The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Closing the Gender Pay Gap in Medicine

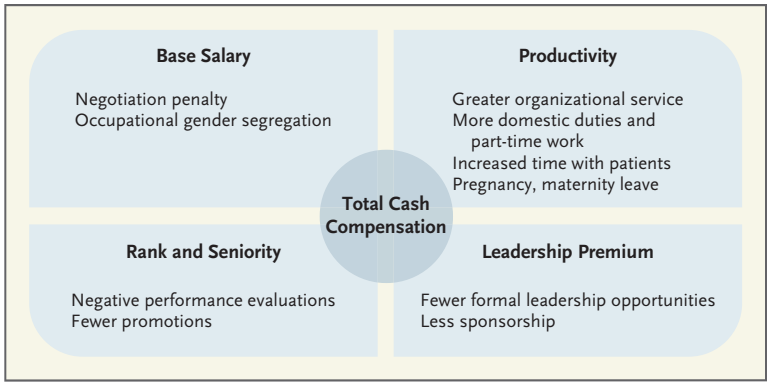
Amy S. Gottlieb, M.D., and Reshma Jagsi, M.D., D.Phil.

The Association of American Medical Colleges (AAMC) has issued a new assessment of salary disparities among U.S. physicians according to gender, race, and their intersection that reaffirms a persistent gender pay gap.[1] Building on decades of research demonstrating that female physicians across practice types, specialties, and ranks earn less than their male counterparts even after adjustment for potential confounders, the AAMC provides much-needed detail on the associations of compensation with race, ethnic background, and gender among academic physicians in the United States.[1,2] The findings are both striking and familiar. In an echo of trends in the U.S. labor market as a whole, female academic physicians, regardless of racial or ethnic group, earn less than men of every racial and ethnic group. As compared with male physicians in their own racial or ethnic groups, White women earn 77 cents on the dollar, Black women 79 cents, and Asian women 75 cents. Although these data derive only from academic medical institutions, they reflect the compensation of 60,000 physicians.

Our approach to compensating physicians is in desperate need of improvement. Not only have our traditional methods failed to meaningfully prioritize quality and outcomes of care, they have also generated a gender pay gap that is one of the largest in the U.S. labor market, with inequities beginning right out of training.[3] The majority of U.S. physicians are now employees, rather than practice owners, and their organizations have implemented quality-improvement programs that, recognizing the complexity of the forces affecting quality and the interdependence of outcomes, deploy models of continuous innovation and evaluation. We believe institutions need to extend this approach to efforts to achieve salary equity.

As leaders grapple with this goal, they should reflect on components of the compensation calculus that reward the way male physicians have lived and engaged professionally for generations.[4] Viewing compensation determination through this new lens reveals its traditional methods to be a crucible in which the myriad forces that diminish women's perceived professional value within a medical institution converge.[4] These forces are interrelated, and addressing one requires understanding and mitigating the others.

Compensation methods for employed physicians typically involve a formula of base salary (predicated on commercially available benchmarking data) plus monetary rewards for seniority, leadership, and productivity. This framework contributes structurally to gender-based salary ineq-



Factors Reflecting Second-Generation Gender Bias in the Traditional Domains of Physician Compensation.

uities because women's earning potential is diminished in each domain (see diagram). For example, there is often a considerable difference between the low and high ends of base-salary ranges, which allows organizations substantial leeway in setting compensation. Salary expectations and vigor of negotiation during initial hiring are critical to establishing where an employee falls in that range, and these factors are particularly vulnerable to gender bias. Productivity-based compensation is affected negatively by increased demands for organizational service and increased time spent with patients, which results in better outcomes but lower volumes for female physicians than for male physicians. Similarly, women's historically limited access to formal leadership roles and less sponsorship for taking on these roles translates into less compensation for performing them.

To identify, acknowledge, and address these contextual forces, organizations need to explore a phenomenon known as second-generation gender bias, which is not overt, like the sexism that was common before Title VII of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972.[5] Instead, it involves prejudices that are embedded in unconscious beliefs about what leaders look like, how men and women should behave, and how women's work is assigned and valued in our professional institutions and society. These prescriptive norms obstruct talented women from reaching their professional potential and receiving the same pay as men in comparable positions. They perpetuate the gendered career paths, disparate responsibility for tasks that do not lead to promotion, and penalties for leading and negotiating that women face in the workplace and that strongly influence metrics determining physician compensation.

In health care, women tend to advance in areas that are consultative and supportive (e.g., faculty affairs dean, chief human resource officer) rather than those with quantitative or significant managerial responsibility (e.g., research dean, chief operating officer). The latter roles are incubators for dean and chief executive officer positions and thus gateways to the compensation accompanying the most senior executive positions. Similarly, female trainees continue to be directed toward certain specialties, such as pediatrics, that are seen as requiring traditionally "feminine" attributes (e.g., nurturing qualities, relationship orientation) and away from procedural and more technical specialties such as orthopedics. This phenomenon, known as occupational gender segregation, has tremendous consequences for pay equity: in the U.S. labor market, a loss of prestige and decline in earnings tend to occur after a large number of women enter a field or occupation. When an entire specialty loses ground in relative compensation and therefore salary benchmarks, the earning potential of all women entering that field is put at considerable risk.

Long-standing cultural expectations regarding women's behavior remain at odds with well-accepted traits of leaders and high performers, even though organizations with female leaders often outperform those with male leaders. Women in the workplace are expected to be both directive and participative, decisive and caring, and executive and approachable, and they face backlash when their behavior violates these stereotypes. Women are consistently evaluated more negatively than similarly qualified men as they navigate the expectations of femininity while simultaneously fulfilling requisites of advancement and leadership.

Nowhere do these unconscious social demands manifest more clearly than in job negotiations, during which women are subject to a likability standard that men exhibiting similar behaviors are not. The prevailing cultural narrative that women are less skilled negotiators than men is too simplistic and contradicts decades of experimental research. In fact, women do negotiate, but when

they do, they tend to be viewed as less hireable. Therefore, women and men face very different costs when deciding to question compensation offers and to ask for more salary and resources. Though it's understandable given the potential downside, a decision not to negotiate has tremendous consequences for pay equity, total earnings, and life choices over a long career.

Few health care leaders would argue against equal pay for equal work, but many are daunted by the prospect of operationalizing this concept. Organizations can begin by conducting salary audits, especially at critical career inflection points such as initial hiring and promotion, and implementing process changes that support equity (e.g., establishing a standard salary benchmark for new hires and requiring review for offers above or below it). They can also explore, with an eye toward equity, factors driving compensation calculations and adopt frameworks that consider both gender disparities in opportunity (e.g., leadership representation) and reward for mission-aligned pockets of productivity where women traditionally excel (e.g., citizenship and quality of care). Institutions can rotate critical citizenship roles, redefine productivity beyond the relative value unit to reflect contemporary goals such as reduced costs of care, and require unconscious-bias training for everyone involved in recruitment, hiring, evaluation, promotion, and salary setting.

Organizations will need to scrutinize not only compensation methods, but also differences in access to the resources necessary for demonstrating productivity, ranging from support staff to slots in operating-room schedules, as well as the nature, frequency, and patterns of physician-to-physician referrals. And they will have to monitor gender representation and salary equity over time in hiring, promotion, and leadership appointments, because we can manage only what we measure.

To close the pay gap in medicine, institutional leaders and their colleagues in human resources and finance will need to scrutinize basic assumptions underlying compensation methods to understand the expectations and outcomes they generate, create new approaches that better account for women's traditional contributions and related biases, and track and report gender metrics at all compensation touch points, especially in initial hiring. In addition, as policymakers and payers debate alternative payment models that prioritize quality and value, they must consider the ways in which new frameworks risk recapitulating gender biases. In an era when half of medical students are women, we will not succeed as a profession unless our institutions commit to process improvement to reshape practices and patterns of workplace interaction that inadvertently benefit men, disadvantage women, and sustain an unjustified and deeply troubling gender pay gap among our ranks.

Disclosure forms provided by the authors are available at NEJM.org.

From the Office of the Associate Dean for Faculty Affairs and the Departments of Medicine and of Obstetrics and Gynecology, UMass Chan Medical School–Baystate and Baystate Health, Springfield, MA (A.S.G.); and the Department of Radiation Oncology and the Center for Bioethics and Social Sciences in Medicine, University of Michigan, Ann Arbor (R.J.).

This article was published on October 20, 2021, at NEJM.org.

1. Dandar VM, Lautenberger DM, Garrison G. Exploring faculty salary equity at U.S. medical schools by gender and race/ethnicity. Washington, DC: Association of American Medical Colleges, October 2021 (https://www.aamc.org/data-reports/workforce/report/exploring-faculty-salary-equity-us-medical-schools-gender-and-race/ethnicity).
2. 2019 Physician compensation report: third annual study. San Francisco: Doximity, March 2019.
3. Lo Sasso AT, Armstrong D, Forte G, Gerber SE. Differences in starting pay for male and female physicians persist: explanations for the gender gap remain elusive. Health Aff (Millwood) 2020;39:256-63.
4. Gottlieb AS, ed. Closing the gender pay gap in medicine: a roadmap for healthcare organizations and the women physicians who work for them. Cham, Switzerland: Springer International Publishing, 2021.
5. Ibarra H, Ely R, Kolb D. Women rising: the unseen barriers. Harv Bus Rev 2013;91:60-6.

DOI: 10.1056/NEJMp2114955