

“Women as Deficit”: Re-evaluating Interventions to Establish Gender Equity

Ya-Wen Chen, MD, MPH,*† David C. Chang, PhD, MPH, MBA,*† Katrina A. Armstrong, MD, MSCE,‡
and Cassandra M. Kelleher, MD*✉

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Literature has shown significant gender differences in clinical and research productivity, leadership positions, compensation, and many other metrics that are considered important for advancement in academic medicine.¹ Multiple strategies, including negotiation skills or leadership training courses, have been proposed to mitigate this gender gap.^{2–4} While these recommendations are well-intentioned and have been successful to some degree, these interventions may be limited in their effectiveness because they promote a stereotypical man as the gold standard. Philosophically, the interventions carry with them an unspoken assumption: women have deficits that need to be “fixed”. The thinking has been described as the “women as deficit” concept. The roots of this thinking can be traced to antiquity. Femaleness has been equated to a lack of maleness as far back as ancient Greece. Women have been characterized as a “misbegotten male” (as described by Greek philosopher Aristotle), “the lesser man” (as described by Victorian poet Alfred Lord Tennyson), or as “a castrated man” (as described by the father of modern psychiatry, Sigmund Freud). This thinking implies that being a woman is simply the failure to be a man.

The “women as deficit” concept affects our thoughts insidiously. It essentially nullifies the legitimate description of women as simply different from men, and implies that female gender automatically equates to inadequacy. An analogous assumption would argue that Venus is a “misbegotten Mars” or a “lesser Mars” rather than recognize Mars and Venus simply as two neighboring planets. In the 21st century, “women as deficit” thinking perpetuates the perception that the differences between men and women are not simply differences, but rather deficiencies. From there, it begets the harmful assumption that women lack appropriate skills and that “female” skills are inherently less valuable than “male” skills. However, the differences between men and women are best described by Shakespeare who said, “There is nothing either good or bad but thinking makes it so.” The objective of this editorial is to illustrate how “women as deficit” thinking continues to fuel gender disparity in academic medicine on multiple levels: the individual, the team, and the organization.

We see a clear influence of “women as deficit” thinking at the individual level in what has long been considered the traits necessary to be a good surgeon. Good surgeons are tough, tireless, technically

talented, stoic, and have little time for their private lives. The is the so-called “iron surgeon” stereotype:

... the “iron surgeon”—powerful, invulnerable, untiring. Those trained by him pass on the mystique, transmitting from one surgical generation to the next an embodied professional ethos. The iron surgeon does battle with death, exterminates disease, declares war on softness, sloth, and error. He is technically brilliant, clinically astute, technologically sophisticated. His feelings, if he has any, are private; his inner life, if he has time for one, is unengaged by his work. The feelings of his patients are also private. Their personalities, problems, hopes, aspirations, are irrelevant. The iron surgeon’s task is to excise disease. The rest is for nurses or social workers.⁵

As the described traits are quintessential male traits, a message such as this establishes that a good surgeon is likely to be a man, or a woman who has adopted male traits. Not only has the indicated framework promoted male traits, it has precluded the possibility that quintessential female traits can also be valuable assets for surgeons. So, we select for medical students who exhibit a preponderance of the traits, and then we train our residents to adopt even more male traits, telling them, for example, that surgeons need to be tough, and surgeons should not cry, and above all, surgeons are never wrong and should not apologize. In the same vein, as women apologize more than men, the gender equity movement has focused on getting women to stop apologizing. But should we hold that as the gold standard? Apologies after medical errors are important and often not given. Empathy is an important clinician characteristic that is sometimes best expressed by saying “I am sorry” even when no fault is implied. Therefore, we should consider re-calibrating our concept of the gold standard and rather than teaching women to apologize less, interventions should focus on training physicians how to apologize for an error.

“Women as deficit” thinking also influences our concept of teamwork. Male behaviors have traditionally defined the gold standard in teamwork, another reflection of “women as deficit” thinking. But perhaps like apologizing, the definition reflects our underlying bias, more than evidence, that the male behavior leads to optimal patient outcomes. In patient care teams, women residents are more frequently asked to perform nonmedical tasks, such as getting a glass of water or a blanket, by both patients and nurses. Further, nurses are more likely to ask female physicians questions about patient care. The current strategy to address these disparities has hinged on the “women as deficit” concept, suggesting that women residents should be treated more like male residents, and be asked questions less often. But since a lack of interprofessional communication is a major risk factor for medical errors in the hospital, we should encourage nurses to ask male residents more questions, instead of asking female residents fewer questions. And since patients are vulnerable and often alone in the hospital, wouldn’t it be better if all doctors were willing to help patients who ask for assistance even if the request does not require a medical license to deliver?

From the *Department of Surgery, Massachusetts General Hospital/Harvard Medical School, Boston, MA; †Codman Center for Clinical Effectiveness in Surgery, Massachusetts General Hospital/Harvard Medical School, Boston, MA; and ‡Department of Medicine, Massachusetts General Hospital/Harvard Medical School, Boston, MA.

✉ckelleher3@mgh.harvard.edu.

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At the organizational level, “women as deficit” thinking influences how healthcare systems select and train their leaders. The historical dominance of male leaders risks normalizing and perpetuating the belief that male traits are the most important leadership skills: decisive, assertive, logic-driven, transactional, competitive, uncompromising, and individualistic.⁶ Organizations have developed leadership training programs that “teach” people such skills. Traditionally, little credence has been given to the importance of female traits (humility, multitasking, collaborative, adaptive, persevering, compassionate, relationship building) in leadership.⁷ Recent world events have brought attention to this paradox, as the countries with the most effective initial response to COVID-19 have female leaders.⁸ Their responses were believed to be effective in fighting the pandemic because they used leadership characteristics that are traditionally considered ‘female’ qualities: they were transparent and humble about the risks, actively consulted their advisers, were compassionate and recognized the suffering in their population, and adopted new science and technologies to adapt to the novel situation.⁷ Further, the possibility that masculine traits could potentially be harmful is often ignored. For example, confidence does not always equate competence, and over-confidence can have deleterious consequences.⁹ In another recent illustration, over-confidence in mortgage-backed securities by the near universally male bank CEOs in the early part of the present century led to the housing market crash and financial crisis of 2008. Perhaps venerating male stereotypes without equally beneficial ‘female’ qualities will not train the best future leaders. Truly excellent leadership courses must teach both traditionally male and female traits.

Gender equity can be reached in two ways: to ask women to do more or less, or to ask men to do more or less of something. To date, the interventions meant to establish equity have been predicated on

“women as deficit” thinking and therefore focused on changing women. However, erasing inequities will require us to re-evaluate our current approaches to gender inequities and design novel interventions that are also focused on changing men. Women do not inherently have deficits that need to be fixed; on the contrary, what needs to be fixed are our deeply-ingrained societal biases.

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