

Women in Emergency Medicine Committee

## Myth Busting: Women in Emergency Medicine

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Over the past year, I've participated in great discussion forums about women in medicine. From large conferences to local meetings and online groups, I've witnessed insightful conversation centered on the recruitment, retention and promotion of women leaders in our field. However, there are a handful of stale talking points I hear repeated over and over.

These myths make me cringe every time. Men and

women, to move this conversation forward, I'd like to propose we examine the evidence and put the following myths to rest, once and for all.

### **Myth 1: The lack of female physician leaders is a pipeline problem.**

According to the AAMC, women represent 50.7% of new medical school enrollees in 2017, surpassing men for the first time.<sup>1</sup> Emergency medicine reflects this same shift – albeit slower – with an ever-growing number of women in training.

One recent study showed 38% of EM residents are women, up from 28% in 2001.<sup>2</sup> Yet, women account for 38% of full time faculty, only 21% of full professors, and a measly 16% of deans.<sup>3</sup> One clever study in *BMJ* showed that men with mustaches

significantly outnumber women as leaders of U.S. medical departments. They quantified the proportion of women over the proportion of mustaches at major academic institutions and found the overall “mustache index” to be 0.72.<sup>4</sup> The authors set a challenge that every department should strive for an MI greater than or equal to 1 – at least one woman in a leadership position for every mustache. Scan the room at the next high level meeting you attend. We don't have a pipeline problem – we have an advancement problem. If we quit focusing on the pipeline, which has been improving on its own every year, we can focus on the barriers keeping women from climbing the ranks.

**Myth 2: Most problems for women physicians stem from child-rearing issues.** Across many types of settings, I have seen potentially groundbreaking discussions about how to fix the advancement problem devolve instead into a complaint session about maternity leave. I'll be the first to say, having a parental leave policy on paper is a game changer and every workplace should strive for this goal (see Myth 3). However, focusing too much on maternity leave, we alienate women who are pre- or post- family planning and those without children. There are issues that unite women at all ages and stages of their careers. For example, the

problem of gender bias in evaluation of residents. One recent study demonstrated qualitative differences in the feedback that male and female residents received, from faculty of both genders.<sup>5</sup> There are also different rates of milestone attainment tracked for men vs. women in EM training.<sup>6</sup> Let's come together to closely examine the tools we use to evaluate our trainees and see whether bias may be at play during these formative years, then track performance measures across a woman's career. That's an area with potential for lasting impact.

### **Myth 3: A champion of women, whether in academics or the community, is someone who listens.**

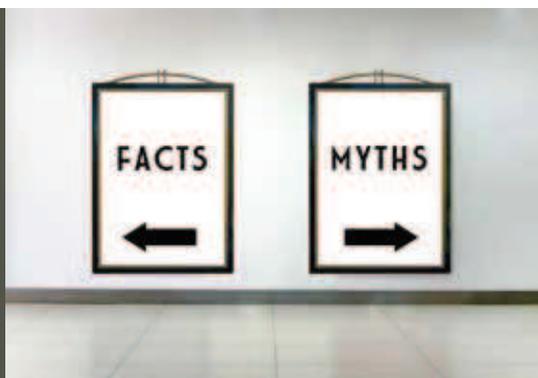
I heard a panel in front of hundreds of physicians with two celebrated “champions of women in EM.” Both panelists were men, so I was irritated from the get-go. One was a regional manager of a huge contract management group who claimed his shops were “family friendly” because he would sit down with individuals and be

“extremely flexible” about their needs. Beware: this load of fluff means go ahead and take as much unpaid time as you want, we are happy to have you back at the end of it all. Keep in mind, recruitment and training of new docs is expensive. Male and female physicians should

be wary of companies that claim to support families, with a modus operandi that tells a different story. Remember to carefully scan those contracts for sneaky due process waivers and restrictive covenant tricks – these are the least “family friendly” implements out there. A champion gets policies on paper and makes institutional change. One final point to keep in mind regarding finding a true champion: you'll want this type or person not only in your chair or site director, but also in the individual professional relationships you build. Mentoring is great, but what is most needed for women physicians in their early career is a person who thinks of you when a new opportunity comes up and vouches for you as the best choice. This active process distinguishes a champion from a typical mentor.

**Myth 4: Men in primary caregiver roles do a sub-par job.** I found it difficult to listen to one talk recently on a household with “flipped” roles from the “traditional” model, with the woman working full time in EM, and the man doing child rearing. Though a tongue in cheek talk, the physician lamented over the boxed mac and cheese being prepared and the video

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Continued on next page

games being played, and learning to “let it go.” What should we let go of? The tired notion that men can’t, don’t, or won’t prepare healthy food or provide stimulating activities for children. Personally, if left to my own devices I’d choose Wawa for every meal (come to Philly, you’ll understand) and would prefer to never leave the house all winter, whereas my husband crafts meals with grains I’ve never heard of and regularly ventures out on his bike with our toddler year-round. I’d argue these differences have much more to do with our personalities and childhood experiences than XX/XY. We can’t move forward if we keep referencing the 1950s. The share of two-parent homes with two full-time working parents is 46%. It’s time to think creatively about division of household duties, including caring for other family members, like aging parents.

I’m heartened that in recent years, emergency medicine has recognized the importance of all kinds of diversity in leadership. Within AAEM, I’ve seen tremendous growth in opportunities for women and promotion of new voices and ideas at the table. I believe we can do even better for ourselves, and in turn our patients, if we ditch the tired myths above, ask the right questions, identify the most threatening problems and work to fix them in priority order. After all, we are emergency physicians – who is better up for that task? ●

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