

VIEWPOINT

Closing the Gender Wage Gap and Achieving Professional Equity in Medicine

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On July 1, 2018, an updated equal pay law went into effect in Massachusetts to address gender pay disparity. The updates to the Massachusetts Equal Pay Act (MEPA) of 1945 provide more clarity as to what constitutes unlawful wage discrimination and adds protections to ensure greater equity. Among other provisions, the law defines comparable work, makes it illegal to ask about current salary during compensation negotiations, and makes it illegal to penalize or retaliate against employees for discussing their salaries. Why did MEPA need to be updated in 2018? Because 73 years after its enactment, gender pay inequity remains a major concern in society in general and in medicine.

In Massachusetts, women working full time on average still earn only 84.3% of what men earn.¹ The gap is even larger for women of color.¹ In examining the gap by occupation, physicians and surgeons have one of the largest gender pay gaps.² A 2018 report published by the American Association of University Women and based on data from the 2017 US Census and the Bureau of Labor Statistics revealed that the collective wage gap for women physicians is in the billions, with women physicians and surgeons paid

potential selection bias of survey respondents. However, data from a more homogenous cohort consisting of mid-career academic physician researchers revealed similar findings.⁴ Male gender was associated with higher salary (+\$13 399; $P = .001$), even after adjustment for specialty, academic rank, leadership positions, publications, and research time.⁴

Perhaps more concerning than the actual presence and magnitude of the gender pay gap among physicians is that the gap is pervasive across medical specialties, has persisted over decades, and has recently widened. In a national physician survey of a faculty cohort over 17 years, the same gender disparity in compensation persisted from 1995 to 2012-2013,⁵ suggesting no real improvement over 2 decades. Recent evidence suggests that the gap may be widening; the Doximity survey³ found that women physicians were making 26.5% less than men physicians the year before the survey was administered. Furthermore, the inequities persisted across all 40 specialties and the 50 metropolitan areas analyzed, although the data were limited to self-reported salary and nonrespondent data could not be captured.

When there are gender gaps in compensation, various rationalizations are often suggested, including differences in work hours, differences in the number of patients seen, and even differences in professional outcomes. With regard to outcomes, recent data suggest that pro-

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an estimated \$19 billion less annually than men physicians and surgeons.² The report affirmed that even today, women physicians and surgeons are paid 71% of what their male counterparts are paid.²

Similarly, a 2018 survey of 65 000 physicians by Doximity revealed that in 2017, women physicians, on average, earned 27.7% less than their male counterparts.³ That translated to an average gap of \$105 000 less pay per year for women. Some might argue that the gender wage gap persists because women work fewer hours than men. However, the 2018 Doximity report was based on compensation survey data completed by full-time, licensed US physicians who practiced at least 40 hours per week. To control for differences in specialty, geography, and other physician-specific factors, the researchers used multivariable regression with fixed effects for physician specialty and metropolitan statistical areas and also controlled for how long each physician had practiced medicine and for self-reported average hours worked per week. A study limitation was that these data relied on self-reported salary, and the findings may not be generalizable to all physicians, given the

professional outcomes for women physicians are not only equal but may be better. For instance, an observational study of 58 344 physicians (32% women) showed that in-hospital mortality and readmission rates were lower for patients cared for by women hospitalists. Women physicians were more likely to adhere to evidence-based medicine, provide preventive care, and demonstrate patient-centered care in the outpatient setting.⁶ Professional competency appears to be, at a minimum, equal by gender.

Assessing equity is complicated because physician job descriptions vary widely. In general, comparable work is defined as work that requires substantially similar skill, effort, and responsibility and is performed under similar working conditions. The updated MEPA provisions do allow for differential pay based on seniority, merit, geographic location, quantity or quality of sales or revenue, education or training, or travel. For physicians, compensation goes beyond base pay to include bonuses, incentives, and professional reimbursement (including continuing medical education). Newly recruited faculty might be reimbursed for moving costs and might receive signing bonuses and

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start-up packages. In academic medicine, institutional support for junior investigators can vary by gender by up to \$1 000 000, with women receiving significantly less start-up support from their institutions than men.⁷ Benefits including paid time off, leave, and malpractice insurance (including dollar limits, scope, claims made vs occurrence, and tail/nose coverage) can have clear financial implications. Women physicians who work part time or take a leave of absence, such as for maternity leave, have an estimated loss of \$28 000 in salary.⁵

In addition, some key features of a job description do not easily translate into dollar equivalencies but may have important influences on productivity and income. In clinical practice, allocation of support staff, scribes, examination rooms, and operating room block time can all make practice more or less efficient and productive. For example, assignment of operating room blocks allows surgeons to have guaranteed procedural time and regularity in case scheduling that directly affect surgical case volume and, by extension, income. Inequities in operating room block time could, in theory, explain why orthopedic surgeons have among the highest gender wage gaps, but such data are currently lacking.

Administrative support for nonclinical time, expectations for other duties, and responsibilities such as service on committees and teaching roles all affect the availability of time to produce scholarship. Salary equity analyses are often conducted at the level of a department or institution, but many of the drivers of salary are controlled at the section or divisional level. Clinical practices, research laboratories, and leaders need to assess equitable distribution of research supports, clinical allocations, and citizenship service tasks (such as service on committees and mentoring) to ensure that these are not systematically disadvantaging women's ability to generate revenue and scholarship.

It will take some time to assess the outcomes of the updates to MEPA, especially considering that pay disparities have been a refractory problem. Beyond this law, leaders in medicine must work to mitigate unconscious bias, encourage women to follow their passions rather than steer them away from traditionally male specialties, and embrace the fact that half of the profession may take maternity leave (and some may take paternity leave). Doing so will help close the gender wage gap and contribute to achieving professional equity in medicine beyond salary.

ARTICLE INFORMATION

Published Online: April 5, 2019.
doi:10.1001/jama.2019.4168

Conflict of Interest Disclosures: Dr Asgari reported receiving grants from Pfizer. Dr Bates reported serving as past chair of the steering committee of the Group on Women in Medicine and Science of the Association of American Medical Colleges. No other disclosures were reported.

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