3-1-2022

Priority strategies to improve gender equity in Canadian emergency medicine: proceedings from the CAEP 2021 Academic Symposium on leadership

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Canadian Journal of Emergency Medicine (2022) 24:151–160
https://doi.org/10.1007/s43678-021-00245-1

CAEP ACADEMIC SYMPOSIUM PAPER

Priority strategies to improve gender equity in Canadian emergency medicine: proceedings from the CAEP 2021 Academic Symposium on leadership

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Received: 25 October 2021 / Accepted: 24 November 2021 / Published online: 16 January 2022

Abstract

Objectives Gender inequities are deeply rooted in our society and have significant negative consequences. Female physicians experience numerous gender-related inequities (e.g., microaggressions, harassment, violence). These inequities have far-reaching consequences on health, well-being and career longevity and may result in the devaluing of various strengths that female emergency physicians bring to the table. This, in turn, has an impact on patient healthcare experience and outcomes. During the 2021 Canadian Association of Emergency Physicians (CAEP) Academic Symposium, a national collaborative sought to understand gender inequities in emergency medicine in Canada.

Methods We used a multistep stakeholder-engagement-based approach (harnessing both quantitative and qualitative methods) to identify and prioritize problems with gender equity in emergency medicine in Canada. Based on expert consultation and literature review, we developed recommendations to effect change for the higher priority problems. We then conducted a nationwide consultation with the Canadian emergency medicine community via online engagement and the CAEP Academic Symposium to ensure that these priority problems and solutions were appropriate for the Canadian context.

Conclusion Via the above process, 15 recommendations were developed to address five unique problem areas. There is a dearth of research in this important area and we hope this preliminary work will serve as a starting point to fuel further research. To facilitate these scholarly endeavors, we have appended additional documents identifying other key problems with gender equity in emergency medicine in Canada as well as proposed next steps for future research.

Keywords Emergency medicine · Gender equity · Gender · Resuscitation training · Leadership advancement · Wage gap · Allyship · Equity · Medical education

Résumé

Objectifs Les inégalités entre les sexes sont profondément ancrées dans notre société et ont des conséquences négatives importantes. Les femmes médecins subissent de nombreuses inégalités liées au genre (par exemple, microagressions, harcèlement, violence). Ces inégalités ont des conséquences considérables sur la santé, le bien-être et la longévité de la carrière et peuvent entraîner la dévalorisation des différents atouts que les femmes médecins urgentistes apportent à la table. Ceci, à son tour, a un impact sur l'expérience et les résultats des soins de santé des patients. Au cours du Symposium académique 2021 de l'Association canadienne des médecins d'urgence (ACMU), une collaboration nationale a cherché à comprendre les inégalités entre les sexes en médecine d'urgence au Canada.

Méthodes Nous avons utilisé une approche en plusieurs étapes basée sur l'engagement des parties prenantes (en utilisant des méthodes quantitatives et qualitatives) pour identifier et classer par ordre de priorité les problèmes d'équité entre les sexes en médecine d'urgence au Canada. À partir d'une consultation d'experts et d'une revue de la littérature, nous avons élaboré

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des recommandations visant à apporter des changements aux problèmes les plus prioritaires. Nous avons ensuite mené une consultation nationale auprès de la communauté canadienne de médecine d'urgence par le biais d'un engagement en ligne et du symposium universitaire de l'ACMU afin de nous assurer que ces problèmes prioritaires et ces solutions étaient adaptés au contexte canadien.

Conclusion Grâce au processus ci-dessus, 15 recommandations ont été élaborées pour traiter 5 domaines problématiques uniques. Il existe un manque de recherche dans ce domaine important et nous espérons que ce travail préliminaire servira de point de départ pour alimenter d'autres recherches. Pour faciliter ces efforts de recherche, nous avons annexé d'autres documents identifiant d'autres problèmes clés en matière d'équité entre les sexes en médecine d'urgence au Canada, ainsi que des propositions d'étapes pour de futures recherches.

Introduction

Women and gender minorities have experienced a legacy of gender-related inequities that result in far-reaching health and social consequences. These pervasive inequities are maintained through gendered norms that often reinforce the social powers and privileges of cis-gendered men and typically favour characteristics ascribed to men and maleness [1].

For physicians, gender bias can minimize the important strengths of those identifying as female and has an impact on their well-being, career satisfaction and longevity [2, 3]. Research shows there are benefits to patients who are cared for by female physicians with regard to both outcome and satisfaction [2], most pronounced when patients themselves are female [4]. Rather than being celebrated however, female physicians' practices and communication styles are often undermined in clinical practice through microaggressions and at times, overt harassment [5].

Gender-related health inequities for patients are pervasive and multi-factorial resulting from differences in disease exposure, health behaviours, access to medical care and lack of gender-specific research [6, 7]. While certain factors that result in this inequity are difficult to address, one actionable approach is to address gender-related inequities in medical education and staffing [8]. By supporting healthcare providers who identify as women to progress in their careers and take on leadership roles, we expect that gender-related inequities in patient care will be seen and addressed.

A recent position statement asserted the existence and impact of gender bias and discrimination on those training and working in emergency medicine (EM) in Canada [9]. This position statement [9] and other previous reports [10, 11] suggests that many policies and systems fail to reflect certain women's needs or to adequately compensate them for their work [10, 11]. These barriers disincentivize those identifying as female to choose a career in EM. A 2019 Canadian survey looking at the overall pool of Canadian physicians under 40, showed that more than half identified as female [10]. However, only 31% of emergency physicians identify as women [12]. Signs suggest these trends will persist as gender parity has not yet been achieved with applications for EM residency spots [13].

Internationally, it seems that our American colleagues may be closing the gap in some regards. Women in at least two American EM societies (Society of Academic Emergency Medicine and American College of Emergency Physicians) appear to receive a similar proportion of awards to their male colleagues as opposed to our own Canadian Association of Emergency Physicians (CAEP) [14]. Even in the United States, however, where gender equity has been a priority for several national societies for approximately a decade, women are persistently under-represented in advanced leadership positions and academic positions [15, 16]. Addressing these issues to support equal representation and recognize and celebrate diversity within our workforce is essential.

To facilitate our continued journey to achieve gender equity in EM within Canada, we undertook a multistep, stakeholder-engaged, evidence-based review to develop recommendations for CAEP's 2021 Academic Symposium.

Methods

Design and conceptual framework

The CAEP Gender Equity Working Group was developed to identify barriers to gender equity amongst emergency physicians working in Canada. The work was developed under the umbrella of the CAEP 2021 Academic Symposium on Equity, Diversity and Inclusion. Monthly meetings took place with chairs of the leadership committee and leads of two other working groups (addressing anti-colonialism and anti-racism in EM, and EM residency training about sexual and gender minorities). These meetings were essential for symposium cohesion and to recognize the intersectionality common to our equity-seeking groups.

Throughout this work we acknowledge that gender is a spectrum. When we refer to "women" and female perspectives we include all who identify as women or have had experience as women and/or on the feminine side of the gender spectrum. When we refer to men and male perspectives we are referring to cis-male perspectives (e.g. those who have only lived on the

masculine side of the gender spectrum). See Online Appendix A for a complete glossary of terms used in this publication.

Study setting and procedure

This work was undertaken by a CAEP working group with the intent of establishing guidelines for its members and was designated as a quality improvement project. It was reviewed and granted a program development exemption from the Hamilton Integrated Research Ethics Board, Hamilton, Ontario according to Tri-Council Policy Statement 2 [2018], under Article 2.5.

We conducted a multi-phase study to elicit and then refine the consensus recommendations. The process included the following ten steps: (1) recruiting collaborators (2) internal discussions within the symposium group; (3) analysis of discussions to isolate problem statements; (4) creation of survey tool with all problem statements; (5) survey of emergency physicians and trainees to prioritize problem statements; (6) selection of top problem statements based on

Table 1 2021 CAEP Academic Symposium gender equity panel methods

Step	Details
Step 1: November 2020 Initial recruitment for stakeholders	We broadly recruited stakeholder volunteers from within the CAEP membership and other Canadian emergency physicians using email lists and social media platforms. Respondents ($n=68$) were recruited for further involvement with this work
Step 2: November 2020 Virtual focus groups to identify problem domains	A virtual meeting (48 of 68 stakeholders, 70.6% engagement rate) with four facilitated focus groups (gender bias, trainee concerns, leadership advancement, and organizational policies and procedures) took place. Literature-based structured interview guides were used. Meetings were recorded. Key themes from the discussions were captured (see Online Appendix B)
Step 3: December 2020 Drafting of the problem statements	Focus group notes and themes were reviewed (EMB, JM) to develop problem statements. Draft problem statements were presented and revised at a second virtual meeting ($n=22$). They were then sent to a larger collaborators group ($n=68$) for feedback
Step 4: January 2021 Creation of survey tool to identify priorities	Statements were further refined (EMB) and reviewed (JM and TMC, AB and PC) to develop survey items. The survey draft was agreed upon by consensus (virtual meeting, $n=13$) and was also sent to the larger group ($n=68$) for additional commentary (see final survey in Online Appendix C)
Step 5: February 2021 Survey of emergency physicians and trainees to prioritize problem statements	Survey (English and French) was open to all Canadian emergency physicians and trainees doing any amount of emergency medicine. It was sent to the CAEP mailing list ($n=1517$, one invitation and one reminder), posted on social media platforms and emailed to various Canadian physician organizations
Step 6: March 2021 Selection of top problem statements based on survey data	Survey results were reviewed at a virtual meeting of study authors and collaborators. Results (prevalence of issue and importance of issue) were presented. With those results, five problem statements were selected by consensus considering topics already covered by the CAEP Women in Emergency Medicine committee statement [9]
Step 7: April 2021 Literature review and expert consultation to construct solutions from the medical literature and beyond	A targeted literature review was completed for each problem statement selected (2–3 people per group). Literature review outside of medicine was completed (social sciences content expert AB)
Step 8: May 2021 Drafting of the recommendations	Based on the literature review, each group drafted recommendations for each problem statement. They were then refined by consensus by the author group
Step 9: June 2021 Presentation at CAEP 2021 Academic Symposium	Recommendations were presented to a group of 74 academic leaders and community stakeholders for review and discussion. Participants were randomly distributed to breakout rooms to provide in-depth feedback on recommendations. Participants were also asked to rank their top three recommendations for each problem statement using an online survey tool during the symposium
Step 10: July 2021 Final recommendations generated	Final recommendations for each problem statement were chosen based on symposium feedback and author group consensus

survey data; (7) literature review and expert consultation to construct solutions from the medical literature and beyond; (8) assembly of identifiable gaps in the EM literature; (9) presentation at 2021 CAEP Academic Symposium for Consensus; (10) final recommendations generated. Table 1 depicts the details of these procedures.

Data collection tools

Focus group guide

A structured, focus group guide (see Online Appendix B) was developed based on review of a recent Canadian position statement identifying core barriers in Gender Equity in EM from the literature [9]. The focus group guide was also reviewed by an expert (AB) who has a background in organizational behaviour with a focus on women's career and leadership trajectories. This interview guide was used to prompt discussion in virtual focus groups via Telus web-conferencing software (Telus, Inc., Toronto, ON, Canada) and ensure that key points in the literature were addressed.

Survey

Survey development Once the focus groups were completed, a thematic analysis of the issues which emerged from the focus group data were used to construct our stakeholder consultation survey. The survey was developed by the authorship team leads (EMB, JM) with pilot testing and consultation from the rest of the authors.

Survey content After gathering demographics, participants in the survey were presented using two, five-point Likert scales. Survey respondents were asked "To what extent do you agree or disagree with the statement according to your personal experience?" and second "If this is a true problem in Canada, how important is it to address?". The first item aimed to assess the prevalence of a given problem statement and the second item aimed to address the importance of the issue regardless of prevalence. See Online Appendix C for complete survey.

Results

Qualitative problem statements

Authors EMB, JM and TC analyzed notes from virtual focus groups (see Table 1, Step 2) to bring together related themes to describe specific problems with gender equity in EM in Canada. These problem statements were further developed and revised with the involvement of a larger group of collaborators (see Table 1, Step 3). For a full list of problem statements please see Online Appendix D.

Survey results for problem statement prioritization

All problem statements were then presented in a national survey of Canadian Emergency Physicians. Respondents were asked to rate, on a five-point Likert scale, the degree to which they agreed with a given statement in their own workplaces, and then the degree to which they thought the issue was important, regardless of prevalence in their workplace. The survey was completed by 710 respondents with 607 (85%) completing at least the first statement rating scale. 382 (54%) were CAEP members. We had a reasonable distribution of gender, geographic location and practice experience. Priority problem statements were chosen according to top ratings for each domain (Gender Bias, Trainee concerns, Leadership advancement, and Organizational Policies and Procedures) as well as authorship group consensus. Given that the problem statement #12 on allyship appeared to cover a unique domain, and was very highly rated, it was also prioritized.

Problem statements

Literature review provides further context and supporting qualitative problems with gender equity in EM. While literature is sparse, we found supporting evidence for qualitative concerns which were described in our priority problem statements. Table 2 describes our priority problem statements with relevant context and background evidence discussed.

Summary of Recommendations

From our literature review and based on expert opinion, targeted recommendations to address the priority problem statements were developed. During the Academic

Table 2 Priority problem statements and background

Domain	Context
Gender bias	Problem statement: *Women and non-binary emergency physicians encounter microaggressions and other subtle gendered barriers in the day-to-day professional culture of EM. For instance, women and non-binary physicians are less often referred to as "doctor" by patients, nurses and other physicians. In addition, women and non-binary physicians experience more unprofessional comments (e.g. about age, appearance or marital status) than their cis-male counterparts while at work* Background: Microaggressions are regular exchanges of verbal statements, actions, and inadvertent discrimination towards underrepresented or marginalized groups such as women [17]. These often go unnoticed by individuals who are not a target of these microaggressions [18]. However, the frequent implicit acts and words can take a toll on the victim, resulting in feelings of inadequacy, hopelessness and burnout [19]. Long-term effects of microaggressions against female physicians may result in wage gap, leadership gap and a reduction in awards and academic promotions [8]. Unfortunately, the burden of responsibility of addressing microaggressions also falls on these victims to raise awareness and find solutions
Resuscitation training	Problem statement: *Medical training opportunities can be influenced by people's expressed gender. Staff and/or patients most often look first to cis-male residents for clinical leadership, particularly in resuscitation scenarios. This can result in a loss of vital opportunity for women and non-binary trainees to exercise leadership and make independent, time-sensitive decisions. This can result in reluctance from women and non-binary physicians to take on high stakes clinical roles such as Trauma Team Leader after residency, which further compounds the issue* Background: Residents believe that stereotypically masculine, highly assertive leadership styles are most effective during resuscitations [20] and are biased against female code leaders despite lack of gender-related differences in resuscitation leadership quality or clinical care [21]. Similarly, nurses rate male residents as more competent than female colleagues [22], and medical trainees rated male physicians to have better leadership skills in resuscitation scenarios despite similar objective performance [23]. In fact, studies of video-taped, real-life resuscitations show positive effects for female-led resuscitation teams for both leadership quality and patient survival [21, 24]. Despite this, female trainees feel pressure to adopt more directive, assertive, stereotypically male leadership styles [20] and experience more challenges in attaining the "respect" of the broader medical team [25]. Where there are few gender differences at the start of EM training, differences become evident during residency [26, 27] most so for "high stakes" competencies including emergency stabilization and airway management. This suggests that our training programs fail to adequately address gender gaps that develop and worsen in resuscitation training
Structures and policies impacting leadership advancement	Problem statement: *Structures, policies, and scheduling expectations disincentivize women to achieve clinical and academic leadership positions. Traditional leadership roles usually imply demanding schedules with no leave of absence accepted during their terms. The inflexibility of these positions discourages women and non-binary people from applying and may limit their success in attaining leadership positions, especially if they are planning parental leave or have family obligations. Parental leaves and those related to other caregiving responsibilities can have a further negative impact on women and non-binary physicians' leadership advancement as they are often seen as periods of unproductivity on a resume* Background: There is a leadership gap in EM across a number of leadership levels. Recent studies of national awards, chairships, academic promotions, and EM journal editors suggest that women in EM experience gender inequities that impact their leadership development [14, 15, 18, 28]. Organizational structure, policies, and scheduling expectations disincentivize women who want to achieve clinical and academic leadership positions [15, 18]. Traditional leadership roles (or even simply academic promotions) usually imply demanding schedules with no leave of absence accepted during their terms [29]. The inflexibility of these positions discourages women and non-binary people from applying and may limit their success in attaining leadership positions [11], especially if they are planning parental leave or have family obligations. Parental leaves and those related to other caregiving responsibilities can have a further negative impact on women and non-binary physician's leadership advancement as they are often seen as unproductive periods of time on a resume, instead of being viewed as normal life stages [29–33]
Wage gap	Problem Statement: *Gender bias contributes to the wage gap among emergency physicians. In fee for service environments, women and non-binary people often do more unpaid labour than their cis-male counterparts. For instance, there are gender differences in the amount of time patients expect physicians will spend with them, the amount of nursing support offered (e.g. help setting up for procedures) and in interactions with consultants (e.g. requests for additional history or ancillary tests). Women and non-binary physicians working in other payment models may also lack pay equity, due to variability in salary negotiations, academic salary support and/or other benefits* Background: Since the 1990s more women than men have obtained a postsecondary education [34]. Despite attaining similar levels of employment, these women continue to make less money than their male colleagues who perform the same work. This is known as the gender wage gap. The Canadian Medical Association Journal highlighted the persistent gender wage gap across all specialties in Ontario from 2016 billing data [35]. While the wage gap in Canada and the gender wage gap in medicine is estimated to be between 20 and 26%, there is very little research describing the gender wage gap across medical specialties in Canada [36]

Table 2 (continued)

Domain	Context
Allyship	Problem Statement: *There is a lack of education supporting men in EM to become allies for their women and non-binary colleagues. Research suggests that when cis-men advocate for diversity, their advocacy efforts are more successful than when shouldered by women and non-binary people who may be viewed negatively for engaging in this work. Examples of allyship include men putting their own reputations on the line to sponsor women for leadership positions, championing diversity and inclusion committees, as well as correcting gender bias in clinical work (e.g. correcting patients who make inappropriate comments or fail to recognize women and non-binary trainees as physicians)* Background: As with many disadvantaged populations, much of the advocacy for change in challenging gender bias in EM has rested on the shoulders of women who are often in disadvantaged positions and may face insurmountable challenges when trying to effect change in a timely way. To narrow some of the inequities in EM male allies can play a pivotal role in helping to move this work forward. One of the major barriers to male allyship stems from a lack of understanding among males of the challenges and issues that face their female and non-binary colleagues. In studies, males were less able to recognize and identify gender biases and sexism than their female counterparts [37]. However, research suggests that when cis-men advocate for diversity, their advocacy efforts are more successful than when shouldered by women and non-binary people who may be viewed negatively for engaging in this work [38]. Further to this, male leaders who become allies are often seen more favorably by others, and can also reap career benefits from their actions [39]

Symposium, participants were asked to rank their top three recommendations for each of the problem statements using an online audience engagement platform, Slido (Cisco Systems, Inc., San Jose, CA, USA). The Slido tool generated an averaged, ranked score which was used to prioritize recommendations. Study authors reviewed the recommendation rankings and determined that they were consistent with general authorship consensus. We also used virtual breakout rooms to discuss and improve recommendations. Participants were asked for concerns and improvements on each recommendation as well as for feedback on how to best hold institutions accountable and implement these recommendations. This qualitative feedback was also integrated into our final recommendations.

We present in Box 1 the final recommendations from this academic consensus process in order of ranking during the symposium session. These final recommendations are the result of a national consensus process and represent the priorities CAEP members would like to see met initially. For those interested in further research, please see Online Appendix E which proposes future research questions based on our analysis of priority themes.

Box 1: Final recommendations in five stakeholder prioritized domains

Gender bias and microaggressions

Recommendation 1: Implement educational strategies to assist all emergency physicians to recognize, prevent, and intervene upon microaggressions. Education must address privilege, power, and other structures to determine how best to address microaggressions and ultimately remove them from the workplace altogether.

Recommendation 2: Strongly recommend that EM groups/organizations commit resources (funding, human resources, creating leadership positions), encourage dialogue and utilize diversity within the organization.

Recommendation 3: Acknowledge that microaggressions result in negative impacts for female physicians in EM. Step one in addressing microaggressions is to accept that they exist. The next step is to develop a framework to respond to these at an individual and organizational level.

Resuscitation training and education

Recommendation 1: Support diverse leadership styles and recognize the impact of gender in resuscitation training. Highly directive leadership styles require a departure from gendered behavioral norms which may explain why female trainees experience higher stress and negative emotions during resuscitation scenarios. Training programs should acknowledge how gender stereotypes impact resuscitation training and validate all leadership styles including more collaborative and communicative ones.

Recommendation 2: Training programs should advocate for female trainees to take on challenging resuscitation tasks and leadership. Staff physicians should be trained to encourage and facilitate female trainees to take on resuscitation tasks and give clear, accurate feedback on performance. Simple actions like clarifying who is leading a resuscitation, and ensuring that female trainees have equal opportunity to attempt high-stakes procedures (e.g. airway management), even if they are not the first to volunteer, has an important impact.

Recommendation 3: Focus feedback for postgraduate EM trainees on tangible actions rather than leadership or personality style. Male residents receive consistent feedback with clear suggestions for improvement whereas

female residents are given inconsistent and non-specific feedback. Programs should prioritize development of non-gendered feedback on critical actions and effectiveness rather than style with tangible points for improvement (e.g. closed loop communication vs "assertiveness") to ensure female trainees receive accurate feedback to improve performance.

Policies and structures impacting leadership opportunities

Recommendation 1: Universities and hospitals should create early leadership opportunities. Creating and offering early career support via awards, active mentorship/sponsorship, or training (especially in clinical leadership) is crucial for career advancement. Early success via positions such as chief resident may be important for leadership retention, and ensuring equity at this level is possible.

Recommendation 2: Universities and hospitals should develop strategies to ensure gender parity in leadership positions. It is well known that despite achieving parity in medical school graduations, female physicians face barriers to advancement at all levels contributing to a perception of a "leaky pipeline" for advancement in leadership development. A strategic proposal for medical schools and postgraduate education is to implement formal intervention programs teaching female trainees skills in career planning, negotiation, and leadership. A scholarly project can be integrated to assess the impact of this intervention on gender equity and leadership development specifically within EM.

Recommendation 3: Hospitals, universities, physician business groups and provincial physician associations should support career flexibility. Developing systematic infrastructure for supporting career flexibility (including but not limited to affordances for parents who are of childbearing age as well as support systems for returning to work, breastfeeding etc.) are imperative for equity.

Wage gap

Recommendation 1: Where clinical, academic and administrative salaries are variable, this should be transparent and explicitly stated along with the potential for negotiation and advancement. Where salaries are not negotiable, physician groups should examine if there is a disparity in wage based on gender and undertake an exploration of why this is the case along with potential solutions.

Recommendation 2: Gender inequities in promotion, research funding, publications and compensation must be described and quantified. This could be accomplished by conducting a survey of CAEP membership to collect this data across the country and in a variety of practice environments.

Recommendation 3: Hospital systems and organizations that represent physicians should advocate for paid parental leave. Furthermore, parental leave should be normalized and expected for all genders.

Male allyship

Recommendation 1: EM residency programs and medical schools should provide bias recognition and advocacy training to all their trainees. This will better prepare those trainees to act as allies throughout their career.

Recommendation 2: Teach the EM community allyship. Provide resources for all on bias recognition, allyship benefits, and concrete actions that can be taken by allies.

Recommendation 3: Teach allyship in leadership training programs. These programs should stress the benefits of allyship, practical guides on recognizing biases and actions that can be taken by male allies to promote gender equity.

Limitations

Due to the nature of volunteer participation, we anticipate that there may have been a sampling bias in our study that skewed towards those individuals with an interest in gender equity who may have self-selected to be involved in our discussions. It is also possible that our survey may have been preferentially completed by those with interests in gender equity or that those attending the larger academic symposium would have special interests in promoting equity diversity and inclusivity in EM.

Our survey suggests that diverse gender representation is present in EM and that further research is required to better understand the experience of those who identify as part of a gender minority group. While this work was reviewed and informed by expert consultation from a stakeholder with gender-diverse lived experience, more research is needed to better understand the experience of gender diverse emergency physicians. Our work is also limited by the fact that it is unable to fully capture intersectional experiences. Almost a fifth of our respondents identified with an additional equity-seeking group beyond gender. Further work in this area is essential and requires dedicated focus.

Next steps

Our qualitative problem statements (see Online Appendix C for complete list) were derived from a broad cross-section of

the EM physician population and may act as a starting point for those seeking to engage in research and/or scholarship in the domain of gender equity within EM. While we have identified key challenges to achieving gender equity, much more research is needed in understanding why these challenges exist and how to change the systems we work within to better improve equity in our field. We invite members of the CAEP community and beyond to consider engaging in this domain of scholarly work to help us in achieving gender parity within our specialty.

Conclusions

Gender inequity is a national problem for Canadian emergency medicine providers. We have clear evidence that gender inequities in emergency medicine can result in diminishment of the strengths that physicians identifying as women bring to their work [3, 18]. Further we know from past research that this impacts career satisfaction and longevity for female emergency physicians. Ultimately these factors can negatively impact healthcare satisfaction and outcomes for our patients [2, 4, 40]. We have not yet reached gender parity in many aspects of Canadian emergency medicine and this is likely, at least in part, due to persisting gender inequities and bias [9, 13, 14].

This academic symposium panel has described both important problems related to gender equity and has provided actionable recommendations for all emergency physicians to consider. We hope that these recommendations can be implemented in emergency departments across the country and that this research sparks further investigations into the important challenges with gender equity in emergency medicine in Canada that we have identified.

Supplementary Information The online version contains supplementary material available at https://doi.org/10.1007/s43678-021-00245-1.

Acknowledgements We would like to acknowledge the Canadian Association of Emergency Physicians (CAEP) for providing the academic symposium venue for this important work to take place. We would like to acknowledge the work of our collaborators who helped to identify and describe problems related to gender equity in emergency medicine in Canada. In addition, this group has offered their comments and feedback on various iterations of this work. Thank you to Drs. Brittany Cameron, Paula Cameron, Joan Cheng, Eileen Cheung, Roisin Dempsey, Sara Gray, Nour Khatib, Kelly Lien, Kelsey MacLeod, Shauna Martiniuk, Wanda Millard, Marika Moskalyk, Anna Karolina Nowacki, Nadia Primiani, Anita Pozgay, Nidhi Sahi, Lisa Salamon, Sheryl Seidman, Sydney Tam and Michelle Yee

Author contributions EMB, JM, RL and TMC designed the study and directed data collection and interpretation of data. They were also involved in creating intellectual content and drafting and revising the final work which they stand by. KJ, AB, TB, KH, MM, IM, AP, CP, JS and AZ were involved in creating intellectual content for subsections of the work. They have also reviewed data acquisition tools, and given their approval and feedback to the final draft of this work.

Funding None.

Declarations

Conflict of interest The authors declare that they have no conflict of interest.

Ethical approval An exemption was granted from the Hamilton Integrated Research Ethics Board after a review.

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