Gender Bias in the Emergency Department

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We applaud the authors' exploration of the topic of provider gender bias in miscarriage care in the Emergency Department (ED) in the article *Emergency Physician gender influences early pregnancy loss management: a multisite retrospective cohort study*.[1] Unfortunately, in most settings, patients are generally dissatisfied with their miscarriage management and approximately half change providers as a result of the care they receive. As 50% of patients will change their decision based on provider recommendation, physician bias plays a critical role in practice management and ultimately patient decision-making.[2 3] This is particularly important in the emergency setting as 70% of patients with early bleeding in pregnancy present first to the ED.[4] Bias in medicine is omnipresent and, as the authors discuss, studies have shown that physicians who identify as female are more likely to refer to subspecialists, consider patient preference, and be more risk adverse.[5] These gender differences may, in and of themselves, be a result of bias in education and the workplace. It is important to study provider bias in order to acknowledge its presence and influence on the provision of medical recommendations and counselling to patients. In a world where abortion is being increasingly criminalised, it is vital for a non-biased equitable approach to patients who present with bleeding and pregnancy in the ED, particularly since patients who present to the ED tend to be underserved, young, medically complex and more susceptible to provider bias.[6]

This study focuses on four busy EDs in Calgary where there is universal healthcare and surgical management of early pregnancy loss is not performed in the ED. In addition to these limitations in generalisability, it also has the inherent problems of a retrospective study usingInternational Classification of Diseases, Tenth Revision (ICD-10) codes. Beta-human chorionic gonadotropin (beta- hCG) is used as a proxy for gestational age which is ripe for criticism, but may not be relevant for the findings. For example, total hCG levels show a peak in the 9th and 10th week of gestation, after which, a steady decline is observed and levels at each gestational age have a wide margin.[7] Further, when a patient presents with bleeding, we do not know if the values are increasing or decreasing. The phrase dilation and curettage (D&C) is technically outdated as modern surgical miscarriage management is performed by suction aspiration.

We would be remiss if we did not highlight the difficulty of assuming binary gender of both providers and patients in this study. Physician gender was determined by an emergency physician database. More patients were referred to obstetricians by 'female physicians' who then unsurprisingly received a D&C earlier and were less likely to return for a D&C later. Despite differences in clinical experiences and training of 'male' ED physicians and 'female' ED physicians, in a multivariate analysis these differences did not influence the results. We do not know if any of the providers had a personal history with miscarriage which may confound provider recommendations. It would also be important to understand the cultural background of the involved physicians, which was not analysed in the present study.

Importantly, the hypothesis of gender bias contributes to the strongly held prejudices within medical practice. Female identifying physicians are expected to demonstrate communal rather than agentic traits, which may influence consultation patterns. Communal traits, such as empathy, warmth and consensus-building, are not highly valued in the medical hierarchy and may predispose physicians to refer in certain patterns in order to avoid scrutiny and criticism.[8]

Regardless of the above limitations of this study, it is critical to research and call out physician bias and, as obstetricians, we appreciate the focus on miscarriage management in the ED. We want to acknowledge that many practitioners, other than obstetrician/gynaecologists (OBGYNs), can safely provide suction aspiration including ED and Family Medicine (FM) providers and advanced practice providers[9 10] and this is likely to influence access and patient satisfaction. We also know that miscarriage management can be safely initiated in the ED and non-obstetrician offices and that patients with early pregnancy failure seen in the ED are overall less satisfied and their management requires more time to resolution. Timely resolution of early pregnancy loss is a factor in patient satisfaction.[6] As OBGYNs and abortion providers practising in the USA in this moment in time, we must emphasise the importance of non-biased and timely management of early pregnancy bleeding in the ED and we want to encourage ED and other providers to initiate patient-centred treatment either surgically or medically for patients who desire active immediate management. There are potentially enormous implications for our patients, particularly in regions where early pregnancy management is under scrutiny, and it is paramount to address pregnancy loss equitably in a safe and expeditious manner.

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Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Commissioned; internally peer reviewed.

To cite Ghazaryan N, Autry AM. *Emerg Med J* 2023;**40**:240–241.

Received 20 February 2023
Accepted 21 February 2023
Published Online First 3 March 2023

Linked

► http://dx.doi.org/10.1136/emermed-2021-212214

Emerg Med J 2023;**40**:240–241.
doi:10.1136/emermed-2023-213177

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