Towards gender equity in emergency medicine: a position statement from the CAEP Women in Emergency Medicine committee

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Abstract

As of January 2019, over half of all doctors working in Canada under the age of 40 were women. Despite equal representation in the profession of medicine, women still experience harassment, discrimination, and pay inequity when compared to their male colleagues. Gender discrimination is present at all levels of medical training and negatively impacts women who want to become emergency physicians. The right to gender equity is part of the Canadian Charter of Rights and Freedoms. The World Health Organization states that “gender inequities are socially generated and, therefore, can be changed.” CAEP recognizes that gender equity is important to its members and that it intersects with inequities experienced by other minority groups. This position statement from the committee for Women in Emergency Medicine (EM) is intended to support women and those who identify as women who have chosen EM as their career. Furthermore, it is meant to inform and support policy makers as they consider the unique challenges that women face in their pursuit of excellence in EM.

Keywords Emergency medicine · Gender equity · Discrimination · Gender pay gap

Résumé

En janvier 2019, plus de la moitié des médecins de moins de 40 ans travaillant au Canada étaient des femmes. Malgré une représentation égale dans la profession médicale, les femmes sont toujours victimes de harcèlement, de discrimination et d'inégalités salariales par rapport à leurs collègues masculins. La discrimination sexuelle est présente à tous les niveaux de la formation médicale et a un impact négatif sur les femmes qui veulent devenir médecins urgentistes. Le droit à l'égalité des sexes fait partie de la Charte canadienne des droits et libertés. L'Organisation mondiale de la santé affirme que "les inégalités entre les sexes sont générées par la société et peuvent donc être modifiées". L'ACMU reconnaît que l'égalité des sexes est importante pour ses membres et qu'elle recoupe les inégalités vécues par d'autres groupes minoritaires. Cette déclaration de position du comité pour les femmes en médecine d'urgence (MU) est destinée à soutenir les femmes et ceux qui s'identifient comme femmes ayant choisi l'EM comme carrière. En outre, elle est destinée à informer et à soutenir les décideurs politiques dans leur réflexion sur les défis uniques auxquels les femmes sont confrontées dans leur quête d'excellence en matière de médecine d'urgence.

Please note that this position statement has been reviewed and approved by the CAEP membership, the CAEP public affairs committee and the CAEP board of directors.

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Introduction

As of January 2019, over half of all doctors working in Canada under the age of 40 were women [1]. Despite equal representation in the profession of medicine, women still experience harassment, discrimination, and pay inequity when compared to their male colleagues. Gender discrimination is present at all levels of medical training and negatively impacts women who want to become emergency physicians [2].

The right to gender equity is part of the Canadian Charter of Rights and Freedoms [3]. The World Health Organization states that “gender inequities are socially generated and, therefore, can be changed [4].” CAEP recognizes that gender equity is important to its members and that it intersects with inequities experienced by other minority groups. This position statement from the committee for Women in Emergency Medicine (EM) is intended to support women and those who identify as women who have chosen EM as their career. Furthermore, it is meant to inform and support policy makers as they consider the unique challenges that women face in their pursuit of excellence in EM.

List of recommendations

More research is needed to understand the implicit biases of Canadian emergency physicians

Implicit biases are internalized schemas that people develop over a lifetime to understand the world around them and which may lead them to unintentionally act in a discriminatory manner [5]. Implicit bias, unlike explicit prejudice, is independent of a person’s level of education and can affect even those who view themselves as valuing fairness and diversity [6]. Many institutions have implemented diversity training as a way to bring awareness about implicit bias to individuals on various boards [7]. A systematic review of implicit bias training suggests that while these types of interventions may temporarily reduce bias there is not enough evidence yet to suggest that they yield any meaningful changes in reducing bias in the long term [6, 8].

There must exist a non-punitive process to investigate claims of harassment and discrimination, which ensure blame free and rapid resolution of grievances

within institutions (both training programs as well as hospitals/hospital systems). This process should be readily disseminated and reviewed, and real action should be taken to protect complainants

Despite more women in EM, harassment and gender discrimination are pervasive at all levels of training [9]. The emergency department (ED) is a unique environment with a large number of staff, shift work, and a hierarchical structure. It can be a chaotic and stressful environment which often lends itself to increased tensions and transgressions. These factors often lead physicians to use coping mechanisms that include inappropriate jokes, language, and behaviors [10]. Sexual harassment includes suggestive language, comments, and sexist jokes that convey exclusion or impart a second-class status and can lead to unwanted sexual attention. Sexual harassment continues to be a prevalent form of mistreatment encountered by female physicians particularly during residency training. Female physicians are also more likely to experience physical assault and sexual harassment by patients and their family members [11].

Medical students and residents who are training in EM must have a learning environment that is free of gender bias. We acknowledge that the need for gender equity intersects with the need for a learning environment free from racism and other forms of discrimination that are beyond the scope of this position statement

Gender discrimination is the most reported form of abuse described by resident physicians, without significant variation between years of training [9]. Trainees who reported frequent harassment were more likely to provide suboptimal patient care, have increased disruptions in emotional health, and family and social responsibility, in addition to lower completion rates on academic assignments. One study noted that 39% of trainees were significantly disturbed by harassment and 5% reported considering leaving their specialty because of it [9]. Physicians who experience gender-based discrimination were significantly less inclined to choose the same speciality if they were to retrain, suggesting that these encounters had potential to reshape their career trajectories [12] (Table 1).

Table 1 Summary table of recommendations

Problem	Recommendation
1. Implicit bias and gender discrimination	More research is needed to understand the implicit biases of Canadian emergency physicians
2. Sexual harassment	There must exist a non-punitive process to investigate claims of harassment and discrimination, which ensure blame free and rapid resolution of grievances within institutions (both training programs as well as hospitals/hospital systems). This process should be readily disseminated and reviewed, and real action should be taken to protect complainants
3. Trainee discrimination	Medical students and residents who are training in EM must have a learning environment that is free of gender bias. We acknowledge that the need for gender equity intersects with the need for a learning environment free from racism and other forms of discrimination that are beyond the scope of this position statement
4. Parental leave	Emergency department medical directors and residency program directors should ensure that there are clear parental leave and breastfeeding policies in place at their institutions and that all physicians are aware that these policies exist. These policies should be reviewed and updated by a gender balanced committee at regular intervals
5. Gender wage gap	Further research is needed to understand the persistent and pervasive gender pay gap in EM in Canada
6. Gender discrimination in academia	Canadian medical schools and EDs should ensure diverse composition of hiring and selection committees and an equitable process for selection of individuals for training, administrative and academic leadership positions
7. Lack of mentorship and sponsorship for women	A Canada-wide woman-specific mentorship program needs to be developed. Academic institutions and Canadian EDs must actively mentor and support female emergency physicians at all stages of their career
8. Underrepresentation in leadership positions	Leaders in EM need to develop recruitment and retention strategies that focus on gender equity. Ensuring women are represented on panels and as speakers in conference will increase the visibility and role-modeling of women leaders in EM

Emergency department medical directors and residency program directors should ensure that there are clear parental leave and breastfeeding policies in place at their institutions and that all physicians are aware that these policies exist. These policies should be reviewed and updated by a gender balanced committee at regular intervals

In Canada between 1976 and 2015 the number of households with two working parents increased from 36 to 69%, and 75% of parents in dual-earner couples with children now work full-time [13]. Female physicians report being partnered with a working spouse more often than male physicians and they still bear most of the responsibility for childcare [14]. As a result, many women are forced to work fewer hours in their professional jobs beyond maternity leave. On top of the economic consequences of childbearing, women in EM also face potential dangers to their own health and the health of their infant due to the exposures and demands of the shifts that they work [15]. Women who do shift work are at a higher risk of miscarriage, preterm birth, and small for gestational age infants [16]. To protect the health of these women and their families it is critical that maternity leave and breastfeeding policies are in place at all EDs in Canada.

Further research is needed to understand the persistent and pervasive gender pay gap in EM in Canada

Today, women in Canada earn 87 cents for every dollar earned by men [17]. The two largest factors explaining this gender wage gap from 1998 to 2018 were the distribution of women and men across industries and women's overrepresentation in part-time work. This still does not explain nearly two-thirds of the gender wage gap. In primary care, the wage gap has been estimated to be between 20 and 26% and female surgeons earn 24% less than their male counterparts [18, 19]. Recent data based on 2016 billing data from Ontario show a clear gender pay gap in EM with men making more than women in a fee-for-service model [20].

Canadian medical schools and EDs should ensure diverse composition of hiring and selection committees and an equitable process for selection of individuals for training, administrative, and academic leadership positions

Women rarely advance to the top rungs of the EM academic ladder. In 2019, Bennett et al. reported that in the U.S., women made up half of all medical students but only 28% of the academic EM workforce, and only 10% of all professors in academic medicine [21]. While

women residents in many other specialties have reached or exceeded gender parity, women represent only 35% of all EM residents [22]. A retrospective analysis of CIHR grants and awards also revealed that compared with men, women were significantly less likely to be funded, and overall, had significantly lower personal award success [23]. A 2017 study showed a salary gap of \$19,462 in Academic EM, with women earning less than men regardless of rank, clinical hours, or training. They also reported that more women than men were fellowship-trained but fewer women held administrative roles or high academic rank, such as associate or full professor [24]. Promoting equity, diversity, and inclusivity, within a specialty's physician workforce is a key step toward successful recruitment, engagement, and retention of high-quality medical students, residents, and faculty.

A Canada-wide woman-specific mentorship program needs to be developed. Academic institutions and Canadian EDs must actively mentor and support female emergency physicians at all stages of their career

Mentorship and networking are core strategies which can be used in the recruitment, retention and promotion of female EM faculty [25, 26]. Many women in EM do not have the same networking opportunities as their male counterparts (i.e., informal get-togethers for a beer or sports) due to competing priorities at home or because it is perceived that they would not be interested. Hence, they have been less likely to benefit from these informal mentorship and sponsorship opportunities that may arise during such informal gatherings [27]. Due to the historical underrepresentation of women in the specialty of EM many women have found it difficult to find senior women mentors [28]. By starting the female mentorship relationships as early as residency, the former mentees can then be encouraged to become mentors as they graduate from residency as demonstrated by Welch et al. [29].

Leaders in EM need to develop recruitment and retention strategies that focus on gender equity. Ensuring women are represented on panels and as speakers in conference will increase the visibility and role-modeling of women leaders in EM

There is a clear gender leadership gap in EM in Canada. There are very few female EM department heads within Canadian Universities and very few female ED medical directors. The paucity of medical leaders who are women is often referred to as a “leaky pipeline.” Kang and Kaplan explain that just as many women are in the pipeline as men, but they are excluded at each stage of their professional

lives, from recruitment and recommendation to evaluation, promotion, training, and compensation [30]. Women also report being disrespected by colleagues, being held to a higher standard than male colleagues, being treated less formally than male colleagues (being introduced by their first name instead of by their formal titles), and not being invited for major talks like grand rounds [31].

Next steps

The next step in solving the problem of gender discrimination in EM in Canada is to describe it accurately. Much of the research in this area comes from other countries and may not accurately reflect the experiences of female emergency physicians in Canada. The CAEP Women in EM committee calls on physicians in EM to analyze this crucial problem. It is only through research and knowledge translation that the problem will be described and can be solved.

Conclusion

CAEP is committed to gender equity for all members and non-members in the EM community. Women in EM deserve to work in an environment that provides equal opportunity and equal pay for equal work. There are many strong women leaders in EM; however, the voices of all women in all EDs in Canada deserve to be heard, and opportunities must be provided for all women to develop and demonstrate leadership skills. Female physicians, along with those who identify as female, deserve to learn EM in a supportive, non-judgmental, and non-discriminatory environment. CAEP will not tolerate discrimination and harassment of female physicians and will work tirelessly to ensure that its members feel supported and safe in their working environments.

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