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EDITORIAL

A paradigm shift: from overcoming to dismantling equity barriers in EM

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I entered the room and introduced myself as the emergency physician on duty.

The elderly gentleman paused, his nose scrunched up as he eyed my stethoscope. "They allow women to be doctors now?" he said incredulously as he leaned forward on his cane, squinting to inspect my ID badge.
- J.K., patient interaction from 2019

Gender parity among Canadian physicians has come a long way in this patients' lifetime. Over 50% of medical school matriculants [1] and 42% of Canadian physicians [2] now identify as female. Despite these overall advances, Sheppard et al. and Jagelaviciute et al. remind us that the journey to gender equity in Emergency Medicine (EM) remains a work in progress [3, 4]. It's time to use these findings to drive structural changes and targeted training to bridge this gap.

Only 31% of emergency physicians are women and Jagelaviciute et al. highlight research suggesting that female trainees may express less interest in EM due to gender-based bias negatively impacting their career progression and well-being [4]. Key themes from their study identify possible reasons for these perceived inequities: females continue to perceive microaggressions, experience imposter syndrome, and document struggles with work-life balance. Sheppard et al. corroborate these findings and call for institutional and policy-level changes to foster gender equity [3].

Sheppard et al. found that male-identifying respondents did not perceive the same level of gender inequity as their female peers [3]. This disparity in the perception of gender inequities highlights a phenomenon often seen in equity work: members of the advantaged group, who benefit from unearned privileges associated with their identity, often don't—or can't—see the nuanced challenges faced by their equity-seeking counterparts. This 'invisibility' of inequities hinders progress, underscoring the need for critical engagement and allyship on equity initiatives by advantaged group members. As McIlveen-Brown et al. write, "research suggests that when cis-men advocate for diversity, their advocacy efforts are more successful than when shouldered by women and nonbinary people who may be viewed negatively for engaging in this work" [5].

Addressing inequities in EM is an issue of fairness and is critical to improving physician-workforce planning. Gender bias impacts female-identifying physicians' well-being, career satisfaction and longevity [5]. Attrition by female emergency physicians in the USA is 12 years earlier than their male colleagues [6]. Efforts to foster gender equity in EM is a strategic investment in the health, wellbeing and longevity of our clinical teams, at a time when our specialty is grappling with burnout, attrition and staff shortages.

The Coin Model of Privilege by Nixon [7] offers a framework for understanding and addressing inequities. In this metaphor, the coin represents social structures or norms that maintain inequities and illustrates how privilege operates in society. The social structures that make up the coin—sexism, heterosexism, racism, for example—are often *invisible and systemic*, privileging some over others regardless of merit or behaviour. Each person finds themselves either on top (the privileged side) or the bottom (the disadvantaged side) of different coins. This model shows that privilege and disadvantage are interconnected and mutually reinforcing—and suggests that those who benefit from privilege often do so unconsciously, at the expense of the disadvantaged.

In the EM context, these privileges are exemplified in scenarios like team meetings or resuscitations, where certain voices are heard more over those of others, often aligning along socio-demographic lines. Similarly, opportunities for

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leadership roles and advancement might skew toward certain groups at the expense of others, not necessarily based on competence or interest, but influenced by underlying implicit biases.

The Coin Model suggests that we are often so busy navigating around systemic barriers that we may not appreciate the need to actually dismantle them altogether. According to Kuhn [8], scientific progress is not a smooth, continuous accumulation of knowledge, but rather a series of revolutions or paradigm shifts—fundamental changes in underlying assumptions, concepts, or practices. Applying the Coin Model to our EDs requires a paradigm shift—from viewing inequities as isolated challenges faced by disadvantaged groups to understanding them as symptoms of broader systemic issues that also privilege others. Equity work is too often designed by people of privilege aiming to alleviate the challenges of the disadvantaged, instead of a system-based approach to dismantle the barriers themselves, i.e. eliminating the coin altogether. Dismantling these systems requires people from both sides of the coin to work together to achieve a common goal. This shift in perspective is crucial for developing transformative solutions that target the root causes of gender inequities in EM. For guidance on how to put change into action, we can look to consensus recommendations developed by CAEP [5].

As individual physicians, we can each commit to ongoing education about gender-bias, microaggressions and systemic biases. Learning to identify, intervene and eliminate microaggressions will foster more inclusive work environments within EM. By supporting and advocating for equity-seeking colleagues, through mentorship, sponsorship, and speaking out against injustices, we can each contribute to a culture of equity and respect. Part of the paradigm shift must include a culture of accountability, where all members of the EM community feel responsible for promoting and sustaining gender-equity.

The Coin Model suggests that we all carry a pocket full of change. Each coin represents one system of oppression or privilege that we are born into. We find ourselves on the heads side of some coins and at the tails side of others. How these coins fall on the table defines how we relate to others in any situation. While the focus of this commentary is on gender-equity, there also needs to be a conversation on equity more broadly, which considers non-binary or transgender individuals, racial minorities including Black and Indigenous practitioners, ableism, and those whose experiences in EM may be compounded by intersecting identities. Shepperd et al.'s finding that the privileged group was less aware of the inequities experienced by those not in their group underscores the need to seek out the unique perspectives of equity-seeking members of the EM community and work together to dismantle systemic barriers.

Declaration

Conflict of interest No conflicts of interest to disclose.

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