Introducing Dr. Smith, Dr. Wang, and Emily

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Accepted: 24 June 2021 / Published online: 18 July 2021

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Introduction

In the field of gastroenterology, women comprise about a fifth of all practicing physicians and roughly a third of all fellows [1]. While striving for equal representation is important, “the problem is not merely the number of women in gastroenterology—it is also their lived experiences and opportunity to succeed once in training and practice” [2]. Unfortunately, in many facets of their professional lives, women face discrimination that undermines their perceived authority and expertise. For instance, several studies of major medical conferences have revealed that women are less likely to be introduced by their formal doctoral titles when compared to men [3–5]. Differences in use of formal titles by gender, though subtle, serve to enforce the barriers that women face in medicine.

Background and Discussion

In this issue of *Digestive Diseases and Sciences*, Feld and colleagues investigated use of formal titles by gender at the virtual 2020 American College of Gastroenterology (ACG) annual meeting [6]. The current work is the first to assess gender bias in speaker introductions at a prominent gastroenterology conference [6]. Feld et al.’s study contributes to the existing literature on gender bias in speaker introductions at national medical conferences by examining introductions at a virtual meeting in light of the COVID-19 pandemic and

exploring the concept of formal title use in self-introductions [6].

Similar to recent studies investigating speaker gender bias at medical conferences, Feld et al. did not find a difference in formal introduction use for female vs. male speakers [5–7]. Of the 78 introductions reviewed at the 2020 ACG meeting, all but one introduction utilized a formal form of address to introduce the speaker, and all female speakers were introduced using their formal professional title [6]. The consistent use of formal introductions by moderators at the ACG is an encouraging finding, though it would be interesting to know if the high rate of formal introduction use was a result of the meeting’s entirely virtual format or perhaps a result of meeting organizers intentionally recommending a standardized script for speaker introduction. When Duma et al. published their findings that female speakers were less likely to be introduced by their formal title when compared with male speakers (62 vs. 81%, $p < 0.01$) at the American Society for Clinical Oncology (ASCO) Annual Meeting, ASCO’s Cancer Education Committee responded by publishing recommendations (“The Language of Respect”) on the consistent use of formal doctoral titles (i.e., “Dr.”) by all session participants and requested that session chairs reiterate this policy at the start of each session [3, 8]. Since the publication of “The Language of Respect,” increased awareness of speaker gender biases has sparked discussions among multiple medical specialties; the existence of these guidelines may even be responsible for the lack of differences in formal introduction between female and male speakers in subsequent studies [5–8].

Novel to this analysis, Feld et al. investigated the use of formal forms of address in self-introductions by the meetings’ speakers. Of available presentations, 83.3% provided a self-introduction [6]. Overall, 40% of speakers used a formal introduction, and 50% used an informal introduction [6]. Of self-introductions, female speakers introduced themselves formally 36.4% of the time compared with men who introduced themselves formally 41.9% of the time [6]. While Feld and colleagues found no statistically significant difference in the use of formal self-introductions by gender,

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female speakers did have a slightly lower rate of formal self-introduction [6]. Perhaps female speakers at the ACG annual meeting feel a strong sense of belonging and are comfortable with forgoing their formal titles—knowing that they will be regarded as an expert in their field. Conversely, in a more troubling interpretation, it is possible that the female speakers eschewed their formal titles to avoid being perceived as “uptight” or “unapproachable,” labels that may be more commonly targeted toward women. Brought to light by Feld and colleagues’ study, the concept of self-introductions should be further explored in future studies. In comparison with moderator-generated introductions, self-introductions may reflect the speaker’s own sense of belonging in a professional society [6].

Difference in the way female speakers are introduced compared with male speakers is just one specific way that women experience bias. Demonstrating the lack of difference in speaker introductions by gender, while encouraging, does not mean that gender inequities have been eliminated in academic medicine. It is not coincidental that the body of literature on bias in speaker introductions at medical conferences is largely focused on subspecialties, including general surgery, radiation oncology, urology, and gastroenterology, which in 2019 had active workforces that were 22.0%, 27.4%, 9.5%, and 18.9% female, respectively [1, 5–7]. Especially in fields that lack representation of women, use of formal titles for female speakers can help signify their expertise; otherwise, without their credentials displayed, women may be perceived as lower in status in comparison with their male colleagues [9]. In calling for standardization of formal title use at professional conferences, some have suggested that formality stifles collegiality and stops an exchange of ideas [9]. Nevertheless, as one female physician stated: “If you are fortunate that people assume you are a doctor when you enter a room and are qualified to speak on a subject, sure be casual. Use your [first] name. If, like some of us you don’t have that benefit, your title is like a passport letting people know you belong in the room [10].”

Ultimately, women want to be respected for their academic work and training, feel like they belong, and feel to be on equal footing as their male colleagues. When women speak out about the discrimination they experience or when they produce research that investigates potential sources of bias, it is necessary to listen to their narratives and enact systemic changes.

Future Directions

Building off the work of Feld et al., future studies could include identifying other barriers to women’s sense of belonging in medicine and should aim to provide strategies that can be used to combat the microaggressions that

women experience at professional conferences and in the workplace [6]. Specifically for the ACG, trending the use of formal introductions over time in addition to comparisons of formal introduction use before and after moderator guideline implementation could shed light on the efficacy of such guidelines. Although difference in speaker introductions by gender is one of the most obvious ways that women experience bias, there are many other forms of discrimination that are less overt such as delayed promotion, lower grant scores, and the gender pay gap—all of which may be hidden at the individual level and require system-wide analyses to reveal [2]. Study of diversity, equity, and inclusion initiatives across medical societies and their endpoints can also help elucidate which strategies are effective at creating change and if they could be broadly implemented. Furthermore, the current literature on differences in formal introduction use by introducer and speaker gender only scratch the surface of how our implicit biases influence behavior, and future studies on race and intersectional identities are crucial for exposing the inequities that plague our society and can help provide concrete solutions for how we can protect our communities’ marginalized populations.

Conclusion

In summary, Feld and colleagues found no difference in moderator-generated introduction or self-generated introduction by gender at the virtual 2020 ACG annual meeting [6]. Although their results offer hope that academic medical communities are becoming more aware of their implicit biases and that organizations are taking action, active dismantling of structural barriers and a true cultural shift are still needed to achieve gender equity in medicine. Within academic medicine, failure to foster a culture of inclusion can and will continue to deter recruitment of women to fields that are historically male-dominated and slow progress toward gender equity. Importantly, on an individual level, we must recognize our own biases and do our part to educate our communities on how to create an inclusive culture of belonging.

Declarations

Conflict of interest The authors have no relevant conflicts of interest to disclose.

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