EVERYBODY IN: WELLNESS FOR MEDICINE THROUGH INCLUSION, LEADERSHIP, AND EQUITY FOR WOMEN

Susan Thompson Hingle, MD, MACP, FRCP, FAMWA

November, 2019

SIU SCHOOL of MEDICINE

1

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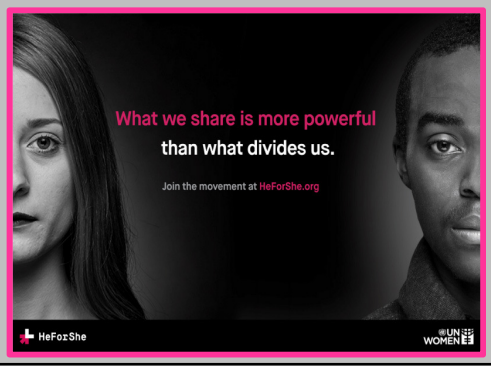
#HeForShe

HeForShe is a solidarity campaign for the advancement of gender equality, initiated by UN. Its goal is to achieve equality by encouraging both genders to partake as agents of change and take action against negative stereotypes and behaviors, faced by women.



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Gender Equity

- **Improves**
  - Communication
  - Creativity
  - Employment
  - Health
  - Job satisfaction
  - Policy development
  - Productivity
  - Work engagement

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Templeton et al, May 28, 2019

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Studies of Burnout in US with Data Reported by Gender

Reference	Population	%women burnout	%men burnout	P Value
McMurray et al., JGIM 2000	IM, pediatrics, subspecialties	26	21	< 0.05
Linzer et al., JAMWA 2002	IM, pediatrics, subspecialties	28	21	<0.01
Dyrbye et al., Archives of Surgery 2011	Surgeons	43	39	0.01
Shanafelt et al., J Clinical Oncology, 2014	Oncologists	50	40	< 0.001
Rabatin et al., Primary Care Community Health, 2016	Primary care	36	19	<0.001
Peckham, Medscape 2018	All specialties	48	38	NR
Shenoi et al., Critical Care Med, 2018	Pediatric critical care	60	42	0.005
LaFaver et al., Neurology 2018	Neurologists	65	58	0.007

Templeton et al, May 28, 2019

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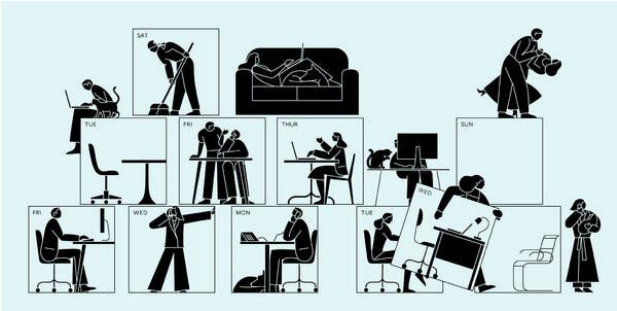
Contributing Factors

- Work-life fit
- Autonomy and workload
- Gender bias and discrimination
- Sexual harassment



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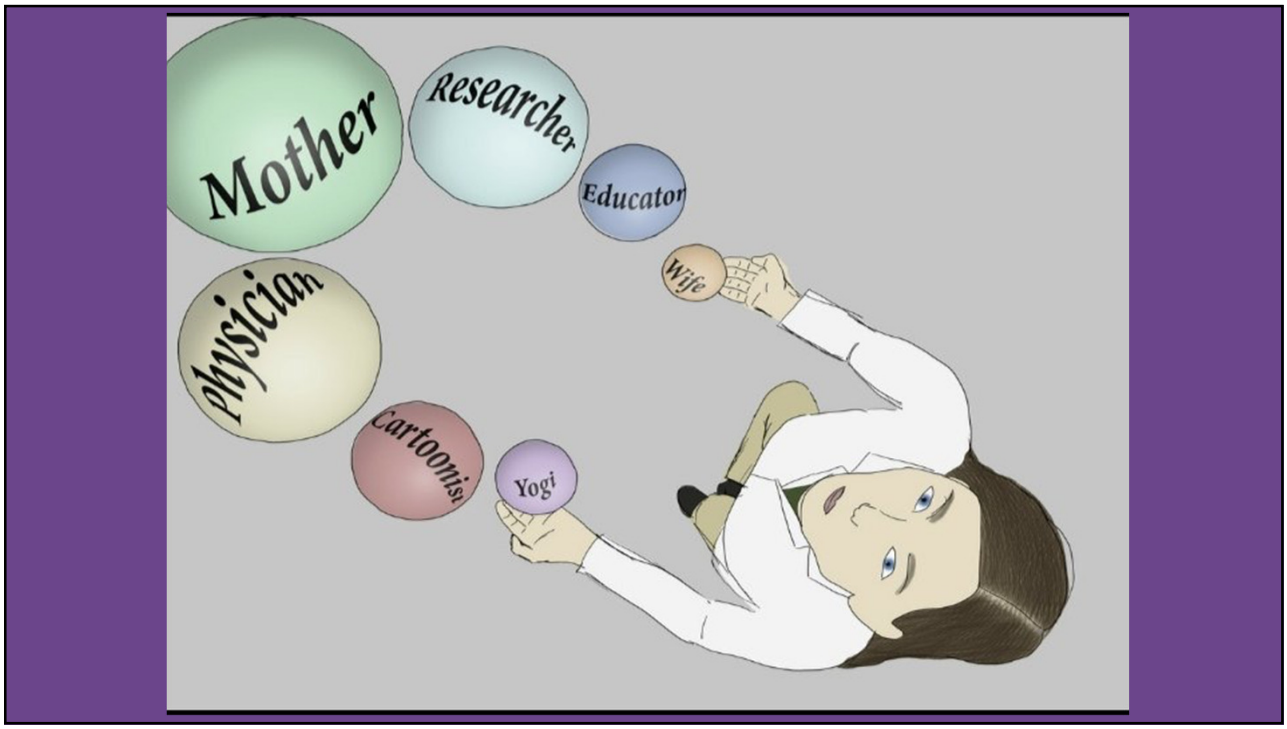

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Case

- Dr. G prides herself on being a highly sought-after internal medicine specialist because of the comprehensive, patient-centered care she provides to her patients. Many women patients seek care from her because she will take care of not only their medical problems but also their Pap smears and psychosocial issues. Her quality metrics and patient satisfaction ratings are the highest in her practice. During her annual performance review, she is notified that she will need to increase her productivity or take a pay cut because her RVUs are lower than those of her colleagues. She believes that this is due to the additional time she spends per patient visit.

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Annals of Internal Medicine

POSITION PAPER

Achieving Gender Equity in Physician Compensation and Career Advancement: A Position Paper of the American College of Physicians

Renee Butkus, BA; Joshua Serchen, BA; Darilyn V. Moyer, MD; Sue S. Bornstein, MD; and Susan Thompson Hingle, MD; for the Health and Public Policy Committee of the American College of Physicians*

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POSITION 1

ACP affirms that physician compensation (including pay; benefits; clinical and administrative support; clinical schedules; institutional responsibilities; and lab space and support for researchers) should be equitable; based on comparable work at each stage of physicians' professional careers in accordance with their skills, knowledge, competencies, and expertise; and not based on characteristics of personal identity, including gender. Physicians should not be penalized for working less than full-time.

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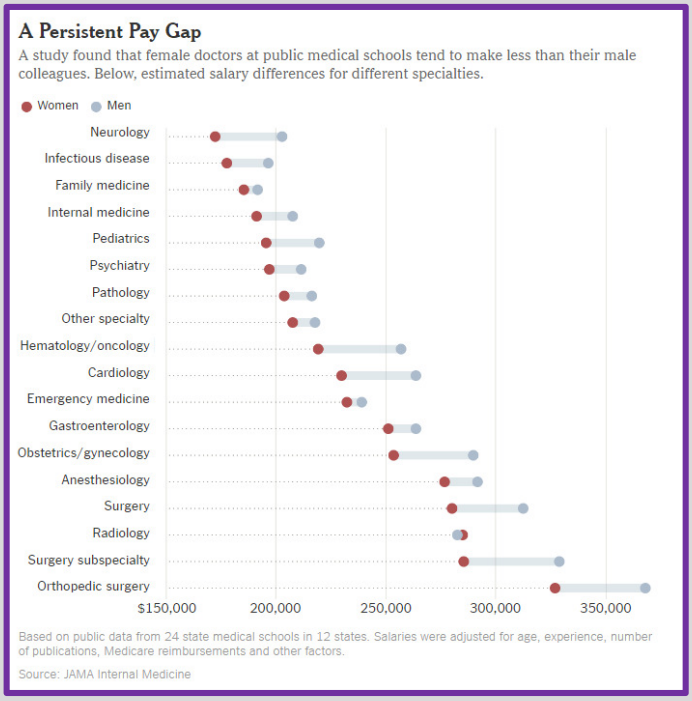

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Annals of Internal Medicine®

From: Compensation Disparities by Gender in Internal Medicine

Ann Intern Med. Published online August 07, 2018. doi:10.7326/M18-0693

Median annual income $227,500
Women $200,00
Men $250,000

Date of download:
10/15/2018

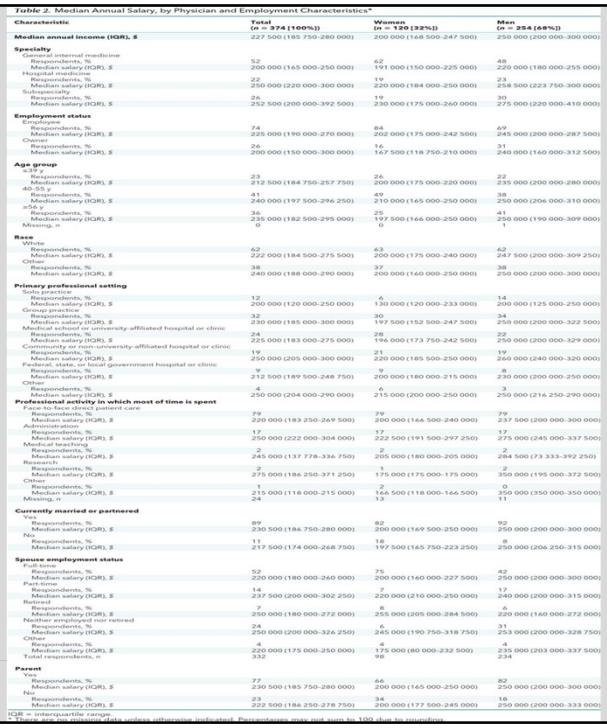

Table 2. Median Annual Salary, by Physician and Employment Characteristics*

Characteristic	Total (n = 374 [100%])	Women (n = 120 [32%])	Men (n = 254 [68%])
Median annual income (IQR), $	227 500 (185 750–280 000)	200 000 (168 500–247 500)	250 000 (200 000–300 000)
Specialty			
General internal medicine			
Respondents, %	52	62	48
Median salary (IQR), $	200 000 (165 000–250 000)	191 000 (150 000–225 000)	220 000 (180 000–255 000)
Cardiology			
Respondents, %	22	19	23
Median salary (IQR), $	250 000 (220 000–300 000)	220 000 (184 000–250 000)	258 500 (223 750–300 000)
Subspecialty			
Respondents, %	26	19	30
Median salary (IQR), $	252 500 (200 000–392 500)	230 000 (175 000–260 000)	275 000 (220 000–410 000)
Employment status			
Employee			
Respondents, %	74	84	69
Median salary (IQR), $	225 000 (190 000–270 000)	202 000 (175 000–242 500)	245 000 (200 000–287 500)
Owner			
Respondents, %	26	16	31
Median salary (IQR), $	200 000 (150 000–300 000)	167 500 (118 750–210 000)	240 000 (160 000–312 500)
Age group			
≤39 y			
Respondents, %	23	26	22
Median salary (IQR), $	212 500 (184 750–257 750)	200 000 (175 000–220 000)	235 000 (200 000–280 000)
40–55 y			
Respondents, %	41	49	38
Median salary (IQR), $	240 000 (197 500–296 250)	210 000 (165 000–250 000)	250 000 (206 000–310 000)
≥56 y			
Respondents, %	36	25	41
Median salary (IQR), $	235 000 (182 500–295 000)	197 500 (166 000–250 000)	250 000 (190 000–309 000)
Missing, *n*	0	0	1
Race			
White			
Respondents, %	42	63	42
Median salary (IQR), $	222 000 (184 500–275 500)	200 000 (175 000–240 000)	247 500 (200 000–309 250)
Other			
Respondents, %	38	37	38
Median salary (IQR), $	240 000 (188 000–290 000)	200 000 (160 000–250 000)	250 000 (200 000–300 000)
Primary professional setting			
Solo practice			
Respondents, %	12	6	14
Median salary (IQR), $	200 000 (120 000–250 000)	130 000 (120 000–233 000)	200 000 (125 000–250 000)
Group practice			
Respondents, %	32	30	34
Median salary (IQR), $	230 000 (185 000–300 000)	197 500 (152 500–247 500)	250 000 (200 000–322 500)
Medical school or university-affiliated hospital or clinic			
Respondents, %	24	28	22
Median salary (IQR), $	225 000 (183 000–275 000)	196 000 (173 750–242 500)	250 000 (200 000–329 000)
Community or non–university-affiliated hospital or clinic			
Respondents, %	19	21	19
Median salary (IQR), $	250 000 (205 000–300 000)	220 000 (185 500–250 000)	260 000 (240 000–320 000)
Federal, state, or local government hospital or clinic			
Respondents, %	9	9	8
Median salary (IQR), $	212 500 (189 500–248 750)	200 000 (180 000–215 000)	230 000 (200 000–250 000)
Other			
Respondents, %	4	6	3
Median salary (IQR), $	250 000 (204 000–290 000)	215 000 (200 000–250 000)	250 000 (216 250–290 000)
Professional activity in which most of time is spent			
Face-to-face direct patient care			
Respondents, %	79	79	79
Median salary (IQR), $	220 000 (183 250–269 500)	200 000 (166 500–240 000)	237 500 (200 000–300 000)
Administration			
Respondents, %	17	17	17
Median salary (IQR), $	250 000 (222 000–304 000)	222 500 (191 500–297 250)	275 000 (245 000–337 500)
Medical teaching			
Respondents, %	2	2	2
Median salary (IQR), $	245 000 (137 778–336 750)	205 000 (180 000–205 000)	284 500 (73 333–392 250)
Research			
Respondents, %	2	1	2
Median salary (IQR), $	275 000 (184 250–371 250)	175 000 (175 000–175 000)	350 000 (195 000–372 500)
Other			
Respondents, %	1	2	0
Median salary (IQR), $	215 000 (118 000–215 000)	166 500 (118 000–166 500)	350 000 (350 000–350 000)
Missing, *n*	24	13	11
Currently married or partnered			
Yes			
Respondents, %	89	82	92
Median salary (IQR), $	230 500 (186 750–280 000)	200 000 (169 500–250 000)	250 000 (200 000–300 000)
No			
Respondents, %	11	18	8
Median salary (IQR), $	217 500 (174 000–268 750)	197 500 (165 750–223 250)	250 000 (206 250–315 000)
Spouse employment status			
Full-time			
Respondents, %	52	75	42
Median salary (IQR), $	220 000 (180 000–260 000)	200 000 (160 000–227 500)	250 000 (200 000–300 000)
Part-time			
Respondents, %	14	7	17
Median salary (IQR), $	237 500 (200 000–302 250)	220 000 (210 000–250 000)	240 000 (200 000–315 000)
Retired			
Respondents, %	7	8	6
Median salary (IQR), $	250 000 (180 000–272 000)	255 000 (205 000–284 500)	220 000 (160 000–272 000)
Other employed nor retired			
Respondents, %	24	6	31
Median salary (IQR), $	250 000 (200 000–326 250)	245 000 (190 750–318 750)	253 000 (200 000–328 750)
Other			
Respondents, %	4	4	4
Median salary (IQR), $	220 000 (175 000–250 000)	175 000 (80 000–232 500)	235 000 (203 000–337 500)
Total respondents, *n*	332	98	234
Parent			
Yes			
Respondents, %	77	66	82
Median salary (IQR), $	230 500 (185 750–280 000)	200 000 (165 000–250 000)	250 000 (200 000–300 000)
No			
Respondents, %	23	34	18
Median salary (IQR), $	222 500 (186 250–278 750)	200 000 (177 500–245 000)	250 000 (200 000–333 000)

IQR = interquartile range.
* Those did not provide data unless otherwise indicated. Percentages may not sum to 100 due to rounding.

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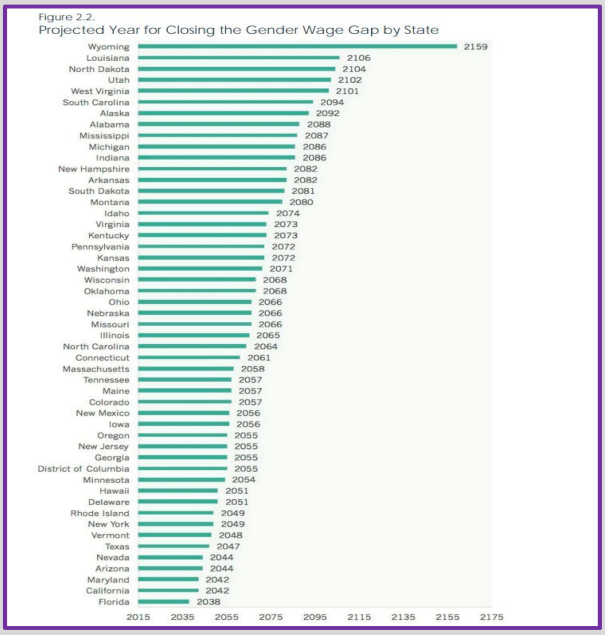

Institute for Women's Policy Research
March 2017

World Economic Forum Gender Equality Calculator =
US Overall 2186

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Case

- Dr. W is a third-year resident in internal medicine who is exploring her career options after residency. She is very interested in returning to her hometown to serve the indigent where she was raised. She knows that there is a dearth of African American physician role models so is excited to return home. As she is discussing her contract with a colleague who is also interested in working for the same clinic with identical experience and position description, she is made aware that her contract offer is 30% less than that of her white male colleague

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POSITION 2

ACP supports transparency and routine assessment of the equity of physician compensation arrangements by all organizations that employ physicians.

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POSITION 3

ACP supports the goal of universal access to family and medical leave policies that provide a minimum 6 weeks of paid leave and calls for legislative or regulatory action at the federal, state, or local level to advance this goal. Such legislation should include minimum paid leave standards and dedicated funding to help employers provide such leave. Paid leave policies should ensure that all employees have increased flexibility to care for family members, including children, spouses, partners, parents, parents-in-law, and grandparents.

- *a. ACP opposes discrimination on the basis of reproductive status, for those who choose to have children biologically or via adoption and for those who choose not to have children.*
- *b. Family and medical leave and paid leave policies should be a standard part of physicians' benefit packages, regardless of gender.*
- *c. Residency and fellowship programs, academic medical centers, community hospitals, and physician practices should develop and implement paid leave policies to provide compensation to eligible male and female physicians and trainees for a minimum of 6 weeks to care for a newborn, newly adopted, or seriously ill child and to attend to other qualifying life events, such as care of seriously ill family members other than children.*
- *d. Medical schools and residency and fellowship training programs should publish and distribute their family and medical leave policies to all applicants.*
- *e. Accrediting bodies for medical education and training should establish policies regarding family and medical leave for students and trainees, supporting a minimum of 6 weeks to care for a newborn, newly adopted, or seriously ill child and to attend to other qualifying life events, such as care of seriously ill family members other than children.*
- *f. Medical specialty boards should be flexible in their requirements for board eligibility in circumstances when trainees took family or medical leave.*

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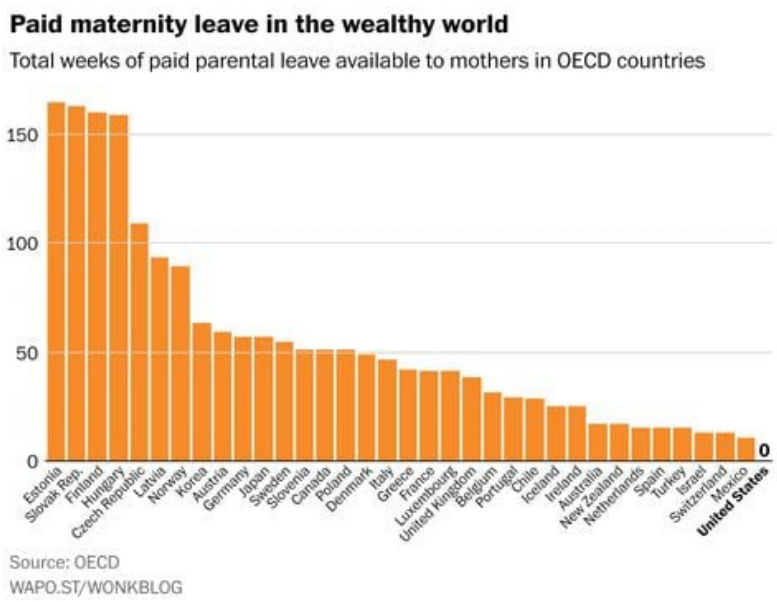

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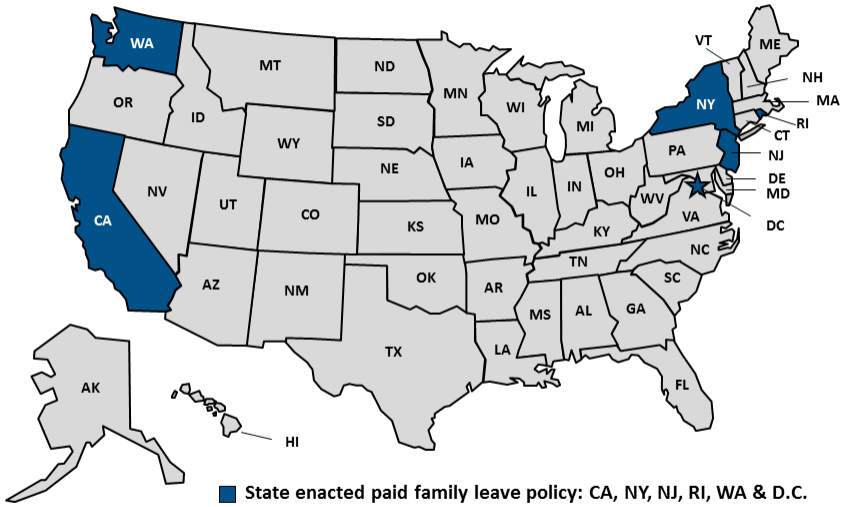
Figure 1

State Policies on Paid Family Leave, 2017



NOTE: New York law takes effect in 2018, and D.C. and Washington's benefits will be effective in 2020.
SOURCE: National Partnership for Women and Families. State Paid Family Leave Insurance Laws. July 2017.

THE HENRY J. KAISER FAMILY FOUNDATION

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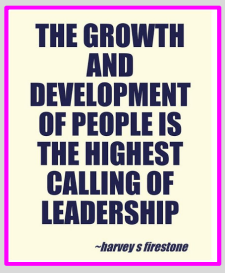
POSITION 4

ACP supports the provision of programs in leadership development, negotiation, and career development for all physicians and physicians-in-training.



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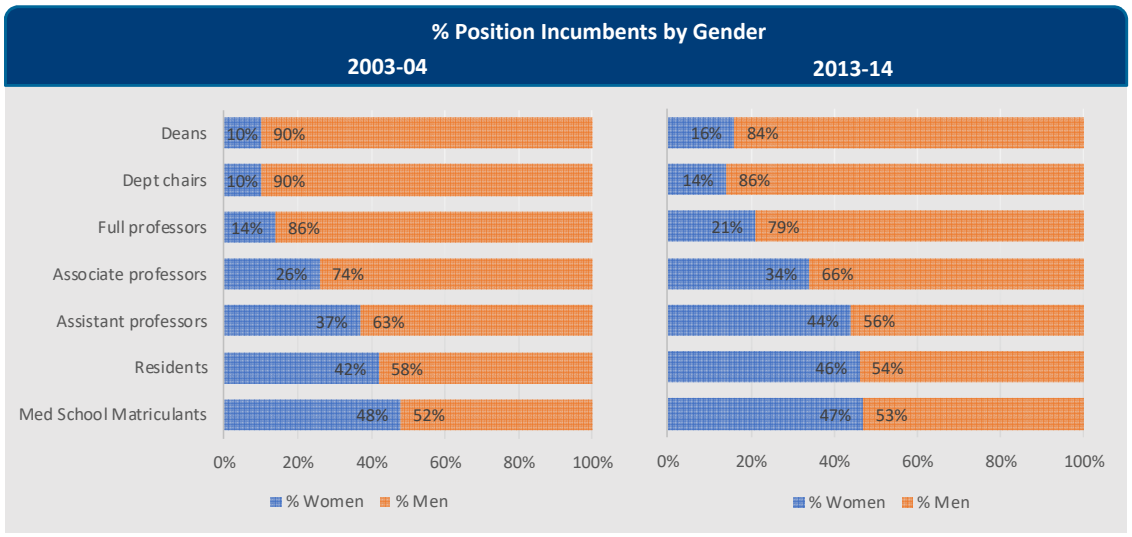
Medical schools are making modest progress in moving women physicians into positions of academic leadership, but progress is slow and gaps persist



Source: AAMC, "The State of Women in Academic Medicine, 2013-14", https://members.aamc.org/eweb/upload/The%20State%20of%20Women%20in%20Academic%20Medicine%202013-2014%20FINAL.pdf

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Table 4. Professorship Status by Specialty and Medical School Research Ranking

	Full Professorship[a]			
	No. of Full Professors/Total (%)		Absolute Difference in Proportion	
	Men	Women	Unadjusted, %	Adjusted, % (95% CI)
Specialty[b]				
Anesthesiology	723/3914 (18.5)	151/1743 (8.7)	−9.8	−3.4 (−5.2 to −1.5)
Cardiology	1044/3337 (31.3)	115/659 (17.5)	−13.8	−4.6 (−8.1 to −1.2)
Emergency medicine	330/2507 (13.2)	56/1001 (5.6)	−7.6	−2.5 (−4.6 to −0.4)
Family medicine	416/2208 (18.8)	119/1587 (7.5)	−11.3	−4.4 (−6.6 to −2.1)
Gastroenterology	519/1570 (33.1)	44/417 (10.6)	−22.5	−6.1 (−10.8 to −1.4)
Hematology/oncology	831/2199 (37.8)	176/949 (18.5)	−19.3	0.2 (−2.0 to 3.2)
Infectious disease	501/1247 (40.2)	118/729 (16.2)	−24.0	−6.9 (−10.4 to −3.4)
Internal medicine	1131/5255 (21.5)	303/3647 (8.3)	−13.2	−3.9 (−5.3 to −2.5)
Neurology	946/2652 (35.7)	161/1228 (13.1)	−22.6	−5.1 (−7.7 to −2.5)
Obstetrics and gynecology	572/1864 (30.7)	195/1958 (10.0)	−20.7	−5.1 (−7.6 to −2.7)
Orthopedic surgery	571/2244 (25.4)	26/233 (11.2)	−14.2	−2.5 (−8.0 to −3.7)
Other	2700/7770 (34.7)	583/3904 (14.9)	−19.8	−3.2 (−4.7 to −1.6)
Pathology	826/2112 (39.1)	262/1367 (19.2)	−19.9	−6.3 (−9.0 to −3.7)
Pediatrics	1709/6252 (27.3)	686/6144 (11.2)	−16.1	−4.0 (−5.2 to −2.9)
Psychiatry	835/3003 (27.8)	183/1786 (10.2)	−17.6	−5.2 (−7.3 to −3.0)
Radiology	918/3573 (25.7)	230/1430 (16.1)	−9.6	−2.0 (−4.0 to 0.4)
Surgery, general	1117/3561 (31.4)	115/894 (12.9)	−18.5	−4.6 (−7.6 to −1.6)
Surgery, subspecialty	1665/5341 (31.2)	100/788 (12.7)	−18.5	−3.6 (−7.0 to −0.2)
Research ranking of medical school[c]				
Ranked in top 20 in US	5761/17 173 (33.5)	1337/8893 (15.0)	−18.5	−4.5 (−5.5 to −3.4)
Not ranked in top 20	11 593/43 436 (26.7)	2286/21 571 (10.6)	−16.1	−3.8 (−4.5 to −3.2)

[a] Sample includes faculty of all ranks.

[b] Presents estimates of the association between faculty rank and physician sex in each specialty, adjusting for age, years since residency, publications (total, as well as first and last author), number of NIH grants, whether a physician had conducted a clinical trial, and whether a physician was faculty at a top-20 US medical school in terms of US News and World Report 2013 medical school research ranking.

[c] Subgroup analysis conducted among physician faculty and top-20 and non-top-20 schools in terms of medical school research ranking. For each group (top-20 vs not), we estimated the association between faculty rank and physician sex, adjusting for age, specialty, years since residency, publications (total, as well as first and last author), number of NIH grants, and whether a physician had conducted a clinical trial.

JAMA 2015

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From: **Representation of Women Among Academic Grand Rounds Speakers**

JAMA Intern Med. 2017;177(5):722-724. doi:10.1001/jamainternmed.2016.9646

Table. Representation of Women Among Grand Rounds (GR) Speakers and Comparison With National Academic Medical Workforce

Specialty	No. of GR Calendars Surveyed[a]	No. of Sessions Analyzed per Annual Calendar, Mean (SD)	Sessions Presented by Presenter Category per Annual Calendar, Mean (SD), %[b]			Sessions Presented by Women per Annual Calendar, Mean (95% CI), %			Workforce Members Who Are Women, %[e]		*P* Value[f]	
			Nontrainees									
			Intramural[c]	Extramural[d]	Trainees	All Presenters	Nontrainees	Trainees	Faculty	Residents	Faculty	Residents
Anesthesiology	17	37.0 (7.5)	56.0 (11.2)	31.9 (10.5)	12.5 (12.2)	28.3 (22.7-33.9)	26.2 (20.7-31.8) I: 29.0 (21.0-37.0) E: 20.3 (13.8-26.8)	28.0 (14.8-41.2)	34	36.7	.01	.001
Internal medicine	45	36.5 (8.4)	60.0 (23.0)	35.2 (20.5)	4.7 (7.7)	28.5 (25.6-31.4)	27.8 (24.8-30.8) I: 29.2 (26.2-33.0) E: 25.2 (19.3-31.2)	42.4 (31.1-53.7)	35	43.4	<.001	<.001
Neurology	28	33.5 (8.2)	51.0 (18.7)	37.0 (18.6)	11.0 (10.7)	28.3 (24.5-32.1)	26.0 (21.9-30.1) I: 27.5 (22.6-32.4) E: 20.1 (13.9-26.3)	54.2 (42.8-65.5)	33	47.8	.002	<.001
OB/GYN	18	30.3 (7.3)	50.7 (14.6)	25.6 (11.8)	24.1 (10.7)	60.3 (54.6-66.0)	53.3 (46.6-60.0) I: 53.4 (46.5-60.2) E: 54.6 (43.7-65.5)	80.0 (70.1-89.8)	55	82.6	.59	<.001
Pathology	18	21.8 (10.6)	50.5 (25.4)	38.2 (24.9)	11.6 (13.9)	28.1 (21.1-35.1)	25.3 (18.8-31.9) I: 24.5 (15.8-33.2) E: 18.1 (9.6-26.5)	56.0 (40.6-71.3)	37	54.2	.002	<.001
Pediatrics	32	37.7 (6.9)	53.2 (12.1)	44.2 (11.8)	3.6 (8.3)	38.7 (35.1-42.2)	37.1 (33.8-40.4) I: 41.0 (36.8-45.2) E: 32.9 (26.7-39.3)	51.9 (30.5-73.4)	52	70.6	<.001	<.001
Psychiatry	43	25.8 (9.4)	48.1 (21.9)	44.0 (20.7)	7.9 (11.0)	34.4 (31.7-37.2)	33.1 (30.0-36.2) I: 33.0 (27.4-38.6) E: 29.2 (24.5-33.9)	43.2 (32.5-53.9)	40	54.9	<.001	<.001
Radiology	15	14.3 (10.3)	33.5 (28.2)	64.3 (30.0)	2.3 (5.6)	20.0 (14.0-25.9)	19.6 (13.7-25.6) I: 26.1 (7.7-44.6) E: 16.3 (9.6-23.1)	49.3[g]	30	26.8	.002	.02
Surgery	22	26.4 (11.5)	46.6 (19.1)	40.3 (23.6)	12.9 (13.9)	24.7 (19.3-30.0)	23.0 (17.6-28.5) I: 18.6 (12.7-24.4) E: 22.4 (13.2-31.6)	47.7 (29.7-65.7)	18	37.9	.07	<.001

Abbreviations: E, extramural speaker affiliation; GR; grand rounds; I, intramural speaker affiliation; OB/GYN, obstetrics/gynecology.

[a] The 238 surveyed calendars were drawn from 79 institutions.

[b] Rows do not necessarily add to 100%.

[c] Holding any faculty or staff title at a GR-sponsoring university.

[d] Holding no faculty or staff title at a GR-sponsoring university.

[e] Per 2013-2014 Association of American Medical Colleges resident and MD- and equivalent degree-holding faculty gender data. Faculty data are not reported to the same significant figures as are resident data.[3]

[f] Values for nontrainee sessions presented by women per annual calendar vs workforce members who are women.

[g] Insufficient numbers of trainee-presented sessions in the specialty to determine 95% CI.

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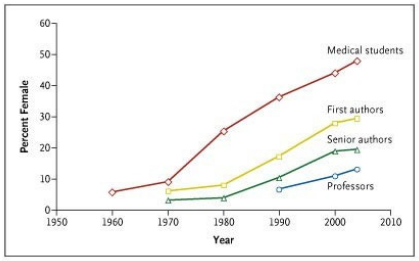
Gender and Authorship



Jagsi et al, NEJM, July 2006

Table 1. Representation of Female Physician-Investigators among First and Senior Authors of Published Original Research in Six U.S. Journals.*

Variable	1970	1980	1990	2000	2004	P Value
	number/total number (percent)					
Overall						
First author	58/982 (5.9)	67/810 (8.3)	137/814 (16.8)	169/614 (27.5)	178/607 (29.3)	<0.001
Senior author	29/783 (3.7)	25/692 (3.6)	69/681 (10.1)	106/578 (18.3)	112/580 (19.3)	<0.001
NEJM						
First author	8/188 (4.3)	14/117 (12.0)	23/143 (16.1)	23/110 (20.9)	13/92 (14.1)	<0.001
Senior author	6/153 (3.9)	3/108 (2.8)	11/122 (9.0)	13/106 (12.3)	11/97 (11.3)	<0.001
JAMA						
First author	13/227 (5.7)	7/151 (4.6)	25/125 (20.0)	26/121 (21.5)	30/113 (26.5)	<0.001
Senior author	5/173 (2.9)	3/128 (2.3)	13/102 (12.7)	19/115 (16.5)	16/118 (13.6)	<0.001
Ann Intern Med						
First author	5/107 (4.7)	8/126 (6.3)	13/106 (12.3)	15/44 (34.1)	17/54 (31.5)	<0.001
Senior author	5/93 (5.4)	4/115 (3.5)	4/92 (4.3)	11/43 (25.6)	7/52 (13.5)	0.009
Ann Surg						
First author	4/175 (2.3)	7/168 (4.2)	7/135 (5.2)	13/110 (11.8)	15/90 (16.7)	<0.001
Senior author	1/153 (0.7)	1/149 (0.7)	1/117 (0.9)	2/101 (2.0)	6/89 (6.7)	0.034
Obstet Gynecol						
First author	12/178 (6.7)	13/161 (8.1)	45/227 (19.8)	62/164 (37.8)	61/150 (40.7)	<0.001
Senior author	8/117 (6.8)	6/116 (5.2)	29/185 (15.7)	41/140 (29.3)	37/132 (28.0)	<0.001
J Pediatr						
First author	16/107 (15.0)	18/87 (20.7)	24/78 (30.8)	30/65 (46.2)	42/108 (38.9)	<0.001
Senior author	4/94 (4.3)	8/76 (10.5)	11/63 (17.5)	20/73 (27.4)	35/92 (38.0)	<0.001

* The analysis was restricted to authors from U.S. institutions holding an M.D. degree or equivalent for whom sex could be determined.

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Editors and Editorial Boards

- **Editors**
  - **10/63 women (16%)**
- **Editorial Boards**
  - **719/4112 women (17.5%)**

Amrein et al Gender Medicine Volume 8, Issue 6, December 2011, Pages 378-387

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Professional Society Boards of Trustees/Regents/Directors

Organization	Number of Women	Number of Men	Percentage of Women
AMA	6	15	28.5%
ACP	6	14	30%
ACS	6	26	18.7%
ACOG	13	17	43.3%
AAFP	4	12	25%
AAP	7	7	50%
APA	12	10	54.5%
AOA	6	22	21.4%

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POSITION 5

ACP supports the provision of regular and recurring implicit bias training by all organizations that employ physicians.

Organizational policies and procedures should be implemented that address implicit bias.

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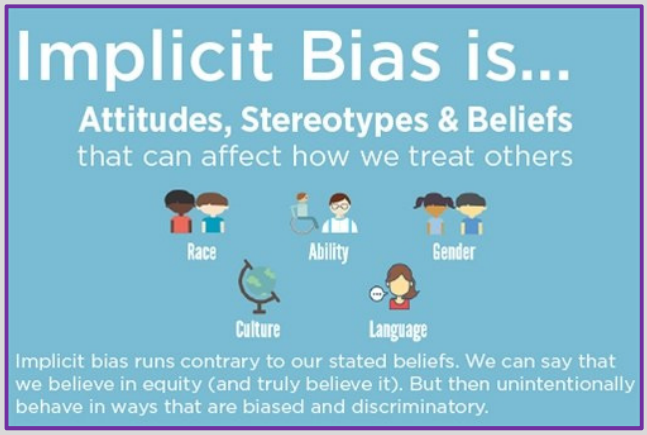
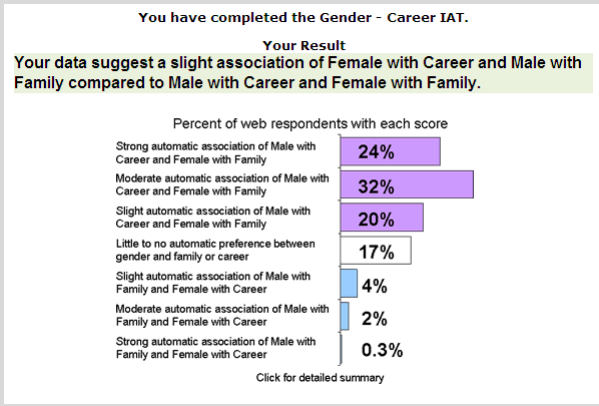
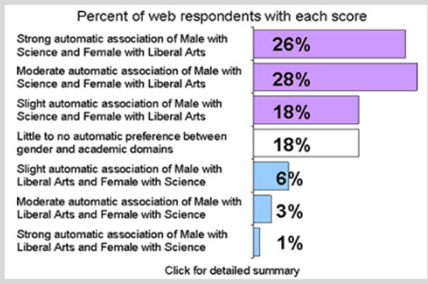


https://implicit.harvard.edu/implicit/





30


I'm so glad you are my nurse
Sounds good honey
You look too young to be a doctor
Children need their mother
Do you breastfeed exclusively?

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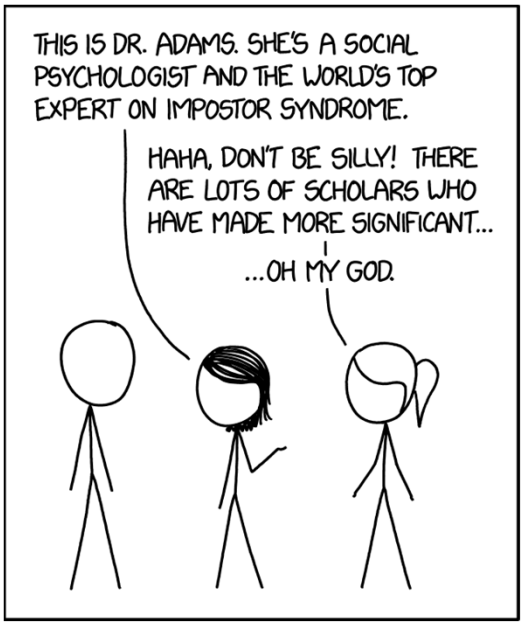
THIS IS DR. ADAMS. SHE'S A SOCIAL PSYCHOLOGIST AND THE WORLD'S TOP EXPERT ON IMPOSTOR SYNDROME.
HAHA, DON'T BE SILLY! THERE ARE LOTS OF SCHOLARS WHO HAVE MADE MORE SIGNIFICANT...
...OH MY GOD.

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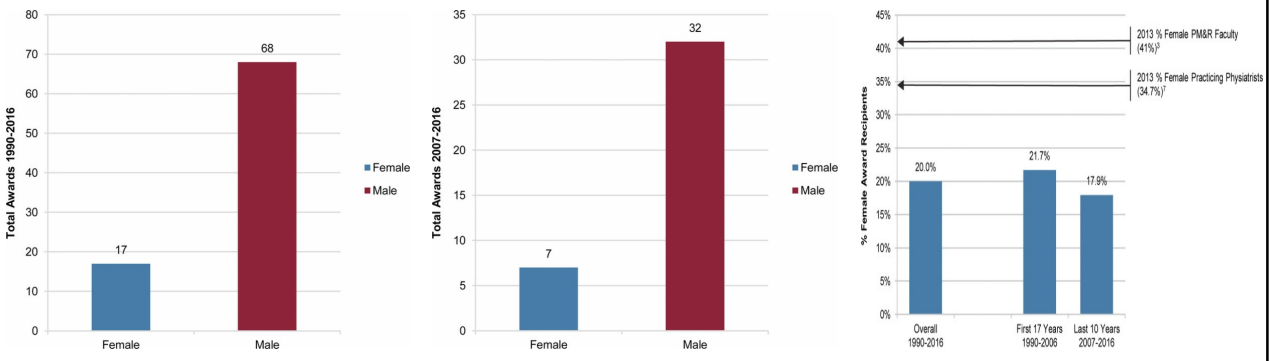
Women Physicians Are Underrepresented in Recognition Awards



Julie Silver et al Am J Phys Med Rehabil. 2018 Jan; 97(1): 34–40.

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Table 2. Characteristics of AΩA and Non-AΩA Applicants[a]

Characteristic	AΩA (n = 966)	Non-AΩA (n = 3689)	*P* Value
Race/ethnicity[b]			
White	691 (71.5)	1914 (51.9)	<.001
Black	7 (0.7)	269 (7.3)	<.001
Hispanic	27 (2.8)	159 (4.3)	.03
Asian or Pacific Islander	168 (17.4)	1002 (27.2)	<.001
Multiracial	58 (6.0)	260 (7.0)	.25
Other	15 (1.6)	85 (2.3)	.15
Female	404 (41.8)	1729 (46.9)	.001
Median age, y	26	27	<.001
USMLE Step 1			
Mean	251	230	
Bottom quartile[c]	19 (2.0)	1159 (31.4)	
Second quartile	77 (8.0)	1135 (30.8)	<.001
Third quartile	274 (28.4)	861 (23.3)	
Top quartile	596 (61.7)	534 (14.5)	
USMLE Step 2[d]			
Mean	259	241	
Bottom quartile[c]	1 (0.1)	149 (5.2)	
Second quartile	45 (6.0)	1190 (41.3)	<.001
Third quartile	197 (26.1)	983 (34.1)	
Top quartile	513 (68.0)	561 (19.5)	
Master's degree	125 (12.9)	690 (18.7)	<.001
PhD	21 (2.2)	145 (3.9)	.008
Published article or presented abstract (yes/no)	546 (56.5)	1942 (52.6)	.03
AΩA selection proxies			
Gold Humanism member (yes/no)	180 (18.6)	313 (8.5)	<.001
Leadership hours			
Median (IQR)	2 (0-287.5)	0 (0-312)	
<50th percentile	465 (48.1)	1931 (52.3)	.19
50th-75th percentile	264 (27.3)	832 (22.6)	
>75th percentile	237 (24.5)	926 (25.1)	
Community service hours			
Median (IQR)	583 (0-1542)	540 (0-1689)	
<50th percentile	474 (49.1)	1854 (50.3)	.93
50th-75th percentile	266 (27.5)	898 (24.3)	
>75th percentile	226 (23.4)	937 (25.4)	

Abbreviations: AΩA, Alpha Omega Alpha; IQR, interquartile range; USMLE, US Medical Licensing Examination.

[a] Data are presented as number (percentage) of applicants unless otherwise indicated.

[b] Overall χ^2 for the correlation between race/ethnicity and AΩA membership is $P < .001$.

[c] Overall χ^2 for the correlation between AΩA membership and USMLE Step 1 and Step 2 score quartiles is $P < .001$.

[d] At the time of application submission, USML step 2 was completed by 756 AΩA applicants and 2833 non-AΩA applicants.

Boatright et al. Jama Internal Medicine 2017; 177(5): 659-665

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POSITION 6

Academic institutions, health care organizations, physician private practice groups, and professional physician membership organizations should take steps to increase the number of women in practice, faculty, and leadership positions and structure equal access to opportunities, including:

a. Encouraging mentorship and sponsorship and providing training for faculty on how to be effective mentors and sponsors

b. Coaching and development programs

c. Flexibility in structuring career paths in academic medicine, health systems, and private practice and adopting flexible promotion and advancement criteria, including promotion tracks that reflect the wide range of responsibilities and unique contributions of female physicians

d. Requiring the inclusion of female physicians as job candidates and members of search committees

e. Ensuring diversity, including gender diversity, on all committees, councils, and boards through leadership development to ensure inclusion, comprehensiveness, and mechanisms for accountability

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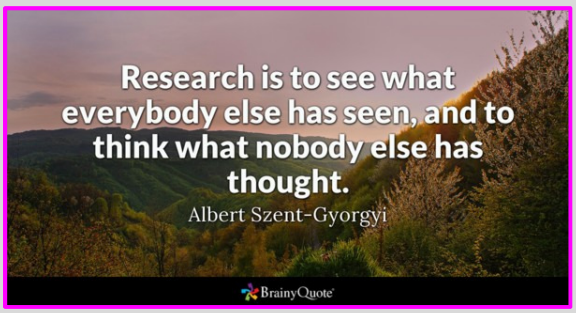
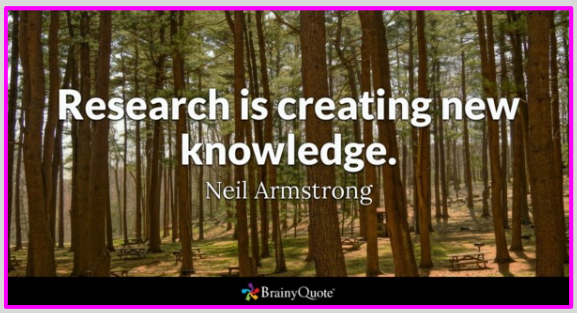
POSITION 7

Further research is needed on the reasons for and effect of gender pay inequity and barriers to career advancement and the best practices to close these gaps across all practice settings.





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POSITION 8

ACP opposes harassment, discrimination, and retaliation of any form based on characteristics of personal identity, including gender, in the medical profession.

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TIME'S UP™ HEALTHCARE

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Top 10 Things You Can Do to Impact Gender Equity in Medicine

1. ***Advocate***: Advocate for family, maternity, and paternity leave. Caregiving, whether of children or of parents, still primarily falls on women. Advocate for education that supports whole-woman care, including contraception and family planning. Advocate for inclusion of more women in clinical trials. Advocate for institutional requirements for hiring and promotion that address and fix inequities. Advocate for equal gender representation on search committees and in applicants. Advocate for recognition of all types of work, including committees, task forces, and comprehensive, complex patient care, and advocate for payment for all work.
2. ***Amplify***: Amplify the accomplishments of women. Give credit when it is due. Don't take credit away from the woman who speaks up.
3. ***Celebrate, Honor, and Support***: Celebrate positive examples and experiences. Celebrate differences. Honor female leaders by promoting them to positions of leadership within your professional community and nominate them for deserving acknowledgments and awards. Find allies with influence. Be an ally with influence. Believe in yourself and in other women. Support each other. Support choices that may not always validate our own.

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4. ***Engage***: Engage everyone, including leadership and men, to make gender equity a priority. Engage minority females to ensure we are looking out for all women—African American, Hispanic, Asian American/Native Hawaiian/Pacific Islander, and Native American women, as well as LGTBQ and those with disabilities—whose pay gap and leadership gap issues are worse. Demand prompt and non-retaliatory corrective actions in response to gender bias, harassment, or discrimination. Insist on gender pay equity.

5. ***Help***: Offer to help. Be available. Offer opportunities. Help make connections. Write letters of support and recommendation that overcome gendered language and expectations. Teach negotiation skills. Help by urging women who are busy but uninvolved professionals to join organized medicine in this fight.

6. ***Measure***: Make measurement a priority. Insist that institutions include markers to address leadership and pay gaps. Make sure these measurements include underrepresented minorities.

7. ***Mentor***: Be a mentor and look for mentors.

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8. ***Promote***: Promote practices that push away biases and create more equity. Use gender-neutral language in position descriptions, conversations, evaluations, and promotion criteria. Promote diversity and inclusion for search committees, task forces, and standing committees. Promote gender inequity awareness at meetings by making it an agenda item.

9. ***Respect***: Respect the person—regardless of gender, cultural, or other identity. Respect the role that the physician has in your organization and/or wants to have. Respect one's ideology.

10. ***Share and Solicit***: Share what makes you successful, share what you know. Share unwritten rules and unspoken knowledge. Solicit female role models to visit your institutions.

Advancing the Careers of Women: What ACP's Female Leaders Think Annals Fresh Look Blog
Fatima Z. Syed, MD, MSc 9/26/2018

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10 Ways for #MenInMedicine to be #HeForShe:

1. Listen and learn from womens' experiences
2. Call out inappropriate behavior as it occurs
3. Mentor, sponsor, and connect women
4. Nominate women for recognition awards
5. Put women on journal editorial boards
6. Promote women to leadership positions
7. Provide equal pay for equal work
8. Share salary data and negotiation strategies
9. Decline to participate in (and do not arrange) all-male panels (#manels)
10. Consider whether a qualified woman would be a fit for the role

Dr. Michael Sinha on Twitter @DrSinhaEsq

Harvard-MIT Center

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WOMEN OF IMPACT CHECKLIST: ADVANCING WORKPLACE EQUITY

- ☐ Is the attainment of equity a strategic goal for your organization?
- ☐ Do you regularly set improvement goals for each measure of equity and transparently share progress across your organization?
- ☐ Do you routinely undertake anonymous surveys to assess perceptions of equity and bias and perceived barriers to career mobility?
- ☐ Do you have an independent ombudsman or ambassador program who can address complaints, maintain confidentiality, and allow a due process for individuals who wish to draw attention to workplace inequity without fear of repercussions?
- ☐ Do you formally examine the diversity of your leadership team and of the leadership pipeline?
- ☐ Do you ask vendors and contractors about the diversity within their leadership teams as part of your contracting / Request for Proposals process?
- ☐ Do you have a recruitment practice that mitigates conscious and unconscious bias?
- ☐ Does your organization conduct a salary equity assessment, at least every year or every other year?
- ☐ Do your leaders have access to a leadership development program?
- ☐ Do you encourage sponsorship programs to enhance external visibility of your budding leaders?
- ☐ Do you have an active mentoring program that pairs women leaders with emerging women leaders?
- ☐ Are there opportunities to create physical spaces and structures or processes to celebrate women's accomplishments in the workplace?
- ☐ Are your family-friendly policies, such as family leaves, opt-out benefits and do you embrace flexible job arrangements where practical?
- ☐ Do you regularly hold standardized exit interviews, with specific queries on culture of inclusion and perceived opportunities for advancement?

Source: The Authors

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our work should equip
the next generation of women
to outdo us in every field
this is the legacy we'll leave behind

progress - rupi kaur

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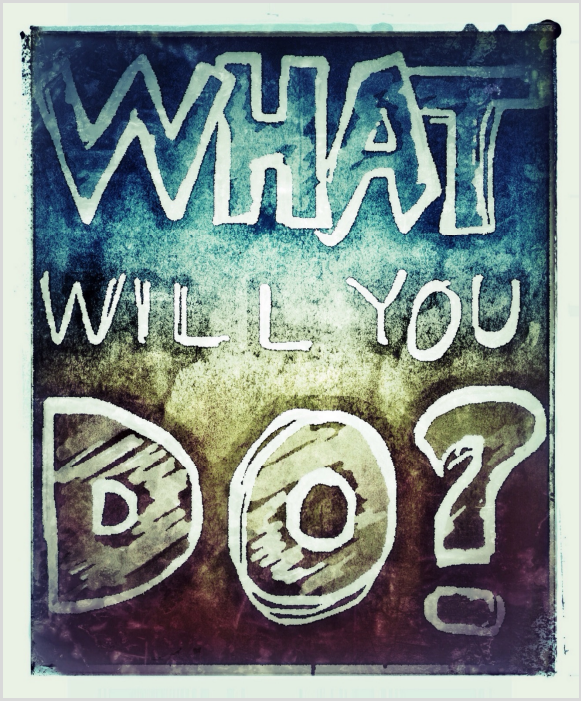

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