Gender Bias: Another Rising Curve to Flatten?
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Abstract
The COVID-19 pandemic and the upheaval it is causing may be leading to novel manifestations of the well-established mechanisms by which women have been marginalized in professional roles, robbing the field of the increased collective intelligence that exists when diverse perspectives are embraced. Unconscious bias, gendered expectations, and overt hostility minimize the contributions of women in academic medicine to the detriment of all. The current environment of heightened stress and new socially distant forms of communication may be exacerbating these well-recognized obstacles to women contributing to the field. Of note, none of these actions requires ill intent; all they require is the activation of unconscious biases and almost instinctive preferences and behaviors that favor the comfortable and familiar leadership of men in a time of extreme stress.

The authors argue that it is time to investigate the frequency of behaviors that limit both the recognition and the very exercise of women’s leadership during this pandemic, which is unprecedented but nevertheless may recur in the future. Leaders in health care must pay attention to equity, diversity, and inclusion given the increased in undermining and harassing behaviors toward women during this crisis. The longer-term consequences of marginalizing women may hamper efforts to combat the next pandemic, so the time to flatten the rising gender bias curve in academic medicine is now.

As a critical component of the academic medicine workforce, women have been on the frontlines of the battle against COVID-19. Since the outbreak of the pandemic, women have been providing direct patient care, transforming medical education, performing research, leading taskforces, writing policies, building prehospital assessment tents, securing personal protective equipment, and much more. Yet, pandemics have an uncanny way of amplifying social inequities. We worry that this pandemic and the upheaval it is causing may be exacerbating disparities not only in public health outcomes among vulnerable populations but also within the profession of medicine. The COVID-19 pandemic has led to novel manifestations of the well-established mechanisms by which women have been marginalized in professional roles, robbing the field of the increased collective intelligence that exists when diverse perspectives are embraced.

In this commentary, we review the literature describing the ways in which unconscious bias, gendered expectations, and overt hostility minimize the contributions of women to the detriment of all. We discuss how these issues are playing out in the current environment, which is characterized by heightened stress and new socially distant forms of communication that may be exacerbating well-recognized obstacles to women contributing to the field. We call for rigorous research to investigate the frequency of behaviors that limit both the recognition and the very exercise of women’s leadership during this pandemic, which is unprecedented in our lifetimes but nevertheless may recur in the future. We conclude by arguing that attention to equity, diversity, and inclusion in this context is far from the distraction that some might view and may be particularly necessary in circumstances such as ours.

Minimizing Women’s Professional Qualifications
Numerous studies have documented that women are less likely than men to be introduced by their professional titles in formal settings, including medical grand rounds and professional society conferences. When a female physician is introduced more casually by her first name while a male peer is addressed formally by his title, this frames the conversation that follows and affects the level of respect afforded to each person’s views. An April 2020 White House COVID-19 Task Force update provides a timely and clear example of this: then, President Trump introduced “Dr. Fauci” and “Deborah.” Dr. Deborah Birx’s professional identity and credibility very literally had been erased by the repeated failure to acknowledge her qualifications (she fared better than her peer at the Centers for Disease Control and Prevention, Dr. Nancy Messonnier, who was not even allowed at the podium). Men in positions of power, who do this consciously or unconsciously, are showing less regard for women, even though many make the excuse that they simply know or like the woman and use her first name is a sign of fond familiarity. As virtual meetings have dominated professional interactions this year, it would be particularly interesting to measure the relative frequency of such incidents using available recordings. Now, perhaps more than ever, language matters.

Women’s Invisibility as Experts
In 2019, Springer Nature publishing company released its conference code of conduct pledging to end male-only organizing committees, end all male panels (known as manels), and ensure equal numbers of speaker invitations are offered to women and men. At the same time, National Institutes of Health director Francis Collins said he would decline invitations to participate in manels. Yet, the impact, widespread acceptance, and memory of this pronouncement seem limited. Multiple
that women exhibit communal behaviors, 12 teaching and clinical care using virtual productivity, including restructuring now compete with time for scholarly new professional service demands to these extraprofessional pressures, labor even before COVID. 11 In addition performed substantially more domestic affected female physician–researchers, who other sources of childcare differentially related school closures and limitations on this change include the way that COVID-19 have been sponsored by professional societies and industry this year. The age-old excuse of not being able to find a female expert in time may seem more compelling in the current exigent circumstances, but it is specious. The problem is not an absence of women with expertise; the problem is that these women remain invisible. They are not invited to speak as subject matter experts. And everyone in medicine suffers when the full talent pool is not represented in such important forums.

The perception that women lack expertise results, in part, from long-standing gendered group dynamics that can silence women’s voices and limit recognition of their contributions. The documented confidence gap between women and men may result in familiar patterns of behavior that are particularly difficult to limit now that virtual communication has largely replaced in-person interaction. 7 Virtual meetings, using platforms such as Zoom, have replaced in-person interactions, and it seems that gendered communication dynamics have not shifted. Unfortunately, women are still dismissed, talked over, and described as emotional on virtual platforms as they are in person. 8 Research is needed to quantify the number of times women versus men are interrupted in online meetings, the frequency with which ideas first articulated by a woman are ultimately attributed to a man who repeats them, and the extent to which men are charged with (or proceed with) leading initiatives proposed by their female colleagues, as compared with the opposite. 9 Recorded meetings may provide a wealth of data for this analysis.

We and our coinvestigators have shown that women make up fewer authors of COVID-19–related research than they did authors who published in the same journals before COVID. 10 Potential reasons for this change include the way that COVID-related school closures and limitations on other sources of childcare differentially affected female physician–researchers, who performed substantially more domestic labor even before COVID. 11 In addition to these extraprofessional pressures, new professional service demands now compete with time for scholarly productivity, including restructuring teaching and clinical care using virtual platforms. Given gendered expectations that women exhibit communal behaviors, 12 female physician–educators may find themselves taking on a disproportionate share of these new service tasks, possibly further encroaching on the time they have to pursue scholarly productivity. Indeed, women more frequently are on clinician–educator tracks 13 and have been characterized “as the ‘housewives’ of the profession, that is, those who take responsibility for the profession’s ‘grunt work’ [. . .] or those tasks [. . .] that are arduous or may lack prestige. . . .” 4 Research should investigate how often rapidly written publications describing COVID-related policy, research, or programs are authored by individuals other than those busy spearheading the initiatives and whether these numbers vary by gender.

Research also should explore the experiences of senior leaders—deans, associate deans, and department chairs—to understand the demographic characteristics of those to whom these individuals, who are still overwhelmingly male, 11 have turned for help in this time of crisis. Are there differences in the extent to which female versus male leaders are engaged in this work? Are women more likely than men to be stripped of their usual scope of authority when the stakes are higher?

If men are given the opportunity to demonstrate their leadership and expertise publicly while women are silenced, this may have long-reaching consequence for academic medicine. Of note, none of these actions requires ill intent; all they require is the activation of unconscious biases and almost instinctive preferences and behaviors that favor the comfortable and familiar leadership of men in a time of extreme stress.

Aggressive Environments

Even before the stress of the COVID-19 pandemic challenged civility, the National Academies had documented a shockingly high prevalence of sexual harassment of women in medicine, higher than in any other academic discipline. 16 This difference was driven by extremely high levels of gender harassment, including sexist remarks and crude behaviors. During times of stress, those who harbor sexist views may not refrain from articulating them. Since the pandemic began, we have heard anecdotal about subtle and unsubtle derogatory comments being made about women’s pregnancies and childcare responsibilities making them unsuited for the medical profession, especially as school closures exacerbated the gendered patterns of dividing domestic labor in our society. Tensions over providing coverage for those physicians typically responsible for home and family can lead to overt hostility in the workplace and aggressive responses toward those who are perceived to be contributing less than they should, even if their choices are limited by long-standing societal constraints. 11,17,18

Additionally, it may be convenient and easy to stereotypically characterize and mock women as overly emotional or “hysterical” (a gendered term) during the time of COVID-19. The frequency of this practice and the impact on the well-being of female physicians should be investigated. Similarly, as more work shifts into the home, the disproportionate impact of domestic violence on women, including female physicians, also merits consideration. In addition, women, nurses, and frontline workers are at higher risk for unfavorable mental health outcomes and may require interventions and psychological support. A study of health care providers in China, for example, revealed significant differences in mental well-being between men and women. 10 Further investigation is warranted, including into the incidence of gender harassment that negatively affects mental health.

Flattening the Curve of Gender Bias

Why is a pandemic the perfect setting for gender bias and aggression to thrive? The elevated level of stress physicians feel and the need to move quickly to combat the virus may subvert deliberative thinking and attention to process. 20 What can be done then to flatten the curve of gender bias, which, at least anecdotally, seems to be on the rise? Societies, organizations, and companies must maintain their commitments to efforts known to promote equity, diversity, and inclusion, including prohibiting manels and all-white panels. All meetings and webinars should have clear codes of conduct. Leaders must recognize that collective intelligence is improved when all voices are heard; they must not retreat to the comfort of allowing only those who agree with them to speak, and they must implement a consistent, transparent, criterion-based selection
process for identifying those charged with important roles in the pandemic response. The situation may seem too urgent to permit attention to usual processes, but that is exactly when such processes are critically important. Ultimately, all of us in medicine must dig deep, ideally leveraging the tools we have from past trainings in implicit bias mitigation that follow evidence-based best practices, to ensure that we reap the demonstrated benefits of diverse teams. We need every advantage to achieve our important mission.

Individual recognition and action, when one witnesses gender bias or harassment, continue to be matters of professional ethics that cannot be abdicated simply because circumstances are challenging.12

We detail our observations here to draw attention to these issues and to encourage future research to quantify the challenges we believe may be intensified in the current COVID-19 environment. We are cognizant of the fact that the very field of equity, diversity, and inclusion has been characterized by some as a distraction at a time when all efforts must focus on the imminent threat of COVID-19.13 But without work toward equity, diversity, and inclusion, we believe efforts to combat the pandemic will be less effective. Status anxiety in academic medicine, or fear for one’s place or standing in the workplace, is real.14 And the longer-term consequences of marginalizing women during this crisis may soon materialize, if the men who visibly “stepped up” to lead COVID-19 response work are rewarded with future leadership opportunities while their female peers’ contributions are ignored. Now more than ever, academic medicine must embrace changes to create work environments where women lead, are heard, and are promoted equitably.15 If we do not, our ability to combat the next pandemic will be hampered. The time to flatten the rising gender bias curve in academic medicine is now.

**Funding/Support:** None reported.

**Other disclosures:** Resa E. Lewis is an uncompensated founding member of TIME’S UP Healthcare, a nonprofit initiative that advocates for safety and equity in health care, and an uncompensated advisor for FeminEM.org, a website that supports the careers of women in medicine. Reshma Jagsi has stock options as compensation for her advisory board role in Equity Quotient, a company that evaluates culture in health care companies. She has received personal fees from Amgen and Vizient and grants for unrelated work from the National Institutes of Health, the Doris Duke Foundation, the Greenwall Foundation, the Komen Foundation, and Blue Cross Blue Shield of Michigan for the Michigan Radiation Oncology Quality Consortium. She has a contract to conduct an investigator-initiated study with Genentech. She has served as an expert witness for Sherinian and Hasso and Dressman Benzinger LeVelle. She is an uncompensated founding member of TIME’S UP Healthcare and a member of the Board of Directors of the American Society of Clinical Oncology.

**Ethical approval:** Reported as not applicable.

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**References**


