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Gender

How to Close the Gender Pay Gap in U.S. Medicine

by Lisa S. Rotenstein and Jessica Dudley

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Summary. Indefensible differences in salary between women and men persist in medicine, with female primary care and specialist doctors earning 25% and 36% less, respectively, than their male counterparts. These differences are especially egregious given that female... **more**

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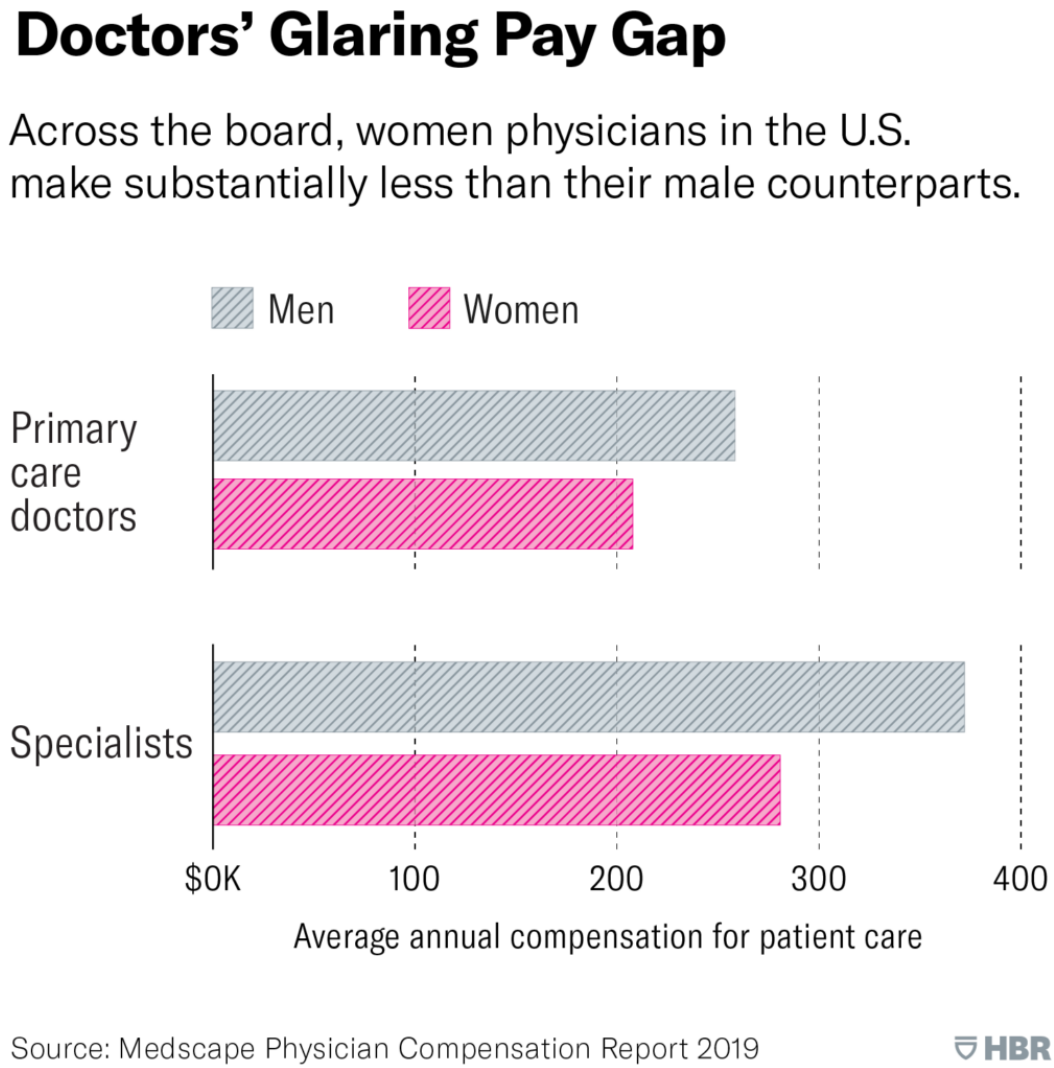
Despite increased attention to gender disparities in the workplace, indefensible differences in salary between women and men persist in medicine. One national study of academic physicians in 24 public medical schools found that female physicians make about 10% less than their male counterparts at

all academic ranks, even after adjusting for specialty, hours worked, and other variables. Medscape's 2019 Physician Compensation Report finds even greater disparities, with full-time male primary care and specialist doctors earning 25% and 33% more, respectively, than their female counterparts.



These differences are especially notable – and disappointing – given that female physicians actually outperform male physicians in some areas; one study of 1.5 million Medicare hospitalizations found that female doctors' patients had significantly lower mortality and fewer rehospitalizations. It's hard to imagine by what calculus a health care organization would pay women less than men for their better outcomes.

The solutions for closing this gap are complex, but achievable. Drawing on existing research, lessons from other fields, and our own experience as researchers and leaders committed to gender

equity, we believe that organizations should pursue three approaches to address the problem.

Enhance Salary Data

Lack of accurate salary data creates a major barrier both to leaders seeking to address inequities and to female physicians as they negotiate. Pay audits and increased transparency could help. Organizations outside of medicine have effectively used audits to reveal pay discrepancies and enhance pay equity. For example, after a 2015 analysis of more than 17,000 salaries at Salesforce, the company found that 6% of the employees (about equally split between men and women) required a salary adjustment, including, CEO Marc Benioff told CNN, "quite a few women" who were paid less than men.

To create the most useful audits in healthcare it will be essential to assure that they capture *total* compensation. Many physicians, particularly those practicing in academic settings, receive compensation from both clinical and non-clinical activities. Evidence from outside of medicine suggests that women are more likely to volunteer or be volunteered for non-promotable work, and, within medicine, women perceive that they are more likely to be given uncompensated work (such as unpaid committee or teaching positions and office-improvement projects) alongside clinical care. Comparing compensation for clinical activities alone would not capture these differences which contribute to lower overall salaries for amount worked.

In addition, auditing should take into consideration the demands that female physicians' patients make relative to those made of male physicians. There is evidence that female physicians have more female patients, and more patients with psychosocial

complexity, than their male counterparts do. Patients in both groups often require longer visits and more management time outside the office. Further, research shows that patients tend to seek a different (and more time-consuming) kind of care from female doctors, often talking and disclosing more and expecting more empathic listening. Accurate auditing will need to account for patient complexity in addition to number of patients seen or the number of patients a physician has on their panel to accurately assess clinical load.

Providing salary transparency is a more controversial approach to promoting equal pay that has been explored in other industries. Public universities such as the University of California system have made compensation data publicly available for many years. In Canada, public disclosure of faculty salaries above a certain threshold reduced the gender pay gap. Some private entities have joined the trend as well. At the software startup Buffer, publicly publishing pay data did not eliminate gender-based salary discrepancies. However, it did push the company to identify and address potential sources of inequity, such as subjectivity in assessing experience and readiness for promotion. While there isn't a case of a health system that has published salary data and demonstrated the subsequent effects, experiences from other industries suggest this approach is worth discussing. We acknowledge that there are certainly many potential negative effects of pay transparency on organizational dynamics, and any transparency initiative should be rolled out with caution. A medical institution considering transparency would need to ensure careful auditing of data ahead of publication, and to have well thought out plans for addressing potential conflicts among staff, as well as between staff and management, that might emerge.

Data from the Harvard Kennedy School shows that women negotiate for lower compensation than men do in the absence of clear industry standards but negotiate for equal salaries when

standard salary information was available, suggesting the value of creating environments in which information about compensation is shared across gender lines.

Engage Allies in Coaching and Sponsorship

Much of coaching and peer support for women physicians has focused on same-gender mentorship and peer groups. While these provide female physicians with role models similar to themselves and create comfortable spaces for reflection, given evidence that men are more likely to get explicit information about paths to advancement in management or to receive mentorship or sponsorship at all, they should be engaged as allies in systematic ways. Men can serve as sponsors who recommend women for new opportunities or as coaches who share a different perspective on salary negotiation or insight about the opportunities being presented to male mentees. Studies in other industries show that male sponsorship is crucial to closing the gender pay gap, and there's every reason to think it could have a similar impact in health care. Mixed-gender peer coaching groups can provide similar opportunities for sharing salary or tactical data.

While the most natural source for recruiting an institutions' mentors and coaches is from within, there may be value to engaging diverse external coaches as well. At Brigham and Women's Hospital, we have started providing female faculty with access to external coaches in the areas of leadership, network development, time management, and technology use, in addition to more traditional peer support and individual coaching.

We acknowledge that in the MeToo era some men have shied away from mentoring or coaching women altogether, which is a loss for all involved. It's up to health care organizations to encourage mixed-gender mentorship, provide the training and guidelines needed to do it well, and outline clear consequences for inappropriate behavior or abuse of the relationship.

Facilitate Equitable Promotion

Much of the pay disparity in in academic medical centers is driven by academic rank differences, making facilitation of equitable promotion a priority. A small proportion of full medical professors across the U.S. are female, despite increased representation of female physicians on faculty and among medical school graduates (in 2017, for the first time, women outnumbered men entering U.S. medical schools).

These data suggest that new approaches are needed to ensure promotion of women in academic medicine. These may include: 1) revamping promotion guidelines to create tracks that reward activities aside from grant-funded research, such as teaching, that are often not rewarded in traditional promotions but are central to academic medicine; 2) requiring that female physicians be included on all search and promotion committees; 3) ensuring that open leadership positions are widely publicized rather than privately directed to a select group of candidates; 4) providing grants to support women's career advancement, including family travel grants that facilitate women's attendance at conferences with children and childcare providers; and 5) providing one-on-one external coaching to help female physicians create career roadmaps, tailor their CV for promotions, and identify what they need to accomplish in order to be ready for the next step in promotions.

While no institution yet serves as a clear beacon in matters of promotion equity, several have instituted programs that may help narrow the recognition and promotion gap. For example, Dana Farber Cancer Institute in Boston names its most accomplished clinicians as Senior Institute Physicians, ensuring that those excelling in clinical care are recognized for their efforts. Many institutions, among them UCLA and Duke, have several promotion tracks for faculty to ascend, including ones that focus on clinical care rather than research.

The initiatives we propose are just a start in solving a complex and persistent problem, and the data on what approaches will be most successful. It's high time that health care aggressively engage in and rigorously evaluate efforts to close the unproductive and unjustifiable pay gap in medicine.

Editor's note: Because of an editing error, we have corrected the statement in the first paragraph that full-time female primary care and specialist doctors make 25% and 33% less than their male counterparts to read that full-time male primary care and specialist doctors make 25% and 33% more, respectively, than their female counterparts.

Lisa S. Rotenstein, MD, MBA is Assistant Medical Director, Population Health and Faculty Wellbeing at Brigham Health and a Faculty Member at Harvard Medical School and Ariadne Labs. She is also co-founder of CareZooming, a social enterprise focused on sharing ambulatory care innovations.

Jessica Dudley, MD, is chief clinical officer at Press Ganey and an assistant professor of medicine at Harvard Medical School.