

Unequal Pay for Equal Work: The Gender Gap in Academic Medicine

Arbitrators recently awarded \$2.2 million to a woman whose employer, a large brokerage firm, systematically paid women less than men for similar work (1). Such discrimination is not unique to the world of high finance. Things seem to be much worse in medicine. In June 2004, the U.S. Census Bureau released an analysis of the earnings of full-time workers that reported that female physicians' wages averaged 63 cents for every dollar earned by their male colleagues (2). The Census Bureau report was limited in that it did not examine factors, such as specialty, practice setting, seniority, and performance, that are likely to contribute to salary differentials. In 1996, a Committee of the Association of Academic University Professors concluded that the gender gap in academic medicine was the result of women practicing in lower-paying specialties (3). If women in medicine decide to forgo increased earning power because of their choice of specialty or the desire to have more flexible working hours, then the salary gap would be expected and would be more acceptable. However, evidence from academic medicine suggests that these factors do not fully explain why women in academic medicine earn less than their male colleagues.

In this issue, Ash, Carr, and colleagues analyzed data from a national survey of academic physicians and reported that women earned less than their male colleagues, even after accounting for specialty, hours worked, and many other measures of productivity and achievement (4). In addition, they found that women were less likely than men to reach the highest academic ranks. However, differences in rank did not fully account for the salary gap. Women still had significantly lower compensation than men at the same academic rank, even after adjustment for confounders, such as specialty, job characteristics, and productivity. More disturbing, women started out with a salary deficit that they never recouped over time; the salary differential increased as seniority increased. The strengths of this study are its national scope, detailed data on factors that are likely to drive compensation and promotion, and careful analyses that adjust for diverse confounders. Limitations include the 60% response rate and the fact that the survey is almost a decade old. Admittedly, the study by Ash, Carr, and colleagues is not the first study to report a salary gap for women in medicine (5–9). Yet, we have not been able to identify a more comprehensive or recent analysis of this contentious issue.

Many factors—measured and unmeasured—contribute to the gender gap in academic medicine. Female physicians themselves are at least partially accountable for their lower compensation. To balance family and career demands, women often make career choices, sometimes voluntarily and sometimes out of necessity, that sacrifice their earning power for greater work flexibility (10, 11). Women also shoulder a disproportionate share of clinical and teach-

ing responsibilities in departments, activities that can restrict their ability to pursue lucrative research and administrative leadership activities (12). One might falsely conclude from this evidence that women in medicine are earning less by choice, but ample evidence, including the article in this issue, shows that women earn less than men, even after adjustment for hours worked, specialty, job responsibilities, and productivity.

Women are also poor negotiators when it comes to the nose-to-nose business of determining compensation or receiving well-deserved promotions. We have personally been in the position of accepting salaries for full-time academic positions and then learning later that our salaries were in the lowest 5% of national salaries for faculty physicians at the same rank. Because information on compensation norms is hard to obtain at academic institutions, it took reviewing grants for the National Institutes of Health and a tip from a colleague about an Association of American Medical Colleges report on salary ranges for academic faculty by specialty and academic rank to garner the evidence that our salaries were way out of line.

A recent book examined women's negotiating skills and found that women of all ages were less likely to initiate salary negotiation and more likely to accept whatever their employer or prospective employer offered (13). However, these traits may be advantageous in other settings. For example, women's receptiveness to the viewpoints and priorities of others may be one reason that they outperform men at patient-centered communication and participatory decision making (14). In addition, women's leadership styles seem to be more attentive to the personal needs of their staff and to rely heavily on trust (15). Without losing these important attributes, women must learn how to advocate for themselves and to value their own work. Toward this end, women should seek and develop workshops on negotiation skills within faculty organizations or professional societies.

Although women's poor negotiation skills undoubtedly account for part of the salary gap, substantial responsibility lies on the broad shoulders of men (mostly) who are in charge of academic medical institutions across the nation. The "old boys' network" is alive and kicking. Evidence also shows that women researchers receive less laboratory space and fewer resources than similarly accomplished male colleagues (16). In a recent survey at an academic center, women reported discrimination more often than men (8). In a study at another academic center, women were significantly more likely than men to report feeling excluded from informal networking (17). Strong mentorship is a key prerequisite for academic advancement and guidance in career (and possibly salary) decisions. Research on women's access to mentoring is contradictory; some studies affirm (17) and others negate differences by

sex (18, 19). In their review, Benz and colleagues concluded that discrimination against women in academic medicine was apparent on many levels, including lack of support for research, effective mentoring, and social isolation (20). Unfortunately, blatant sexism is on the list of factors that contribute to the gender gap in academic medicine. A common story among women in academic medicine involves a superior who told them that, because the woman belongs to a 2-income family, compensation should be less of a concern for her than for male colleagues who are the sole breadwinners for their families.

Fortunately, a handful of local demonstration projects have begun to try to address gender inequity in academic medicine. The Department of Medicine at Johns Hopkins University systematically instituted interventions to increase the success of women in the department; these interventions seemed to result in a substantial increase in the number of women at the associate professor level as well as in an increased number of both men and women intending to stay in academic medicine (21). However, these results appeared in 1996, and, to our knowledge, no recent update is available. The University of Arizona has worked to improve gender equity among its medical faculty through an initiative called GRACE: Generating Respect for All in a Climate of Academic Excellence (22). A recent Association of American Medical Colleges report on increasing women's leadership in academic medicine identifies several faculty mentoring programs at various institutions. The Association expects that these programs will help both women and men achieve success (23). Leaders from several universities have begun to share annual analyses of salaries and resources for women (24), and at least 1 useful guide for women in medicine is available (25).

To make compensation more equitable, every institution needs to have greater transparency in its promotion and compensation practices. Institutional guidelines for academic advancement and salary calculations should undergo scrutiny to ensure that they do not systematically place one group of individuals at a disadvantage. Deans should periodically request that department chairs provide information on faculty salaries by sex, specialty, rank, and measures of productivity and achievement. Institutions should then review this information for evidence of inequities. Institutions must develop venues for addressing concerns about sex discrimination that do not stigmatize the person who dares to complain. Periodic performance reviews should provide opportunities for faculty to compare their compensation and performance with local and national benchmarks. Such reviews would then enable faculty to identify unacceptable disparities or, ideally, opportunities to increase compensation through changes in performance. The profession should not tolerate complacency about the lack of equitable rewards for women and must hold leadership accountable for redressing unconscionable gender differences in salary.

Sex discrimination in academic medicine has been ev-

ident for more than 2 decades (26). The article in this issue and the Census Bureau report are the most recent evidence that, despite near-equal representation of women and men in medicine (23), equal compensation remains evasive (23). The medical profession should be mortified that no other profession in the United States exhibits greater salary disparities by sex (2). Since the strongest evidence of inequity comes from academic medicine, academic medicine is probably the best place to identify solutions. Women may be from Venus and men may be from Mars, but it is high time to ensure that male and female physicians receive equal pay for equal work.

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