Women's Health Strategy
RCEM Consultation Response

Introduction

The Royal College of Emergency Medicine works to ensure high quality care for patients by setting and monitoring standards of care in emergency departments, as well as providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine. We represent over 10,000 members, many of whom are women and the proportion of women entering the emergency medicine workforce has grown in recent years. Our female membership is in a unique position to analyse and comment on issues regarding women's health as they are not only service providers but can also be service users. Furthermore, we know that Emergency Departments are disproportionately attended by those who may be vulnerable in society, and proximity to these patients means our doctors and nurses frequently see the effects of health inequalities and poor health outcomes for women play out. However, it is important to note these very women who provide healthcare to so many can also themselves be victim to the system, which is inherently bias towards the male experience.

This consultation response has been written by the College's Gender Equity Committee, which was set up to develop and lead the College's work programme addressing focused on addressing gender disparities in Emergency Medicine. It is important to mention that the Group has put their name to another response submitted to this consultation, authored by the Inter- Collegiate and National Agency Domestic Violence and Abus (INCADVA) forum which focusses on the health impacts of wider forms of violence against women and girls.

Who attends Emergency Departments?

In 2019/20 50.9% of patients who attended Emergency Departments (EDs) in England were female. That accounts for 97.7 males for every 100 females in the wider population. EDs increasingly serve deprived populations: the most deprived communities use Emergency Department services significantly more than the least deprived communities. The highest number of attendances come from the 10% most deprived areas in England. There is a steady decline in the proportion of attendances as the communities become less deprived.

In addition, EDs serve vulnerable groups, such as those who are experiencing homelessness. Past studies have suggested that homeless people in England use Emergency Departments 5-7 times more than the general population and are admitted to hospitals four times as often.

Due to chronic underinvestment in the Urgent and Emergency Care (UEC) system, EDs are not only the safety net of the patient, but they are also the safety net of the wider healthcare system that is increasingly unable to meet the healthcare needs of our population.

Women's Voice

Chest pain

While there has been slight improvement in recent times, academia has historically been dominated by men. This lack of women's voice has contributed to gender biases in our healthcare system, and this can have very serious and sometimes fatal repercussions. For example, research has shown that women are 50 per cent more likely to receive a wrong initial diagnosis when they are having a heart attack.[1] This is a worrying statistic when those who are initially misdiagnosed have a 70 percent higher risk of dying.[2] This is largely due to the fact that medical concepts of many diseases are based on an understanding of male physiology, and women's symptoms can differ from men's symptoms. The manner in which women describe their symptoms when having a heart attack compared to men can also have an impact. Furthermore, the ALS manual groups women as an 'atypical group'; in other words, not men. It is essential to adjust our terminology to extract the right information from our patients. Many healthcare providers in the emergency department have not received education or training on the gender differences in how patients communicate their symptoms. For example, most ACS research has been done on male humans, and is what is taught in textbooks – this is out of date and irrelevant today.

When combining this with the gender bias that pervades most, if not all, institutions in society, it means that women are more likely to be misdiagnosed, receive sub-optimal treatment, and have poorer health outcomes when presenting with conditions that affect both men and women. One such condition is acute cardiac ischaemia. Women presenting with this to the Emergency Department are more likely to be misdiagnosed and less likely to be hospitalised. One contributing reason may be that women have been reported to have higher rates of atypical symptoms or presentations, such as abdominal pain, shortness of breath, and congestive heart failure. Additionally, a study found that patient delay was longer in women, and they experienced in-hospital death 1.8 times more often than men[3]. Further research has found that was that among patients with acute cardiac ischemia, the adjusted risk of being sent home was more than two times as high among people who are Black, Asian and minority ethnic as among white people.[4] When analysing gendered health inequalities, it is paramount that the manner in which this intersects with race is considered; among women there is a further spectrum of experience that should not be homogenised.

Stroke

Gender discrepancies can also be found in patients who have suffered a stroke. Research suggests that while survival rates are better in women, women that do

[1] https://www.bhf.org.uk/what-we-do/news-from-the-bhf/news-archive/2016/august/women-are-50-per-cent-more-likely-than-men-to-be-given-incorrect-diagnosis-following-a-heart-attack

[2] https://www.bhf.org.uk/what-we-do/news-from-the-bhf/news-archive/2016/august/women-are-50-per-cent-more-likely-than-men-to-be-given-incorrect-diagnosis-following-a-heart-attack

[3] https://www.internationaljournalofcardiology.com/article/S0167-5273(17)37116-4/fulltext

[4] https://www.nejm.org/doi/full/10.1056/nejm200004203421603

survive present with more severe neurologic impairments, are less likely to receive acute stroke therapies, and have worse functional outcomes, especially for Black women. [5][6]

Pain and Pain management

Lower abdominal pain in women is a common symptom prompting emergency presentations. Although such pain may be caused by potentially chronic conditions, very often no clinical cause is found. An example of this is women who suffer with endometriosis. Endometriosis is a common condition that affects around 10% of women, however both women and health care professionals have very poor awareness of the symptoms and treatment. The consequences to women in terms of pain, quality of life, psychological and physical morbidity and fertility can be devastating. In addition, the costs to society in terms of loss of productivity and health costs are significant. There is often a significant delay in diagnosis – the average time to diagnosis is seven years and is not uncommon for women to go much longer without a diagnosis.[7]

Yet we know anecdotally that when such patients attend the ED, they can often be sent away with nothing more than over the counter analgesia, with pelvic pain often being dismissed as period pains with no further investigation. While the ED isn't necessarily the service where endometriosis should be diagnosed, it can sometimes be the first place to encounter the patient suffering with it and should therefore organise appropriate follow up. In a similar vein, provision of healthcare for pregnant women presenting with abdominal pain, headaches, or blood disorders should not default to assuming it is related to being pregnant and teaching that has resulted in this conclusion must be eradicated.

Urgent priority needs to be given to educating and raising awareness in the medical profession, especially primary care and emergency medicine, so that diagnosis is considered and investigated early in women with chronic pelvic pain. Currently, these symptoms are often dismissed if nothing can be found on clinical examination or blood tests. Therefore, there needs to be improved access to diagnostic pathways. The potential benefits of investment in this condition, in addition to improved women's health, would be cost saving in relation to loss of productivity, health costs of repeated GP or ED attendances, and fertility treatment.

There is vast literature on pain management in the Emergency Departments and while the gender of the patient does not seem to explain the disparity, the gender of the clinician does. We know that pain threshold is sex specific, and women appear to feel pain more intensely with a lower threshold than men. Stereotypes such as the silent stoics vs hysterical hypochondriacs mean that male patients receive more pain relief, more frequent pain relief and faster pain relief than women. Oestrogen can influence the generation and transmission of pain meaning that women may struggle to

[5] https://www.strokejournal.org/article/S1052-3057(13)00469-2/fulltext

[6] https://www.thejcn.com/DOIx.php?id=10.3988/jcn.2011.7.4.197

[7] https://academic.oup.com/humrep/article/18/4/756/596537#:~:text=The%20overall%20median%20time%20from,for%20those%20with%20infertility%20complaints.

describe their pain with the usual descriptors or adjectives. Furthermore, progesterone downregulates pain receptors, so renal colic in a non-pregnant female may actually hurt more than labour pain.

Women's health and access across the life course

Homelessness

Healthcare needs, and access to healthcare vary greatly depending on characteristics such as ethnicity, age, and socioeconomic factors. Research shows that the age and social deprivation are significant factors in emergency admissions.[8] In order to learn and improve, data is key to recognising and addressing patterns of inequality. Sadly, data for women who are homeless is largely non-existent, but we know that the average life expectancy for women who are homeless is extremely low at approximately 42 years old. ED staff support these patients to the best of their ability, however, without sufficient data surrounding specific cause of death it is difficult to know how the ED can improve and contribute to dismantling the barriers that these women face.

Inequalities in access

New initiatives such as NHS 111 have been designed to improve innovation and access to healthcare. The premise is that a patient calls 111 and is then directed to the service provider deemed most suitable for their needs. This may sometimes result in a patient receiving a time slot to attend the Emergency Department. While in theory this may provide the patient with a more seamless experience with less waiting involved, we must consider the implications for those who may not be digitally literate. The ED is always open to anyone who might need it, regardless of the phone first service, however the narrative of only wanting the "right patient" to attend is not uncommon, and this rhetoric can be unhelpful to those who may be vulnerable or those who are unsure of how to access healthcare any other way.

Another barrier to accessing healthcare may occur due to child caring responsibilities. This role generally falls to women meaning that they often have to take their children to appointments with them or arrange alternative care, which may not be an option for those without the financial means. There should be greater accessibility for appointments for those with childcare responsibilities who would find it easier to attend during school hours.

Women's health in the workplace

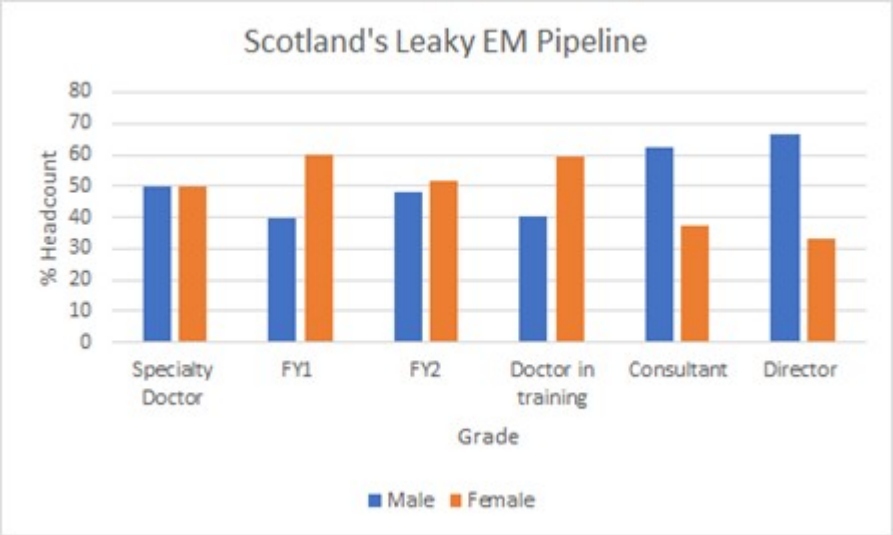
A 'leaky pipeline' is a metaphor used in academic literature to describe when people (usually women), for several reasons, are filtered out of a career pathway at different stages. Emergency Medicine is no exception. Women have long outnumbered men in Medicine and Dentistry courses at university level; in 2017/2018 women accounted for 58% of enrolments in Medicine and Dentistry courses. The proportion of women on these courses has gradually increased since records began. Yet this has not been

[8] https://bmjopen.bmj.com/content/7/2/e014045

followed by an increase in the proportion of women in the Emergency Medicine (EM) specialty. Data from NHS England shows that only 42% of EM doctors are women.

Scotland is the only UK nation with comprehensive workforce data. Figure 3 shows a general filtering out of women as they progress through their careers.

Figure 3 - Emergency Medicine Doctors in Scotland by Grade and Gender 2019



Women's participation in the ED workplace

Women doctors consider future work-life balance when making their career choices. There are clear differences in specialty choice between men and women in the UK. For example, surgery is chosen by mostly men and general practice, paediatrics, and obstetrics and gynaecology are chosen by a predominance of women. In 2013, a study by the Academy of Medical Royal Colleges found that 40% of female doctors report taking on roles in addition to their clinical work, compared to 87% of male doctors.

A BMJ (2017) study carried out a survey with a self-selected sample of doctors (N=1880) across the UK who graduated from medical schools in 2002 (figure 4). The survey revealed that the consideration of children had influenced career choice, as there are some considerable differences across specialities. For example, female GPs (83.1%) were more likely to agree that children had influenced their choice of specialty, whereas EM doctors were less likely to agree (26.1%). The survey also asked doctors whether they regarded their speciality as family friendly. Overall, 64% of doctors answered yes and 36% answered no/don't know. When examining the breakdown by speciality, fewer EM doctors believe their speciality is family friendly, in comparison to hospital medical specialities and general practice.

Figure 4 - Doctor perceptions of family-friendliness of specialties

Responses to the question: 'Do you regard your speciality as a family-friendly employer for doctors with children?'

Group	Men (% agreement)	Women (% agreement)
All	57.0%	69.1
Has child(ren)		
Yes	57.6%	75.6%
No	55.7%	57.2%
Speciality		
Hospital medical specialities	43.0%	60.9%
Surgery	32.6%	31.7%
General practice	79.3%	78.1%
Emergency Medicine	26.7	39.1%
Working hours		
Full time	55.8%	61.5%
Less than full time	76.3%	81.3%

The results suggest that the desire to become a parent plays a role in the pipeline to specialisation. EM is not considered to be a family friendly specialism, potentially resulting in a filtering out women, who are more often than not, the default child-carers.

Burnout

EM training is particularly intense due to shift work, rota difficulties and unsocial working hours. Figure 5 shows that Emergency Medicine trainees reported higher burnout rates than any other specialty. These problems have a knock-on impact on the workforce in terms of attrition and can exacerbate the leaky pipeline in the profession.

Figure 5 - Burnout category share of trainees by specialty

Specialty	Low	Moderate	High
National	50.1%	39.5%	10.4%
Emergency Medicine	30.8%	48.9%	20.3%
Acute internal	43.3%	43.0%	13.7%
Respiratory Medicine	42.7%	43.9%	13.3%
General internal medicine	41.5%	45.1%	13.3%
General surgery	45.2%	42.7%	12.1%

Source: General Medical Council (2019) National Training Surveys

Intense workload and burnout are not only restricted to Emergency Medicine training but are a feature of the specialty as a whole. EM doctors are subject to higher levels of work-related stress due to the organisational structure of emergency care in the UK, exasperated further by the current pressures on our services. The work of an EM doctor is particularly demanding because of the range of complex health needs that require an EM doctor's attention in an ED. It should come as no surprise that EM itself is not

perceived to be a family friendly specialty. Therefore, the career structure of long working hours combined with the desire for parenthood can create a 'role conflict' for women.

The Need for Recovery (NFR) Scale measures clinicians' perceptions of the need to recover from the physical and mental demands of a working day. It is often used to assess the early symptoms of fatigue in shift workers. A 2020 study found that there were statistically significant associations between gender, health conditions, type of ED, grade, access to annual and study leave, and time spent working out-of-hours.[9] Their model developed by the study suggested that males, GPs or consultants, those working in paediatrics, and those with no long-term health condition or disability had the lowest NFR Score. However, the authors of the study advise caution when considering the relationship observed between gender and NFR as it is likely to be simplistic and requires further evaluation.

Impact of parenthood

Parental leave

The impact parenthood has on a career is often referred to as a child penalty. Child penalties disproportionately affect women, as women still spend twice as much time undertaking childcare and unpaid household work. Anecdotally, we know that that paternity, maternity and shared parental leave policies are disjointed and can be very difficult to navigate. This has a negative impact on the wellbeing of new mothers and that of the unborn child. Although there is information available by NHS Employers, it is complex and not easily accessible and is often misinterpreted by HR departments. Urgent attention is required by NHS Trusts to get these processes right in order to protect the wellbeing of women.

Returning to work

The return-to-work experience for female doctors can be very variable. Breastfeeding physiology is not understood or culturally supported in workplaces. More research is required in order to better understand the needs of breastfeeding and pregnant women in EDs. Anecdotally, our members report that this is not considered important in the workplace, and at times it is viewed as a lifestyle choice.

All workplaces are legally required to provide suitable facilities for mothers to rest whilst they are pregnant or breastfeeding. This should not be a toilet, yet we have heard reports of mothers expressing milk in the toilets due to the lack of physical space in the ED for women to breast pump. This lack of knowledge or support can leave women at risk of mastitis, sepsis, and even burnout and mental health issues. It should be possible to return to work and continue breastfeeding.

Interpersonal factors

The Annual Gender Gap Report by the World Trade Forum made a call for action to address gender parity as it revised its target of globally achieving parity in pay and jobs from 80 years to over 170 years - attributing this "glacial pace of change" largely to unconscious bias.

[9] https://bmjopen.bmj.com/content/10/11/e041485.full

Stereotypes and societal norms can be internalised by both men and women and dissuade some women from actively seeking out leadership roles. Some research has flagged that on an interpersonal level, unconscious bias, microaggressions, and 'club culture' creates a difficult environment for female leaders within health organisations.

Societal norms can be internalised by colleagues and patients. Assumptions regarding gender and role still exists within Emergency Medicine. A 2006 US study of EM patients found male physicians were more often recognized as doctors than female physicians. These stereotypes can compromise workforce wellbeing and team function.[10]

Neurodiversity in medicine

The ED environment can be challenging for neurodiverse patients and staff. It is largely undiagnosed in women and there is growing evidence that women have been historically missed in neurodiversity diagnoses.[11] With diagnosis comes support and awareness in the workplace. There is a large growing number of doctors being diagnosed with neurodiversity and many of these are women who have struggled all their lives. Improving access to diagnosis and support for women who may be neurodiverse could help improve inclusivity in the ED and prevent mental health issues.

Research, evidence and data

There is a plethora of research examining gender disparities in clinical practice. A scoping review examining a range of interventions conducted to address gender bias in clinical medicine found that despite the growing evidence of a gender disparity, only a few studies have tried to tackle this bias. The study recommended that future clinical practice interventions should be developed to specifically tackle gender bias.[12]

Neurodiversity and gender are areas that are understudied and under researched. There is no available data on neurodiversity of women who have gone through medical school and are working in the NHS. This data would help us capture their experiences and consider the ways in which the ED occupational environment could be made more inclusive for women.

There is evidence of a gender bias in clinical trials. A good example of this is the lack of consideration given to pregnant women and the covid19 vaccine as pregnant and breastfeeding women were not included in the trials for the vaccines.

The classification of diseases as 'typically male' or 'typically female' can have a fatal effect: stereotyped diseases are not recognized in the other gender because they tend to show different symptoms in men and women. The legacy of male bias within pharmaceutical research, regulation, and commercialization needs to be rectified.

To provide optimal individualized medical care for both men and women, the concepts of sex and gender health need to be introduced early and become systematically embedded into medical school and postgraduate curricula, as well as

[10] https://www.liebertpub.com/doi/pdf/10.1089/jwh.2018.7571

[11] https://www.fenews.co.uk/featured-article/42884-where-have-all-the-girls-gone-missed-misunderstood-or-misdiagnosed

[12] https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-020-01283-4

continuing medical education (CME). These curricula continue to primarily be taught in a unisex fashion that has the potential of introducing conscious and unconscious biases in learning and ignores the differences between men and women in response to diseases and treatments. EM is uniquely positioned to influence acute care as a specialty; it is increasingly being used by other specialties and primary care practitioners to perform complex diagnostic workups and remains the primary access point for the majority of hospital admissions.

Recommendations:

- Recognition and prioritisation of research into gender-related disparities in emergency presentations and treatment.
- Investment in research and education into gender-specific presentations such as endometriosis.
- A commitment to monitoring and addressing the differential effects of policy changes e.g., Phone-first services on gender (particularly multiply-marginalised groups).
- A commitment to workforce planning and strategies that promote gender diversity in the specialty.