Ensuring Equity in Compensation and Career Advancement for Female Physicians

See also page 35

"Why can't a woman be more like a man?" When Henry Higgins first intoned this question in the 1956 production of *My Fair Lady*,[1] the emphasis was all on **man**. In medicine today, the intonation is substantially different. Why **can't** a woman be more like a man? The focus is on equity not only in salary, but in other areas of academic success that include promotion and access to top leadership positions.

In this issue of *Mayo Clinic Proceedings*, Hayes et al,[2] who include the former president/chief executive officer of Mayo Clinic and the current president/chief executive officer, examine their structured compensation model, in existence for 40 years, to understand whether it ensures gender equity in pay. The model examines total compensation for all permanent staff physicians at Mayo Clinic locations in Minnesota, Arizona, and Florida (30% female). As described by Hayes et al,[2] initial salary for each new hire is a predetermined percent of the target salary within the specialty. Although experience and training before hire can modify initial pay, within 5 years of hire all individuals in the same specialty are expected to reach the target. The model does not consider relative value units, length of service, tenure, or academic rank. A compensation committee reviews annual salary and adjustments. The effectiveness of the model was analyzed with statistically validated methods through an outside consultant specializing in compensation analysis (Infor, New York, New York). This approach is an important distinction over the usual reliance on self-reported salaries or satisfaction surveys.

As reported in the article, pay equity was affirmed in 96%. Gender-based differences were seen both at the low end of the salary scale (1.1% men, 1.4% women) and at the high end (3.1% men, 2.3% women). Two factors underlying gender differences for salaries that exceeded the 95% confidence interval included (1) receipt of permanent pre-2014 pay increments for past leadership positions for twice as many men as women; and (2) the high representation of men versus women in the highest compensated specialties, which were defined as a target salary of greater than $500,000. Both of these differences were statistically significant. How clinical productivity is ensured was not addressed.

Virtually every medical specialty has reported gender-based discrepancies in pay that cost women physicians anywhere from $16,159 a year[3] to more than $1 million over the career span. Even those specialties in which women predominate (ie, pediatrics and family practice) are not protected from salary disparities.[4,5] Salary data from 998 pediatricians (27.5% men, 72.5% women) who worked in general pediatrics, hospitalist care, or subspecialty care showed that women earned 76% of what men earned ($51,000 average annual shortfall), before adjustment for labor force characteristics such as demographics, work hours, and subspecialty. After adjustment, women earned 87% to 94% of what men earned ($8,000 to $26,000 annual shortfall).[4]

Other approaches to address the potential for gender-based wage gaps include structured compensation models based on rank and time-in-rank in a given subspecialty. A compensation model developed by the Department of Pediatrics at Cincinnati Children's Hospital Medical Center (710 full-time faculty, 47% women) in 2015 is not based on individual productivity (eg, relative value units) but rather is tied directly to nationwide standards of compensation from the Association of Academic Administrators in Pediatrics (AAAP), which tabulates annual salary data from approximately 100

academic pediatric departments and provides both national and regional data at the 25th, 50th, and 75th percentiles by rank (instructors, assistant professors, associate professors, and professors) in each subspecialty. In our model, full-time faculty at a given rank are expected to progress from the 25th percentile to at least the 50th to 60th percentile within the AAAP salary band over 5 years; thus, if performance is satisfactory, time-in-rank is the differentiator. If a first-year assistant professor is given a salary that is higher than assistant professors with similar duties who are longer in rank, then upward adjustments must be made. Salary data are provided annually to division directors, and gender-based equity in faculty salaries is a component of the division directors' annual evaluation. As was seen at the University of California at San Francisco, substantial institutional investment may be required to align salaries of both women and men at the outset.[6]

A number of lessons from this article stand out. First, as shown by the authors, commitment cannot be tacit and must be coupled with action. A recent precise appraisal[7] examined statements about gender equity from various pediatric organizations and then tabulated the number of women subsequently elected or appointed to their councils, boards of governors, and C-suites. The actual numbers showed little if any improvement in gender balance.[7]

Secondly, the compensation model must be definitive, preferably based on national standards, and broadly understood among the faculty. In circumstances in which women may be especially disadvantaged because of labor force characteristics such as work hours and subspecialty, equitability and fairness may be more likely achieved by a total compensation model without in-built incentive pay, other productivity-based bonuses, or differences in nonsalary benefits.

Annual review of gender equity in salaries at the level of individual subspecialty units (eg, divisions) must be a stated responsibility of division directors, with follow-up by departmental or institutional leaders. Finally, predetermined salaries for leadership positions and explicit delineation of protected time for a given role are essential, as is the provision of adequate administrative support.

Nevertheless, as Hayes et al[2] point out, salary is not the sole factor that handicaps the careers of women in medicine. Start-up packages for researchers are known to be higher for men than for women, with some publications showing more than a $1 million differential.[8,9]

The oft-heard response that women's lower salaries are a result of delayed promotion can be corrected at least in part by definitive guidelines for promotion. Phrases such as "a substantive number of papers" or "a substantial portion of salary funded from extramural grants" are ambiguous and open to subjective interpretation. Revision of our promotion guidelines in the Department of Pediatrics in 2017 provided precise expectations for numbers of publications and type of grant support for advancement at all ranks in both tenure and nontenure tracks; as a result, the promotion of women faculty increased by 30% from 2017 to 2019, compared with the period from 2014 to 2016. Another key component is an office of academic affairs, led by an experienced senior faculty member equipped to counsel men and women faculty on their readiness for promotion. For both women and men, daycare is a family issue, and the importance of institutional attention cannot be underestimated.[10]

Implementation of term limits for leadership positions (eg, department chairs, division directors)[11] can open the door to women's advancement. Access to sponsorship for leadership positions has long been a major hurdle for women. Sponsorship, as opposed to mentorship, entails purposeful advocacy by a current senior leader to advance a woman's career. Leaders of critical care, pulmonary, and sleep medicine departments acknowledged this deficiency and proposed remedies, including proportional representation of women on awards committees and in editorial roles, as well as training in implicit bias for organizational leaders and review committees.[12]

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Sponsorship is a critical lift that women are only beginning to access.

Hayes et al[2] are to be congratulated for a model that ensures equity in salary and allows women to take the first step on the path to success in medicine. Equity in promotion, in opportunities for national and international prominence, and in access to top leadership positions is required if women are to reach the destination in step with their male colleagues.

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