COMMENTARY

Preinvisible: An Early-Career Perspective on a Midcareer Phenomenon

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ABSTRACT

In this commentary, a female early-career academic physician reflects on her experiences with microinequities in the workplace. Using a recent publication describing the experience of midcareer academic women physicians as a launching point, the author discusses the experiences that early-career women in medicine commonly have. In training and early career, women are exposed to subtle barriers, aggressions, and inequities, which build over time. By midcareer, some women leave medicine or if they remain in medicine, they have likely not reached the salary or promotion levels of men. Ultimately, the author questions if trainees and early-career women in academic medicine are simply in a "preinvisible" phase of their careers. Ways to address the microinequities are offered.

INTRODUCTION

I recently read an article by Lewiss et al[1] titled "Is Academic Medicine Making Mid-Career Women Physicians Invisible?". The piece described a phenomenon whereby female midcareer academic physicians become invisible because of various barriers, aggressions, and inequities. The intentional support and professional attention that women physicians may receive early in their careers wane as they advance to midcareer, making these women invisible. The article offered surprising insights into my own early-career experiences. If midcareer is a time when some women realize that they have become invisible, perhaps I should evaluate my own trajectory. Am I on that path? Am I "preinvisible"?

In 2010, I graduated from medical school. At that time, women comprised 48.3% of allopathic medical school graduates[2] and just over 40% of residents and fellows in emergency medicine programs accredited by the Accreditation Council for Graduate Medical Education.[3] At the time, some authors were positing that there were *too many* female medical graduates.[4] Women seemed to be making progress, and concerns about gender inequities were not on my radar.

But, in 2019, although women comprise greater than 75% of the health care workforce,[5] they continue to face disparities in compensation, promotion, and leadership. They are less likely than men to hold the rank of associate or full professor, despite adjustments for relevant contributing factors.[6,7] Perhaps more telling, women continue to receive less compensation than men for the same job.[8] Still, I attributed the glaring disparities in gender equity within leadership positions to the fact that senior women physicians had faced greater discrimination decades ago than I had. And perhaps not enough time had passed for my larger cohort of women physicians to take on these leadership roles. After all, the opportunities seemed boundless in my first few years as an attending physician. There were teaching fellowships and awards geared specifically for early-career physicians. Many departmental faculty sought to engage me in research projects and medical school education initiatives. How surprised I was to find that the abundance of these opportunities would not sustain. I began to see that maybe the culture of academic medicine had not changed.

The article by Lewiss et al introduced me to the concept of microinequities. Unlike macroinequities, which are blatant and observable, microinequities often stem from unconscious bias.[9] Macroinequities, such as promotion and salary disparities, are measurable and well documented. Microinequities, on the other hand, are less frequently described yet no less prevalent. They are subtler, more difficult to measure, and unfortunately dismissed as the complaints of oversensitive women. Yet they are real. And these microdisparities accumulate as women transition from training to early career to midcareer.

What struck me as I read about these concepts was the applicability to my own experiences. Thinking back, I recalled firsthand examples of microaggressions that led to microinequities, and I was nowhere near midcareer. I realized that they start in training and early career. I realized that I was in a "preinvisible" stage.

EXAMPLES OF MICROINEQUITIES

See Me by My Title

I am an Asian American woman in my 30s. Every day, my patients assume that I am their nurse, even though I introduce myself as "Doctor." Once, a neighbor in my apartment building, seeing me in scrubs, asked if I was the home health aide for an elderly resident of the building. Patients call me by my first name (found on my identification card),

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even though I never introduce myself that way. Somehow the "MD" on the same card remains invisible. Meanwhile, my male colleagues, who introduce themselves by their first names, have a contrasting experience. Patients naturally tag "Doctor" onto their names without prompting. Some patients comment on my youthful appearance, ask me my age, and question how long I have been a doctor. Other patients comment about my nice accent (*I am American; I grew up in Oklahoma*), ask if I'm Korean (*no, Chinese*), and question whether I went to medical school in the United States (*um—yes*). To be clear: I am not offended by being identified as a nurse, called by my given name, complimented about my appearance, or asked about my heritage. My frustration lies in the persistence of the biases that these seemingly harmless inquiries bely. And I am not alone. Esther Choo, MD, MPH,[10] wrote about her experiences with racial-ethnic and gender bias in a Twitter thread that went viral.[10]

Society is more interested in defining me (and other women or individuals of color) by sex, age, and race than by accomplishments and professions. If my patients do not see me as an academic physician, how can I expect my institution to do so? These are the microinequities that lead to invisibility, and serve as daily reminders of how far little has changed for women.

Follow the Woman Leader

Another common experience: I bring a male medical student with me to see a patient or to speak with a consulting physician. There is an automatic assumption that my medical student is the team leader. Patients direct their questions to the medical student, look at him when I am speaking, and even seek confirmation that he agrees with my plan of care. This often happens despite clear introductions and delineation of roles. It even happens *after* I tell the patient that I am going to teach my *student* how to do a basic medical examination, and then proceed to do so in an intentional way.

It is as if knowledge and competence pale in comparison to a woman's sex. The assumption that men are in charge, men are the team leaders, and men are the doctors is deeply ingrained in society.

Louder Is Not Better

As an emergency medicine attending and medical educator, I have noticed a disproportionate number of teaching awards and accolades bestowed to men. During our department's weekly residency conference, we often have larger discussions that involve the faculty members in attendance. If something is debated, I notice that students and residents often listen to the male voices; they resonate more loudly. The points made by male faculty members are later referenced, even if they are the same ones made by the female speaker or female faculty members.

Additionally, I have seen residents go to male attending physicians for a "second opinion" about how to manage a patient they share with a woman attending. There is almost a reverence that medical students and residents hold for the words and opinions of my male colleagues. I rarely see this applied to female faculty members. It comes as no surprise, then, that men are far more visible when it comes to winning awards and accolades.[11,12]

Let Jennifer Grow Up

I also relate to the "Jennifer" phenomenon referenced in the article by Carnes and Bigby[13] in 2007. The term was originally coined in Barbara Gordon's[14] 1988 book, *Jennifer Fever: Older Men/Younger Women*. Jennifer was the most popular girl's name at that time, and Gordon used it to represent younger women who attracted the attention of older men. The analogy to academic medicine is essentially where trainees and early-career women, or "Jennifers," receive more professional attention and development by their more senior (and often male) superiors.

These opportunities all but disappear by midcareer. Whereas my early career opportunities seemed abundant, the path into midcareer is murkier. As a resident, I looked to many women attendings for inspiration and as role models. Now 6 years into being an emergency medicine attending, I recognize the dearth of women in leadership roles ahead of me. Where do I see myself in 5 or 10 years? Am I to assume this is the pinnacle of my academic career? After all, women represent only 22% of full professors, 18% of department chairs, and 18% of medical school deans.[15] No women have held presidential leadership positions among 10 major medical specialty societies in the last decade.[16] I am reminded again of the often-referenced quotation by activist Marian Wright Edelman: "you can't be what you can't see."

The Baby "Problem"

When I recently became pregnant, I thought about how this life change would affect my professional trajectory. Although I do not anticipate being any less ambitious, wanting any less salary, or submitting promotion paperwork in a delayed fashion, medicine may see me differently. I knew that having children has disproportionately negatively affected the academic careers of women.[17]

I recently reviewed the family leave policy benefits at my large hospital system: paid maternity leave with conditions and fathers were given one paid day off. Women must file for short-term disability before they are then asked to use vacation days they have earned for the year, to make up their maternity leave. If women want any additional time, it is

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considered unpaid leave. This is a rather antiquated policy in light of the recently updated Goldman Sachs family leave policy, which allows 20 weeks of paid leave to all parents, regardless of the parent's sex or caregiver status.[18] It is incredibly disheartening that Wall Street takes care of its bankers better than hospitals take care of their doctors. A woman who is required to use all of her vacation days to take care of her newborn, while her male colleagues are allowed to take only one day off with pay, is at a disadvantage. Not only is she inarguably being asked to delay her career trajectory compared with her male counterparts, she is also often seen as needing *special* accommodations. "She wants to work fewer nights." "She's not being flexible about the lack of space for a lactation room." These are comments I have heard in reference to women physicians.

The truth is that female physicians are more likely to bear high-risk pregnancies, undergo infertility therapy, and experience miscarriage during their reproductive years compared with the general female population.[19] The risk of miscarriage increases for women physicians who work night shifts during pregnancy.[20] The accommodations are not special; they are merely humane.

CONSEQUENCES OF GENDER INEQUITIES

Although initially just irksome, I have come to recognize that these inequities are just the "preinvisible" and sentinel events that lead to the midcareer invisibility about which Lewiss et al[1] wrote. The daily interactions of feeling disrespected, of not being heard, and of not being seen worsen feelings of "imposter syndrome," in which a person doubts her accomplishments and carries a persistent fear of being exposed as a "fraud." Women already experience this psychological pattern more commonly than men. In a survey of 3000 adults in the United Kingdom, women were 18% more likely than their male counterparts to experience imposter syndrome, with two-thirds of women respondents having feelings consistent with the syndrome in the past 12 months.[21] These worsened feelings of imposter syndrome cause women to take even less ownership over their knowledge and accomplishments. The vicious cycle ultimately results in the perception that women are less confident and less suited to lead. And with few women role models in leadership, it is no surprise that women physicians become disillusioned.

ADDRESSING MICROINEQUITIES

Am I at the preinvisible stage? Is early career merely a preview and a prelude to the inevitable invisibility of midcareer medicine? There is no doubt that we can do better.

We need more data, literature, and policy to change the culture and to improve the disparities for women in medicine. Through advocacy, we need to consciously fight discriminatory practices. Pregnancy is not a disability. We should demand fair universal parental policies instead of making women feel guilty for their needs. The approach must be top-down, initiated at the level of the government or institution (eg, with Goldman Sachs), instead of reliant on colleagues to "pick up the slack." The microinequities are real; they are not a figment of our minds. We need more men to step up, speak up, and serve as allies. We need more women to be sponsored and selected to serve as chairpersons and deans. We need more objective and transparent advancement criteria to promote the many qualified women to full professor.

Although the examples given here are my own experiences, they are likely relatable to many early-career women physicians. As I look forward to midcareer, I see the invisibility looming. I want to make it end. ❖

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Authors' Contributions

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