [27]. We attempted to circulate the survey though the Canadian Association of General Surgeons, but with only a single response, we decided to exclude this population; we also attempted to circulate the survey through the Ontario Nurses' Association, but with only two responses, we also excluded this population and decided to focus only on anesthesia providers. Convenience sampling was employed, meaning analysis was conducted on all received responses. The 36-item survey included multiple choice and free-text entry questions; only the free-text responses were utilized for this study. Informed consent was obtained from participants at the beginning of the survey. Participation was voluntary, anonymous, and uncompensated.

Survey design followed the steps described by Artino et al. and Shaughnessy et al.: literature review; literature synthesis and decision of what information to elicit; item development; expert validation; pretesting; pilot-testing; and specification of the procedures for distribution [28,29]. Survey questions characterized the intersection between the respondent's gender or sexual orientation and their experience of discrimination in the workplace. GRL and AMF provided expert content validation. The Canadian Anesthesiologists' Society executive committee served as a pre-test population for both content and usability. Think aloud cognitive interviewing was performed with three non-physicians to ensure question clarity. Iterative revisions were performed by the research team, and the final draft was pilot tested in print and online prior to widespread distribution. Given the sensitive nature of the survey and the importance of confidentiality, no IP address or cookie tracking were used. Participants were asked explicitly to complete the survey once. None of the members of the research team completed the survey.

2.2. Data analysis

In latent projective content analysis, the interpretation of text reveals the meaning constructed around a particular phenomenon [30]. The researcher actively co-constructs meaning of the source text during data analysis by considering mental schema, theories, and lenses [30]. Herein, we present both representative quotes and summarized interpretation of responses. Where necessary, quotations are abridged or censored to protect anonymity. *A trigger warning: some quoted narratives include sexual assault.* Since the objective of this study was to understand gender and sexuality-related experiences of discrimination, we applied Butler's theory of performativity as a sensitizing lens [31]. According to Butler, "a performative is that discursive practice that enacts or produces that which it names" [32]. Gender performativity is defined as "the repeated stylization of the body, a set of repeated acts within a highly rigid regulatory frame that congeal over time to produce the appearance of substance, of a natural sort of being" [31]. Gender is therefore reinforced through recurrent political, cultural, and social behaviours established over time [31]. Through this lens, sociopolitical and sociocultural qualities are linked to certain gendered bodies and behaviours; gender that conflicts with hegemonic power structures may consciously or subconsciously elicit discrimination. According to Butler, "gender proves to be performance - that is, constituting the identity it is purported to be. In this sense, gender is always a doing, though not a doing by a subject who might be said to pre-exist the deed" [31] (Supplemental Table 1). Gender responses of "man" or "woman" were understood to indicate cisgender identities since transgender, gender non-binary, and two-spirit self-identification options were available; moreover, sex was

also collected, and a cisgender identity was understood when there was concordance between sex and gender.

Analysis of all free-text responses occurred after data collection was complete. Responses were inductively open-coded, sentence by sentence (*i.e.,* the predetermined unit of meaning was each individual sentence) by two reviewers in parallel (GRL and JC) [30,33]. The first question was open-coded by two researchers (GRL and JC) together [30]. Subsequently, codes were grouped according to similarity in content, context, or meaning, then further synthesized into sub-themes and themes related to our research questions. Conflicts were resolved by consensus. The coding structure was subsequently applied to NVivo12 (QSR International).

2.3. Trustworthiness

To maintain rigour, we followed Lincoln and Guba's framework for trustworthiness, in which trustworthiness is established through credibility, transferability, dependability, and confirmability [23]. With respect to confirmability, we documented memos, being reflexive of how our pre-existing knowledge and our social identities may have influenced the research process; we also periodically compared the emerging themes of our analysis to the existing literature and our previously published quantitative results. To establish credibility, we engaged in prolonged immersion with the data to better understand the phenomenon. We provided thick description as a means of establishing transferability and hope that readers will ask if, what, how, and why similar behaviours are occurring in their respective contexts.

2.4. Reflexivity

Since latent projective content analysis actively includes the researcher as co-creator of the meaning of survey responses, the assumption of reflexivity (*i.e.,* the effect of the researcher's lived experience on what is being investigated) is inevitable: experiences of privilege and oppression within our team may have influenced each stage of the research process.

3. Results

From 2313 email recipients, the survey was opened 1134 times (view rate 49%), from which we received 490 written responses from 178 total respondents (response rate 7.7%) [15]. Of these 178 respondents, 171 (96.1%) respondents were anesthesia providers (anesthesia staff, fellows, residents, general practitioner-anesthesia providers, and anesthesia assistants) and 7 (3.9%) participants were excluded [2 (1.1%) nurses, 3 (1.7%) surgical providers, 1 (0.6%) medical staff, and 1 (0.6%) other]. The published quantitative study contained 162 respondents (response rate 7%) as we only analyzed and reported data for staff anesthesiologists, fellows, and residents in anesthesiology (164–2 missing = 162 respondents) [15]. However, for this qualitative study, we also included general practitioner-anesthesiologists and anesthesia assistants as integral members of the perioperative team, working within the same clinical environment and culture; this was felt to improve the depth of responses, and therefore the credibility of our study [23,24]. The majority of respondents were heterosexual (140 [78%]) and men (111 [63%]); 36 [20%] respondents self-identified as non-heterosexual and 62 [35%] identified as women. Trainees constituted 31 [17%] of responses. (Table 1) 83 (47%) respondents reported experiencing discrimination at work, with anesthesiologists, surgeons, and other members of the perioperative team reported as the perpetrators in approximately balanced representations. (Table 2) We identified two predominant emerging themes into which responses could be categorized: i) *fitting in: performativity reinforcing the status quo*, and ii) *standing out: performativity as a means of disruptive social change* (Fig. 1).

Table 1
Description of the study cohort.

	Women (*N* = 58)	Non-Women (*N* = 111)	Overall[a] (*N* = 171)
Clinical Independence			
Faculty/Staff	54 (93.1%)	106 (95.5%)	161 (94.2%)
Trainee	4 (6.9%)	5 (4.5%)	10 (5.8%)
Professional Role			
Staff Physician	43 (74.1%)	92 (82.9%)	136 (79.5%)
Fellow Physician	4 (6.9%)	5 (4.5%)	10 (5.8%)
Resident Physician	10 (17.2%)	10 (9.0%)	20 (11.7%)
Non-Physician Perioperative Team	1 (1.7%)	4 (3.6%)	5 (2.9%)
Sexual Orientation			
2SLGBTQ+[b]	7 (12.1%)	25 (22.5%)	33 (19.3%)
Heterosexual	50 (86.2%)	85 (76.6%)	136 (79.5%)
Missing	1 (1.7%)	1 (0.9%)	2 (1.2%)

Respondent professional role, level of training, and sexual orientation stratified by gender identity. We recognize that gender exists as a spectrum, but we grouped the gender identity into binary categories (Women and Non-Women) to minimize the risk of re-identification of gender minorities.

[a] Please note that the overall sum of respondents is equal to the sum of Women and Non-Women, subtracting two given the missing sexual orientation for two respondents.

[b] 2SLGBTQ+ = Two-spirit, lesbian, gay, bisexual, transgender, queer, plus.

Table 2
Frequency and sources of reported discrimination.

	Women (*N* = 58)	Non-Women (*N* = 110)	Overall[a] (*N* = 170)
Reported any experience of discrimination	37 (63.8%)	43 (39.1%)	81 (47.6%)
Experienced discrimination from an Anesthesiologist	27 (46.6%)	33 (30.0%)	61 (35.9%)
Experienced discrimination from a Surgeon	22 (37.9%)	31 (28.2%)	54 (31.8%)
Experienced discrimination from another perioperative team member	27 (46.6%)	29 (26.4%)	56 (32.9%)

[a] The count and proportion of respondents who indicated experiencing discrimination, and the source of discrimination, are depicted, stratified by gender. Two respondents who did not self-identify gender were not depicted in either category but are included in the overall results. Note that respondents could indicate multiple sources of discrimination (*e.g.,* discrimination from an anesthesiologist did not preclude discrimination from a surgeon).

i) *Fitting In: Performativity as a Means of Reinforcing the Status Quo*

Responses falling under the theme of "*Fitting In: Performativity as a Means of Reinforcing the Status Quo*" all involved experiences in which individuals of a particular gender or sexual orientation were rewarded, empowered, or protected for "fitting in". Power structures were observed to favour those individuals who "fit in" with the "majority" gender or sexual orientation.

3.1. Discrimination against women is the status quo

We received responses from heterosexual women describing a gender bias in their workplace, manifesting as either unchallenged unprofessionalism, being "othered", discriminatory policies and practices, and gaslighting - where they were made to question their reality and minimize the harassment. Often, narratives described heterosexual women experiencing unprofessionalism from their colleagues because they did not "fit in" with their department that is predominantly composed of men. This pattern of women being made to feel "lesser" than their colleagues who are men was maintained across a range of topics, including parental responsibilities, remuneration, and sexual objectification.

> *"Comments (intended to be funny) about the need to put birth control in the water at the hospital so that the female physicians would stop having*

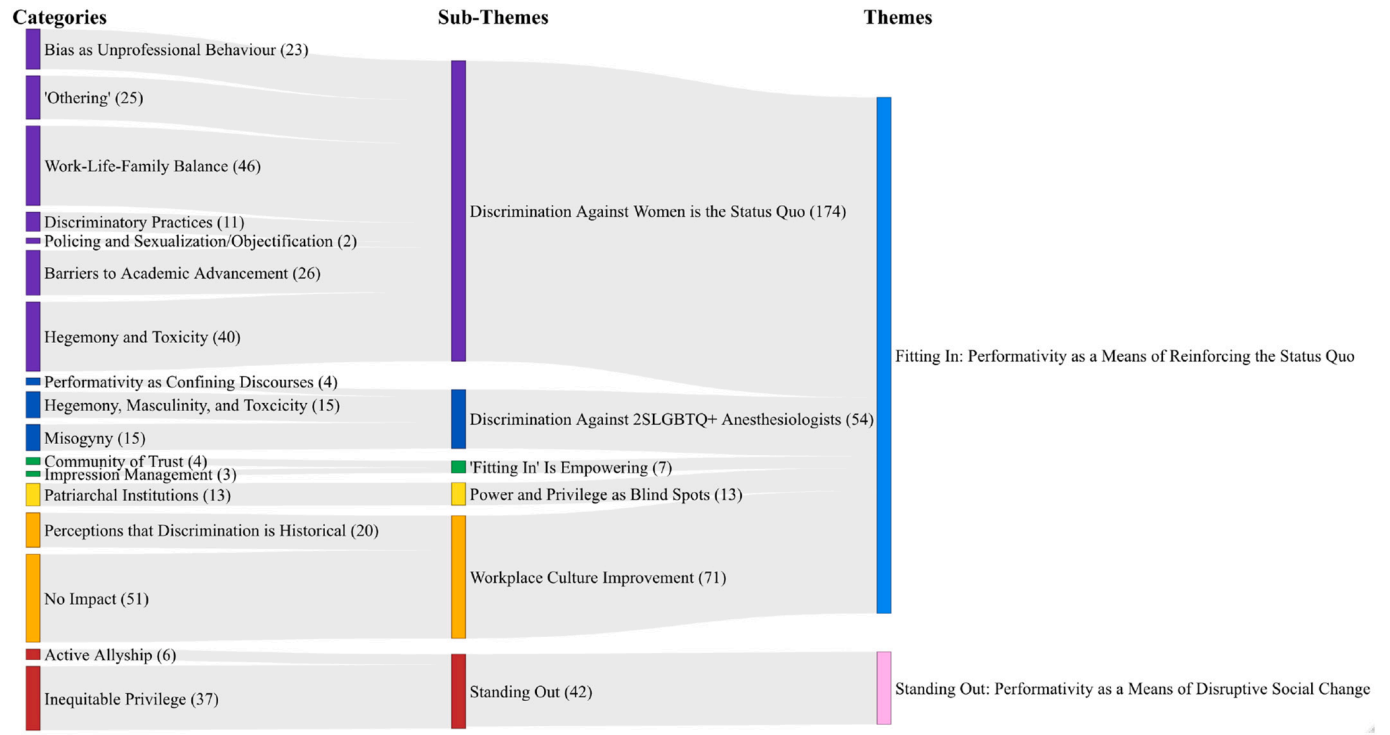

Fig. 1. Sankey diagram of derived categories, sub-themes, and themes.
Survey responses were categorized according to similarity in content, context, or meaning, then further synthesized into sub-themes and themes related to our research questions. We identified two predominant themes: i) *fitting in: performativity reinforcing the status quo*, and ii) *standing out: performativity as a means of disruptive social change.* The count of responses within each category and sub-theme are presented, with the relative contribution of each category to the sub-theme and theme presented both numerically and visually. (2SLGBTQ+ = Two-spirit, lesbian, gay, bisexual, transgender, queer, plus).

babies and taking time off, making the call schedule more onerous for the men." (Participant 296)

The meaning from this narrative is complex. It reveals an expectation of gender roles that privilege men and further suggests that men may overlook their own experiences of privilege. Notably for this section, though, this narrative is an example of women being "othered" in a highly negative and unprofessional way because of their expected gender behaviours.

Sexual objectification of women anesthesiologists was particularly common in our survey responses. At times, this sexualization manifested as women being told to wear certain attire.

"I have been told by a senior colleague that I would gain more attention if I sold myself better by changing the way I dressed." (Participant 131)

This narrative uses the language of commodity ("sold myself better") with the expectation that women should "fit in" with the appearance expected of them in the workplace. Other narratives described objectification while revealing a power dynamic that privileged men.

"I was sexually assaulted as a medical student. [I was] [t]hreatened when I said I was uncomfortable. He made it into a 'he said, she said'. The university saw me as a 'problem' medical student after coming forward informally…he was deemed to be correct because he 'won many awards'. His male colleagues stood behind him and me as a medical student was left isolated, scared, and alone. That was the first time I learned to keep my mouth shut." (Participant 177)

This power differential persisted in responses wherein women raised concern; respondents described being silenced or subjected to gaslighting.

"Faced harassment (stalking behaviour) by a male… The department head's response was to ask me to restrict my practice locations, and when I suggested that is not an appropriate solution, there was innuendo about my stress/burnout." (Participant 526)

Departmental inaction to support the victims (often women) and pursue perpetrators (often men) of alleged sexual abuse suggest that gender bias serves to protect those in the "majority". Respondents often passionately and emotionally described how they were expected to accommodate their workplace, rather than their workplace supporting them. One particularly troubling narrative is shared below, revealing the emotional burden this respondent experienced:

"The harassment…was very frightening and caused a great deal of anxiety. I feared for my safety constantly, changed my routines, avoided underground parking, switched [operating room] assignments, etc, to avoid contact. I also feared for the safety of my children. The delayed response by leadership to take it serious and seeming lack of concern (or lack of action) for workplace safety was also very troubling." (Participant 526)

3.2. Discrimination against 2SLGBTQ+ anesthesiologists

We received responses describing discrimination of 2SLGBTQ+ anesthesiologists who do not "fit in" with the perceived workplace culture. Narratives from women who identify as lesbian or bisexual described discrimination as unprofessional workplace conduct, often layering sexuality-based discrimination upon hegemonic gender roles.

"Pervasive sexism, chauvinism, [and] misogyny from particularly older male colleagues." (Participant 366)

Despite discriminatory and unprofessional comments being made, not all women who identify as lesbian or bisexual perceived these comments to be out of malice.

"[M]any comments about sexual orientation (usually seemed based on ignorance rather than real hate) in general prior to colleagues knowing I was gay." (Participant 366)

Men who identified as gay or bisexual reported experiencing discrimination manifesting as unchallenged unprofessionalism and/or as expectations of masculinity that target non-heterosexual men who do not conform to the normative performances of masculinity.

"Staff having told me to suppress my sexuality (when I was a resident) or that I would never get a job as a staff." (Participant 19)

Responses also frequently involved the leveraging of stigma surrounding HIV/AIDS to humiliate an individual who identifies as gay.

"Nurses have asked me about my risk of contracting HIV and asked if I have it." (Participant 412)

"[I was] told to double glove during intubation by staff physician since patient was gay and 'very likely has AIDS'." (Participant 141)

"I still remember stories recounted where derogatory comments are made about an individual based on their sexual orientation or gender identity; comment[s] made about their health issues based on their sexual preferences, or the subtle hints about making sure we don PPEs." (Participant 158)

Discrimination of 2SLGBTQ+ anesthesiologists was reported to occur by other physicians, other members of the healthcare workforce, and by patients.

Expectations for normative masculine behaviour served to isolate men who identify as gay or bisexual. Behaviours normatively associated with women, such as "effeminate" gesturing, *"Being told that I am a bit too effeminate" (Participant 19)* and wearing pink, were used to humiliate respondents.

"… There was a picture of us taken as a group with hard hats on. A few days later a black and white photo of the group was posted on the anesthesia [department] door. The hard hat on my head was coloured pink. It was the only one…altered. I was shocked and felt disrespected. I immediately sent an email to the chief of anesthesia and insisted the photo be removed immediately. It was gone by the next day. I never received an apology. Nothing more was said." (Participant 353)

Such forms of "othering" are particularly notable as they suggest both the presence of discrimination against women (by considering behaviours typically associated with femininity as lesser) and discrimination against men who identify as gay or bisexual.

Interestingly, men "presenting as heterosexual" – known as "straight passing" - who identify as gay or bisexual (*i.e.,* queer men who routinely perform socialized normative behaviours) reported avoiding discrimination directed at them but nevertheless observing discriminatory comments and unprofessional behaviours directed toward other 2SLGBTQ+ people.

"Often, sentences said by surgeons or anesthesiologists and [operating room] personal laughing at someone who is gay or has gay attitude. I am gay but this is not obvious when people look at me so they tend do feel comfortable to sa[y] bad things about gay people as they don't know I am one of them." (Participant 173)

"Never directed towards me, but comments full of prejudice in the [operating room] made me reflect that 'outing' in that environment could be unsafe." (Participant 418)

"As someone who 'passes' as heterosexual, staff have made comments about patients/other people in life with significant microaggressions which results in me realizing that I need to be back in the closet with this staff member." (Participant 521)

This phenomenon is unique from discrimination of visible minorities and emphasizes how discrimination may be directed toward those who are perceived to not "fit in" because of their behaviour. For some people, straight passing is a privilege that allows some people to fit in: they can choose to come out if they want, but they need not experience the workplace with a queer identity if they choose not to; for other people, this is not an option.

3.3. "Fitting in" is empowering

In the anesthesia workplace culture, respondents described the existence of a "predominant culture" against which individuals would be compared: being made to feel outside of the majority was often at the heart of reported discriminatory experiences. The need to "fit in" was understood to be rooted in an oppressive framework, affecting both the victims of discrimination and those witnessing it. Feelings of powerlessness to speak out against discrimination, either because of perceived futility or fear of retaliation, emerged.

"I placed a formal complaint of disruptive behaviour against a 'star' physician. After that, I experienced harassment and bullying from the formal and informal leadership in my department. This includes being ignored, dismissive treatment, public shaming of patient safety events, and public defaming via e-mail." (Participant 384)

In some cases, respondents shared how the language of discrimination could be couched in a way that makes it difficult for alternative opinions to be voiced. Discrimination is reinforced in the workplace culture because it is permitted by the majority in the workplace. This was especially evident when discrimination was linked to common workplace values. Legitimate attention to the judicious use of healthcare resources was used to permit discriminatory behaviours in the following example; a difference of opinion about transgender health could have been unfairly associated with disregard for judicious resource allocation.

"Briefly, our centre provides gender-[affirming] surgery (e.g., hysterectomy, orchiectomy). It is not unusual to hear staff question the need/indication for these operations or whether it should be the responsibility of the public system to finance[e] such procedures. The language used to criticize these procedures is typically polite or framed in a concerned light. However, intended or not, it usually at least indirectly questions the legitimacy of the trans[gender] [patient] experience or the choice for permanent surgical correction of gender." (Participant 263)

Difficulty to express a difference of opinion reflects the power that comes with "fitting in" with the dominant workplace culture. People observed to "fit in" were perceived to influence workplace culture and thereby, consciously or subconsciously, reinforce their own biases. In these narratives, discrimination manifested as belittling or ostracizing those who do not exhibit the normative performances of gender and sexuality. In the following narrative, for instance, the description of a job candidate as a "big city person" (Participant 242) was understood to be a euphemism for a 2SLGBTQ+ identity, used as a coded rationale to restrict employment to those who "fit in" with the majority.

"Unfortunately, during an interview panel, after the candidate left the room, another interviewer made fun of the candidate's mannerisms and made a comment about the type of person being more of a 'big city person' than someone to get hired where we work…" (Participant 242)

In this example, discrimination was unfairly linked to a legitimate consideration: concern that an individual would not be a "good fit" within the workplace allowed for discrimination to be permitted within the workplace.

3.4. Workplace culture improvement

Fortunately, some respondents indicated that the culture of their

workplaces has changed over time to become less permissive of consciously-biased behaviour. Discrimination on the grounds of gender and/or sexuality was reported to be less acceptable in the anesthesiology workplace.

> *"Becoming much less common. Gratuitous homophobic comments are now rare and seen as unacceptable by most staff." (Participant 417)*

> *"There are numerous occasions where gender-based discrimination presents itself in our society, working in a hospital is no different. Luckily, the frequency [with] which individuals make discriminatory comments/remarks or demonstrate inappropriate behavior is decreasing." (Participant 158)*

> *"Over many years, I have observed examples of discrimination, harassment and bullying on occasion, usually from staff members of Departments of Medicine, Surgery and Anesthesiology. Thankfully, these events are the exception; however, when they occur, they have a disproportional, and unacceptable, negative impact on the individuals and general environment of the workplace." (Participant 482)*

3.5. Power and privilege as blind spots

Qualifiers of these responses were how this change was observed over many years and that these narratives were mostly provided by individuals who identified within the majority. The privilege of "fitting in" was usually invisible to those respondents who benefitted, though many respondents had insight into this phenomenon.

> *"I don't think it makes any difference, but then I am [a] heterosexual [person] so I may not experience what others do!" (Participant 83)*

Individuals who "fit in" with the majority considered accommodation or sensitivity toward sex and gender minorities to be oppressive. One respondent shared "comments that 'we' should not have to hear about LGBTQ2S persons' struggles - 'it's being pushed on us'." (Participant 155) Similarly, respondents

> *"have experienced discrimination from patients who demanded to be treated by a female physician due to their religion. I was distressed that some of my colleagues supported this discrimination, when they would never stand for a male patient demanding to be seen by male physicians." (Participant 308)*

Unconscious bias is revealed: the status quo is suitable for those who are not made to feel "lesser" because of their gender or sexuality, so deviation from the status quo is upsetting.

ii) *Standing Out: Performativity as a Means of Disruptive Social Change*

Responses falling under the theme of "*Standing Out: Performativity as a Means of Disruptive Social Change*" represent the minority of narratives we received, but nonetheless represents an important contrast. This theme involves experiences in which individuals "stand out" against discriminatory workplace culture. Those individuals who "stand out" in these narratives frequently were described as considerate of their broader community and motivated to act on behalf of a particular vulnerable community.

> *"I consider myself an ally of the [2SLGBTQ+] community and hope that any disclosures on either side [are] in the best interests of the patient and more broadly the community of care. I hope that patients find safe spaces where they can freely be who they are and disclose necessary health information without fear of judgement or effects on care." (Participant 235)*

Respondents who shared narratives of allyship described both an awareness of the how privilege was inequitably divided among people in the workplace and an ability to leverage their privilege into meaningful, beyond-performative allyship.

> *"In the [surgical specialty operating] room more often than others. Not directed at any one in the room. Makes others feel uncomfortable. I usually ignored the remarks but occasionally had pointed out it was rude and unprofessional and the comments should stop. As I'm a staff, I think that's the reason I can stop the comments. Our trainees have reported that they did not feel they could say anything in similar situations." (Participant 46)*

Hierarchy and power dynamics must always be considered.

4. Discussion

We sought to better understand Canadian anesthesiologists', anesthesiology trainees', and anesthesiology providers' experiences of discrimination on the basis of gender and/or sexual orientation and the workplace culture from which such discrimination occurred. A latent projective content analysis of narrative responses revealed interconnecting themes of "fitting in": performativity as a means of reinforcing the status quo and "standing out": performativity as a means of disruptive social change.

Based on our results, we posit that discrimination in anesthesiology on the grounds of sexuality and/or gender typically targets individuals whose observed gender expression and behaviour is inconsistent with what is "expected" of them. Sexual objectification of women dehumanizes women, and the assertion that women should be responsible for childcare without inconveniencing men is an example of how women are expected to serve and accommodate men. Discrimination of women who reject this expectation manifested as "othering" of these individuals. Similarly, 2SLGBTQ+ anesthesiologists experienced "othering" intended to stigmatize or humiliate them when their appearance, mannerisms, and relationships were observed to not "fit in" with those of their heterosexual peers. These expectations for gendered behaviour persist in the anesthesiology workplace because they empower or otherwise benefit those of the majority. Aspects of the workplace culture which permit discrimination to persist include workplace cultures that give the "benefit of the doubt" to perpetrators of discrimination (*e.g.* failing to adequately pursue sexual abuse allegations), and cultures that make it difficult to raise objections to the status quo by linking discrimination to resource allocation (*e.g.* criticizing parental leave because of its influence on the call schedule; invalidating gender-affirmation surgery by criticizing its use of operating room resources).

Most studies of gender discrimination in anesthesiology have identified structural forms of discrimination by identifying imbalances in promotion, leadership, or compensation between men and women in academic anesthesiology – forms of gender bias termed "macro-inequity" [7,9,10,18,19] [11,34]. In contrast, the broad definition of discrimination used in our survey ("any behaviour or language toward another that serve[s] to alienate, belittle, humiliate, or trouble") and our latent projective content analysis allowed us to capture more insidious experiences of individual discrimination, which have been previously termed "micro-inequity" [9]. While "micro-inequity" may be less immediately apparent, it is nevertheless damaging [9,34]. As Carr et al. describe it, "many small discriminatory events take a cumulative toll" which may ultimately corrupt or destroy a career [9]. Most forms of discrimination we observed in this study could be described as "micro-inequities" and have been previously under-reported in the literature.

In medicine, and in society at large, historically-reinforced expressions of gender and sexuality have constructed ontologically-fixed expectations for behaviour that revolve around binaries (*e.g.,* woman/man, "homosexual"/heterosexual) and privilege the dominant ideologies (*i.e.,* men, heterosexuality). Bias against individuals who do not meet these normative expectations of gender and sexuality is similarly historically reinforced. According to Butler's theory of performativity, there exists an assembly of norms against which an individual's gender, sex, and desire is evaluated that she names the "heterosexual matrix"

[31,35]. This heterosexual matrix is pervasive in society, and the anesthesiology workplace is no exception: explicit and implicit hierarchies affecting all members of the perioperative team are defined in part by the heterosexual matrix [36–38]. For example, there are clear power differentials and hierarchies between staff anesthesiologists and their trainees as well as staff surgeons and their trainees. Sex and gender minorities who do not "fit in" with the norms comprising the heterosexual matrix are an important way in which hierarchy is established and clinicians are ostracized; however, these power differentials may be clearer to those people experiencing them because they "stand out". The time is now to "fit in" those who "stand out": discrimination of healthcare providers has detrimental effects on both patient outcomes and clinical performance [39]. Expectations about what is "normal behaviour" in the anesthesiology workplace culture must be challenged.

4.1. Limitations

One of the limitations revolves around social desirability. Social desirability in qualitative research is the propensity for participants to respond in a favourable and politically-correct manner [40]. However, since we received candid and vulnerable narratives of discrimination and because we preserved anonymity in this national survey, social desirability may be less of a concern. A limitation of cross-sectional surveys is that we were unable to probe for further clarification, unlike in interviews; the potential exists for responses to have been misinterpreted without the ability of member checking – a technique to establish credibility. In addition, we did not collect social identities other than gender and sexual orientation, in part to protect confidentiality, and we may have missed important intersecting axes of subordination and their interpretations through these lenses. Nevertheless, some participants alluded to other social identities allowing the research team to take this into consideration. Another limitation revolves around sampling; given the methodology used, we could not have sampled purposefully. However, given the wide range of respondents and their social identities, we believe that sampling is similar to maximum variation sampling given the nature of the free text narratives. Furthermore, there is always a component of convenience sampling even within maximum variation sampling. We were considerate of the relatively small number of responses we elicited, with a response rate of 7.7%. While these rates may be a limitation in quantitative survey research, the number of responses is not a marker of trustworthiness in qualitative research; the data richness and thick description in responses we received were considered sufficient to answer the research questions [23,24]. Moreover, as no IP address or cooking tracking were used to maintain confidentiality and anonymity, there may be duplicate data in that a particular respondent may have provided two responses rather than one; however, we explicitly asked participants to complete the survey only once. We also reviewed the data to ensure that there were no verbatim duplicate narrative responses.

5. Conclusion

We performed a qualitative latent projective content analysis of gender and sexuality-based discrimination of Canadian anesthesiologists and anesthesia providers. Our study revealed that individuals whose behaviours "fit in" with those expected for their gender can reinforce a workplace culture that is biased in their favour, whereas those individuals who "stand out" disproportionately experience discrimination. Our results suggest that the dismantling of bias in workplace culture requires individuals (a) who are empowered within their workplace because they "fit in" with the majority; (b) who recognize discrimination toward communities of their peers and/or colleagues; and (c) who actively choose to "stand out". Cultural transformation will require a process of deliberate unlearning and relearning.

Authorship declaration

Dr. John K. Peel: original study conception; study design; data analysis; data interpretation; co-authoring the original manuscript; revisions of the manuscript for intellectual content; final manuscript approval; accountable for this work.

Dr. Alana M. Flexman: original study conception; study design; data analysis; data interpretation; revisions of the manuscript for intellectual content; final manuscript approval; accountable for this work.

Dr. Jeremy Cygler: study design; data analysis; data interpretation; revisions of the manuscript for intellectual content; final manuscript approval; accountable for this work.

Dr. Kyle R. Kirkham: original study conception; study design; data analysis; data interpretation; revisions of the manuscript for intellectual content; final manuscript approval; accountable for this work.

Dr. Gianni R. Lorello: original study conception; study design; data analysis; data interpretation; co-authoring the original manuscript; revisions of the manuscript for intellectual content; final manuscript approval; accountable for this work.

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Disclosures

None as they pertain to this study; ICMJE disclosure forms submitted.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.jclinane.2022.110884.

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