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POSITION PAPER

Achieving Gender Equity in Physician Compensation and Career Advancement: A Position Paper of the American College of Physicians

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Women comprise more than one third of the active physician workforce, an estimated 46% of all physicians-in-training, and more than half of all medical students in the United States. Although progress has been made toward gender diversity in the physician workforce, disparities in compensation exist and inequities have contributed to a disproportionately low number of female physicians achieving academic advancement and serving in leadership positions. Women in medicine face other challenges, including a lack of mentors, discrimination, gender bias, cultural environment of the workplace, imposter syndrome, and the need for better work–life integration. In this position paper, the American College of Physicians summarizes the unique challenges female physicians face over the course of their careers and provides recommendations to improve gender equity and ensure that the full potential of female physicians is realized.

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In 2015, more than one third (34%) of the active physician workforce in the United States was female (1); an estimated 46% of all physicians-in-training and more than half of all medical students are women (2). Although women have made substantial progress in these areas, much remains to be done to improve equity and parity and increase opportunities for promotion and leadership.

Several recent studies have documented the compensation inequity between male and female physicians. A 2017 survey found that male primary care physicians made $229 000 annually, compared with $197 000 for women, a gap of 16% (3). This gap is even wider (37%) for specialists: Men earned $345 000 annually and women $251 000. In academic medicine, female physicians made an average of $227 783 annually, compared with $247 661 for male physicians (a gap of $19 878), after adjustment for factors that included faculty rank, age, years since residency, specialty, funding from the National Institutes of Health, clinical trial participation, publication count, and total Medicare payments. For internists, this difference was $16 159 ($191 338 vs. $207 497) (4). Another study comparing faculty income at 24 medical schools longitudinally over 17 years found that female physicians in academic medicine earned 90 cents for every dollar made by their male counterparts, an annual difference of $20 000 (5). In addition, although the number of women entering the medical field has steadily increased, their proportion of leadership positions continues to be small. Female physicians constitute 38% of full-time medical school faculty but only 21% of full professors, 15% of department chairs, and 16% of deans (6). This lack of female physicians in leadership positions has traditionally been believed to be a pipeline problem; however, because women have made up roughly half of medical student graduates for years, the systematic origins of this problem are becoming more apparent (7). In addition, women in medicine face other challenges, including a lack of mentors, discrimination, gender bias, cultural environment of the workplace, imposter syndrome, and the need for better work–life integration (8, 9).

Many factors have been cited as causes of compensation inequity and the relative lack of career advancement for female physicians compared with male physicians, including specialty choice, years of experience, number of hours worked, choices made to balance work and family, and a dearth of mentors and senior role models (10, 11). Yet, researchers find these disparities even when controlling for age, specialty, number of hours worked, and practice characteristics (4, 12, 13). Although most data on workplace disparities come from public institutions of academic medicine, there is no reason to believe that similar inequities do not occur elsewhere in medicine. Additional research in all practice settings is necessary to determine the extent of the impact of these disparities.

See also:

Editorial comment 741

* This paper, authored by Renee Butkus, BA; Joshua Serchen, BA; Darilyn V. Moyer, MD; Sue S. Bornstein, MD; and Susan Thompson Hingle, MD, was developed for the Health and Public Policy Committee of the American College of Physicians. Individuals who served on the Health and Public Policy Committee at the time of its approval were Sue S. Bornstein, MD (*Chair*)†; Gregory C. Kane, MD (*Vice Chair*)†; Jan K. Carney, MD†; Heather E. Gantzer, MD†; Tracey L. Henry, MD†; Joshua D. Lenchus, DO†; Joseph M. Li, MD†; Bridget M. McCandless, MD†; Beth R. Nalitt, MD†; Lavanya Viswanathan, MD†; Caleb J. Murphy, BS†; Ayteetin Azah, MD†; and Lianne Marks, MD†. Approved by the ACP Board of Regents on 15 February 2018.
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Even greater barriers have been found for minority female physicians (14, 15). The intersection of race and gender compounds the effects of discrimination and inequities related to compensation and career advancement. The American College of Physicians (ACP) *Ethics Manual* states that "discrimination violates the principles of professionalism and of the College." ACP recognizes the equal importance of equity based on other characteristics of personal identity, including but not limited to race, religion, nationality, sexual orientation, and gender identity, but this paper focuses predominantly on gender equity.

As the nation's largest medical specialty society, ACP has more than 152 000 members, 37% of whom are women. ACP is committed not only to highlighting the obstacles that female members face but also to identifying solutions by examining and addressing the recruitment and advancement of women and other underrepresented groups. This position paper summarizes the unique challenges female physicians face over the course of their careers and identifies solutions with the goal of ensuring that medicine can realize and benefit from the full potential of these physicians. The **Appendix** (available at Annals.org) contains the expanded background and rationale for each position. The **Appendix Table** (available at Annals.org) gives brief case scenarios that highlight potential best-practice solutions to many common challenges that female physicians encounter.

METHODS

ACP's Health and Public Policy Committee, which is charged with addressing issues that affect the health care of the U.S. public and the practice of internal medicine and its subspecialties, drafted this position paper. A systematic literature review was not done, but the authors searched for and reviewed relevant studies, reports, and surveys related to gender equity in medicine from PubMed, Google Scholar, relevant news articles, policy documents, Web sites, and other sources. Position statements were based on this material and input from ACP's Board of Governors, Board of Regents, Council of Early Career Physicians, Council of Resident/Fellow Members, Council of Student Members, and Council of Subspecialty Societies and nonmember experts in the field. The policy paper and related recommendations were reviewed and approved by the ACP Board of Regents on 15 February 2018. Financial support for the development of this position paper came exclusively from the ACP operating budget.

ACP POSITION STATEMENTS AND RECOMMENDATIONS

The following statements represent ACP's official positions and recommendations to achieve gender equity in physician income and career advancement. The rationale for each is provided in the **Appendix**.

1. ACP affirms that physician compensation (including pay; benefits; clinical and administrative support; clinical schedules; institutional responsibilities; and where appropriate, lab space and support for researchers) should be equitable; based on comparable work at each stage of physicians' professional careers in accordance with their skills, knowledge, competencies, and expertise; and not based on characteristics of personal identity, including gender. Physicians should not be penalized for working less than full-time.

2. ACP supports transparency and routine assessment of the equity of physician compensation arrangements by all organizations that employ physicians.

3. ACP supports the goal of universal access to family and medical leave policies that provide a minimum 6 weeks of paid leave and calls for legislative or regulatory action at the federal, state, or local level to advance this goal. Such legislation should include minimum paid leave standards and dedicated funding to help employers provide such leave. Paid leave policies should ensure that all employees have increased flexibility to care for family members, including children, spouses, partners, parents, parents-in-law, and grandparents.

a. ACP opposes discrimination on the basis of reproductive status, for those who choose to have children biologically or via adoption and for those who choose not to have children.

b. Family and medical leave and paid leave policies should be a standard part of physicians' benefit packages, regardless of gender.

c. Residency and fellowship programs, academic medical centers, community hospitals, and physician practices should develop and implement paid leave policies to provide compensation to eligible male and female physicians and trainees for a minimum of 6 weeks to care for a newborn, newly adopted, or seriously ill child and to attend to other qualifying life events, such as care of seriously ill family members other than children.

d. Medical schools and residency and fellowship training programs should publish and distribute their family and medical leave policies to all applicants.

e. Accrediting bodies for medical education and training should establish policies regarding family and medical leave for students and trainees, supporting a minimum of 6 weeks to care for a newborn, newly adopted, or seriously ill child and to attend to other qualifying life events, such as care of seriously ill family members other than children.

f. Medical specialty boards should be flexible in their requirements for board eligibility in circumstances when trainees took family or medical leave.

4. ACP supports the provision of programs in leadership development, negotiation, and career development for all physicians and physicians-in-training.

5. ACP supports the provision of regular and recurring implicit bias training by all organizations that employ physicians. Organizational policies and procedures should be implemented that address implicit bias.

6. Academic institutions, health care organizations, physician private practice groups, and professional physician membership organizations should take steps to increase the number of women in practice, faculty, and

leadership positions and structure equal access to opportunities, including:

a. Encouraging mentorship and sponsorship and providing training for faculty on how to be effective mentors and sponsors.

b. Coaching and development programs.

c. Flexibility in structuring career paths in academic medicine, health systems, and private practice and adopting flexible promotion and advancement criteria, including promotion tracks that reflect the wide range of responsibilities and unique contributions of female physicians.

d. Requiring the inclusion of female physicians as job candidates and members of search committees.

e. Ensuring diversity, including gender diversity, on all committees, councils, and boards through leadership development to ensure inclusion, comprehensiveness, and mechanisms for accountability.

7. Further research is needed on the reasons for and effect of gender pay inequity and barriers to career advancement and the best practices to close these gaps across all practice settings.

8. ACP opposes harassment, discrimination, and retaliation of any form based on characteristics of personal identity, including gender, in the medical profession.

CONCLUSION

Although progress has been made toward gender diversity in the physician workforce, disparities in compensation persist, and inequities have contributed to the disproportionately low number of female physicians achieving academic advancement and serving in leadership positions. The medical profession and our patients benefit greatly from a diverse physician workforce. A concerted effort must be made to eliminate the imbalance in compensation and career advancement opportunities and provide a more inclusive environment to realize the full potential of all physicians in the workforce.

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Appendix: Expanded Background and Rationale for Achieving Gender Equity in Physician Compensation and Career Advancement: A Position Paper of the American College of Physicians

Contributions of Female Physicians

It is important to recognize the substantial value that female physicians bring to health care and to address inequities in compensation and advancement. Studies suggest that female physicians have longer and more engaging visits with patients than male physicians. On average, female physicians spend 2 minutes longer per visit than male physicians and engage in more patient-centered communication, including psychosocial question-asking and counseling. Patients of female physicians speak more overall, disclose more medical information, and make more positive statements (16). Female physicians are also more empathetic (17, 18). Other research suggests that patients of female physicians report office visits that are more participatory than those with male physicians (19).

Despite the gap in data for more recent years, research from 1996 suggests that female physicians also engage in preventive medicine at a higher rate than male physicians ($P < 0.001$) (20). After adjustment for both the patient's and the physician's age and sex, the odds ratio (OR) for performing a Pap smear was 1.99 (95% CI, 1.72 to 2.30) for female physicians compared with male physicians; for ordering a mammogram, it was 1.41 (CI, 1.22 to 1.63) (21). Female family physicians were also twice as likely as their male counterparts to test for human papillomavirus ($P < 0.001$) (22). Earlier research found similar results: All patients of female physicians were more likely to receive a Pap smear (OR, 1.47 [CI, 1.05 to 2.04]) and a cholesterol test (OR, 1.56 [CI, 1.08 to 2.24]), and younger patients of female physicians were more likely to receive mammography (OR, 2.69 [CI, 0.98 to 7.34]) (23). Another study found that female physicians felt more responsible to ensure their patients received preventive screening and felt more comfortable performing Pap smears and breast examinations (24).

The value of female physicians is also shown by findings from a recent study based on claims data from Medicare fee-for-service patients hospitalized and treated by general internists. After adjustment for patient and physician characteristics, hospital fixed effects, specific conditions, and underlying severity of illness, data indicated that patients fared particularly well when treated by female physicians, with lower mortality rates (11.07% vs. 11.49%) and lower readmission rates (15.02% vs. 15.57%) for all medical conditions. The researchers estimated that when scaled to 10 million Medicare hospitalizations each year, 32 000 fewer patients would die per year if male hospitalists achieved the same results as female hospitalists (25). The actual differences of these data are small and may be statistically significant only because of the large sample size, and their clinical significance is unclear (26). Also, attributing care to individual physicians is difficult (27). More research is needed to confirm that such results are reproducible and represent the characteristics of both female and male physicians that are associated with improved health care outcomes.

In total, these studies and others like them indicate the value that female physicians bring to the field of medicine. We have included them in this paper to emphasize this value and to show what can be learned from how each gender engages with patients and works together in teams and other characteristics that can be adopted by physicians of all genders to improve patient care.

Challenges Faced by Women in Medicine

Workplace Discrimination

Studies have found that women report higher rates of workplace discrimination than their male peers and that black women are more likely to face gender bias than white, non-Hispanic women. A 2005 study of Massachusetts physicians in various practice environments found that 51.3% of female physicians reported workplace discrimination, compared with 31.2% of male physicians. Female physicians were also 5 times more likely to experience career advancement obstacles and more than 3 times more likely to experience disrespectful or punitive actions. Further, 15.2% of female physicians reported having filed a discrimination complaint with their employer, and 27.6% of these reported wors-

ening conditions after the complaint, compared with 8.2% and 5.6%, respectively, of male physicians (28).

A large, cross-sectional survey of physician mothers found that perceived discrimination is common, affecting 4 of 5 respondents (29). Two thirds of respondents reported discrimination based on gender, and more than a third reported maternal discrimination. Disrespectful treatment by nursing or other support staff was reported by 38.8% of physicians. Among those who reported maternal discrimination, 52.9% reported disrespectful treatment by other support staff, 39.2% reported not being included in administrative decision making, and 31.5% reported pay and benefits not equal to those of their male peers.

Female physicians were more likely than male physicians (69.6% vs. 21.8%) to report an environment of perceived gender bias in their medical careers. Similarly, female physicians were more likely than male physicians (66.3% vs. 9.8%) to report personally experiencing gender bias in their careers. Female physicians were also more likely to report sexual harassment (30.4% vs. 4.2%). Among female physicians who reported harassment, 40% reported that it was severe, 59% perceived a negative effect on professional self-confidence, and 47% reported that these experiences negatively affected their career advancement (30).

Female medical students also report experiencing and observing gender discrimination and sexual harassment in the learning environment. One survey of 14 medical schools found that 69% of female students experienced gender discrimination or sexual harassment in the academic context, 33% in preclinicals, and 63% in core clerkships. Women were most likely to experience gender discrimination and sexual harassment in general surgery, obstetrics and gynecology, emergency medicine, and internal medicine programs and were least likely to experience it in family medicine and pediatrics programs (31). Data from the general workforce suggest that there is reason to believe that sexual harassment in learning environments and the workplace is underreported because of fear of retaliation, worry about not being taken seriously, and embarrassment or shame or the belief that no action will be taken (32).

Implicit Bias, Gender Norms, and Perceptions

Studies have shown that female physicians face higher levels of scrutiny in the workplace than male physicians. One study found that female physicians who disagreed with the patient, set the agenda, and asked medical questions were seen as more dominant, whereas male physicians who set the agenda and asked questions were perceived as nondominant (33). Other studies echoed this finding, reporting that female physicians had significantly less favorable online reviews than male physicians. Some words most frequently used to describe female physicians include "judg(e)mental," "rude," and "unfriendly" (34).

Research has also found that female physicians are less likely to be properly introduced by their title at internal medicine grand rounds than their male colleagues. An analysis of recordings of 321 introductions from 124 grand rounds made at Mayo Clinic locations in Arizona and Minnesota revealed that although women introduced speakers with their proper titles 96.2% of the time, male introducers addressed female speakers by their proper titles 49.2% of the time. The authors concluded that subtle and unintentional acts like these delegitimize female physicians and can negatively affect their career trajectories and satisfaction (35).

A review of award winners at the University of Pennsylvania School of Medicine between 1996 and 2007 suggests that female physicians are also underrepresented as award recipients. Although the percentage of female faculty increased from 24% to 30% during that time, only 28% of research award recipients, 29% of teaching award recipients, and 10% of clinical award recipients were women. Researchers have suggested that the lack of objective criteria for clinical excellence compared with the other categories allows for implicit bias in determining clinical award recipients (36). Another study of professional science societies found that women were underrepresented for science awards and fellow status and overrepresented in service and teaching awards (37).

Intersection of Gender and Minority Status

Gender seems to affect physician experiences, but the literature also indicates that the interaction of multiple personal characteristics can compound effects on compensation, career opportunities, and treatment by patients and peers. For example, 1 study of private practice internists found that the salaries of white, non-Hispanic female physicians were 19% less and those of black female physicians were 29% less than white, non-Hispanic male physicians, after adjustment for various factors (14). An earlier study that looked at the mean annual income of internists after accounting for similar work effort and provider and practice characteristics found a similar trend: White, non-Hispanic women made $36 609 (19%) less and black women made $56 452 (29%) less than white, non-Hispanic men (15).

Minority female physicians often report that their credentials and expertise are called into question because their profile does not fit the public perception of a physician, and in some cases they are mistaken for clinical or support staff (38–40). Minority female physicians also face discrimination from patients based on perceived ethnicity, country of origin, or religion due to the way they look, dress, or sound (41, 42).

Inequities in Compensation

Changing social norms have resulted in women earning 80 cents to every dollar earned by men in 2015, compared with 59 cents in the 1960s (43, 44). This gap can lead to confounding issues for women down the road: Women who earn less in their working years will earn less from retirement income sources, such as a pension or Social Security (45).

Further, the gender pay gap increases as women get older (45). Researchers have offered many possible explanations of why women make less than men, including choice of occupation, time taken away from work to raise children, gender discrimination, and productivity levels. However, studies have found the gender pay gap to persist even after adjustment for "self-selected" factors (46–48).

In medicine, the results of a 2017 survey found that male primary care physicians made $229 000 annually compared with $197 000 for women—a gap of 16% (3). The gap is even wider (37%) for specialists: Male specialists earned $345 000 annually, compared with $251 000 for women. By age, older female physicians tend to face a higher wage gap than younger female physicians, indicating that the gap is decreasing as more women enter the physician workforce. Female physicians aged 34 years or younger face a wage gap of 18% compared with similarly aged men; this figure increases to 36% for those aged 35 to 44 years, 37% for those aged 45 to 54 years, and 35% for those aged 55 to 69 years. Recently published research using U.S. Census data found that median annual income for all physicians was highest among non-Hispanic white and black male physicians ($255 000 and $210 000, respectively), followed by non-Hispanic white and black female physicians ($174 000 and $141 000, respectively) (12).

The salary gap varies according to the setting, but 1 trend remains clear: The gap persists for physicians in academia, research, and practice. A 2016 study of academic physicians found that more female than male physicians made less than $200 000 (57.1% vs. 33.7%) and fewer female than male physicians made more than $400 000 (3.2% vs. 11.6%). After adjustment for faculty rank, age, years since residency, specialty, funding from the National Institutes of Health, clinical trial participation, number of publications, total Medicare payments, and graduation from a medical school ranked in the top 20 by *U.S. News and World Report*, female physicians made $19 878 less annually than male physicians ($227 783 vs. $247 661). For internal medicine physicians, this difference was $16 159 ($191 338 vs. $207 497) (4). More research is needed to examine clinical effort and the effect that practice pattern differences and nonworkplace factors may have on the pay disparity. Another study examining incomes for internal medicine residency directors found that average income was between $200 000 and $225 000 for male directors and between $175 000 and $200 000 for female directors. A statistically significant gap persisted after adjustment for region, program type, academic rank, general internal medicine career, chief medical resident status, international medical graduate status, age, and tenure as a program director (49).

Other research surveyed National Institutes of Health award recipients to determine the pay gap for physician-researchers (14). Male research physicians earned roughly $200 433 annually, compared with $167 669 for female physicians—a $32 764 gap. Further analysis of the data controlling for gender, age, parental status, advanced degrees, academic rank, specialty, rank of current institution, funding institution tier, publications, administrative leadership positions, work hours, and percentage of research time found that female research physicians still made $12 001 less, leaving 37.4% of the initial gender pay gap unaccounted for.

Research also suggests a disparity in the awarding of grants to physician-researchers. An analysis of recipients of the National Institutes of Health K08 and K23 awards found that only 31.4% of K08 and 43.7% of K23 grants were awarded to women. Further, women proceeded to attain the R01 award at a lower rate than men (36.2% vs. 45.6% over 10 years) (50).

Another study used Medicare payment claims data and other publicly available data to analyze disparities in pay for practicing physicians to avoid instances of self-reporting bias that arise from survey methods. After adjustment for years of experience, number of services provided, and number of patients seen, female physicians were reimbursed $18 677.23 less annually than male physicians. When examined at the specialty level, reimbursement of female physicians in 11 of the 13 specialties was significantly lower than that of their male counterparts, including a difference of $10 850.34 for female internal medicine physicians (51).

An area of further exploration is how the care provided by female physicians may be undervalued by the current payment system. One example is provision of Pap smears or breast examinations to women younger than 65 years at a routine physical examination. Female physicians provide Pap smears more frequently than male physicians as part of the physical examination (21). Another example is that, on average, female physicians spend 2 more minutes with a patient during an office visit than male physicians, with more focus on patient-centered communication and psychosocial question-asking and counseling (16). Under many systems, these differences do not affect payment for the physical examination, and the amount of income female physicians may lose from this (in terms of time taken for the examination, additional documentation and follow-up time, and legal liability) compared with male physicians should be evaluated. This could be a substantial issue if male (compared with female) primary care physicians have a greater per-

centage of their female patients screened for cervical cancer by a gynecologist as a separate appointment, rather than including screening in the primary care physical examination. Other reasons for the discrepancy, such as patient choice or other factors, should also be explored.

Physician Mothers or Caregivers

Physician mothers face unique difficulties in obtaining maternity leave and may incur financial burdens to have children. In a survey of a nationwide sample of physician mothers, 52.9% reported losing more than $10 000 in income during leave, with no significant difference between procedural and nonprocedural fields. In addition, maternity leave was included in only 28.9% of female physicians' most recent contracts (52). Studies show that women are likely to take significantly more time for child care and domestic responsibilities (53).

Federal law provides some basic protections for the estimated 79.4% of female physicians who have children (53) (although because of such factors as the size of the institution, time worked at their current job, or financial constraints that do not allow for an extended period without pay, not all physician mothers can use these protections). The Family and Medical Leave Act (FMLA) requires employers of a certain size to provide 12 weeks of unpaid leave to care for a newborn, newly adopted, or seriously ill child for employees who have worked for a certain duration and number of hours. The Patient Protection and Affordable Care Act requires employers of a certain size to provide a private, nonbathroom space and adequate time for mothers with children younger than 1 year to express breast milk.

Beyond motherhood, daughters tend to play a more active role in caring for aging parents than sons. This puts additional time constraints on women in the senior phases of their careers and may limit their ability to consider a change for continued career advancement or assume a leadership role at their current institution. The effect of caregiving by adult female physicians for aging parents has not been well-documented in the medical literature (54); however, it has been addressed in the lay press (55).

Residency programs accredited by the Accreditation Council for Graduate Medical Education must have vacation and leave policies—including maternity leave—in writing and must comply with laws like FMLA (56). However, because medical students are not employed by the institution, they are not subject to federal parental leave protections. Rather, students are subject to the individual parental leave and leave-of-absence policies of their academic institutions, which vary by school (57). Colleges and universities that receive federal funding must have policies that comply with Title IX, which prohibits discrimination based on pregnancy or parental status in education. However, students in other institutions who are pregnant or are parents may have to delay study of class materials, board examinations, clinical rotations, residency interviews, and electives (58).

A national survey of pediatric residents found that 88% of their programs offered medical leave, 63% offered flexible schedules, and 55% offered access to a lactation room (59). Another national survey of physician mothers found that although 71.1% of those in nonprocedural fields and 53.6% of those in procedural fields took more than 8 weeks of maternity leave, roughly 70% of both groups reported that their recent contracts did not include maternity leave (52).

Surveys of female physicians have found that many continue to experience discrimination on the job, contributing to limited career advancement opportunities and other adverse effects. Among physician mothers, 78% reported some sort of perceived discrimination, 66% reported gender discrimination, and 36% reported maternal discrimination. Of those reporting maternal discrimination, 90% attributed it to being pregnant or taking maternity leave, whereas 48% attributed it to breastfeeding on the job (29).

Although technically granted the right to breastfeed, physicians can often face animosity from coworkers and discomfort in asking for a break and help covering their patients, which frequently runs counter to the culture and expectations of the workplace (60). Similarly, female physicians report being afraid that employers may be reluctant to hire them out of concern for anticipated time missed due to pregnancy, delivery, and child care or that they will face backlash from colleagues who will have an increased workload during the leave (61, 62). Some may also hesitate to maximize maternity leave to avoid extending their residency period or exhausting accrued vacation time (63).

Access to child care is a major barrier physician parents face in the workplace. Female physicians are often in their childbearing and child-rearing age during medical school and completion of their residency training; 38% of female pediatricians, 1 of the specialties with the highest proportion of women, became pregnant during their residency. In family medicine, 34% became pregnant in year 1, 40% in year 2, and 23% in year 3 (61). This is also a time associated with high debt, limited income, and 80-hour work weeks. The typical resident graduates with an average medical school debt of $179 068 (64), while bringing in a stipend of $54 170 per year (65). Physician parents must also factor in infant child care costs, which, depending on the state, can range from $4882 to $17 062 annually (66).

A national survey of pediatric residents found that only 24% reported that their programs offered on-site child care, 19% provided care for ill children, 12% offered part-time residency positions to allow time to care for children, and 9% offered subsidized child care

(59). In addition, 85.6% of female physicians' spouses were employed full-time outside of the home, and women who were married with children took on an excess 8.5 hours of parenting and household tasks per week (53). Hence, access to child care often becomes a factor for female physicians when making career decisions, as evidenced by a national survey of medical students that found that female students would be more likely to pursue surgery if child care were available at their hospital (9).

As women continue to make up a growing part of the workforce, lack of child care for physician mothers could have a detrimental effect on the entire health care industry. One literature review points out that 22% of female physicians work part-time and that they are more likely to be the mothers of young children. With a shortage of physicians due to an aging population and limited entry positions in graduate medical education, adequate child care might lead some part-time female physicians to increase their full-time equivalency hours and reduce the physician shortage (67).

Work–Life Balance

Although both male and female physicians face work–life balance concerns and burnout, these issues can more commonly deter female physicians from seeking leadership positions and furthering their careers: 57% of female physician leaders felt that their career got in the way of their personal life, compared with 48% of nonleaders (68). A higher percentage of female physicians (55%) than male physicians (44%) reported burnout; administrative tasks were the most common reason for burnout for both sexes (69).

The high incidence of burnout, especially among female physicians, has detrimental effects for everyone involved in delivering primary care: Physicians have less career satisfaction, medical students are less likely to consider internal medicine as a specialty, patients receive poorer care, and practices incur added costs (70).

The primary reported reasons for declining a leadership position among female physicians were related to time management—they felt they were too busy for additional responsibilities and worried about the position interfering with their personal lives (68). An August 2016 commentary provided insight into why more women in medicine has not translated into more women leaders in medicine, noting that "women often have a slower start as they balance career and family responsibilities. This initial phase, when family needs and career demands are at their highest, deters some women from even considering careers in academic medicine, and the lack of academic success in this early period is responsible for the decision of many medical women in academic positions to leave research" (71). Female physician-researchers with partners who were employed full-time were more likely than men to take time off when child care was disrupted (42.6% vs. 12.4%), and women took on more domestic roles (53).

Dual-Physician Households

The roughly 26% of physicians—and 44% of female physicians—who are married to a physician face unique challenges in work–life balance (72). In such arrangements, female physicians were more likely than both male physicians and those of either gender in non–dual-physician households to report having to arrange their work schedules to care for children and were less likely to report achieving career goals. Moreover, female physicians in dual-physician households were more likely to report limitations in their careers for family reasons than those not married to another physician; male physicians regardless of marital arrangement rarely reported such limitations (73).

A database analysis found that in dual-physician households without children, men worked an average of 57 hours per week, compared with 52.4 hours per week for women. For couples with children younger than 2 years, men worked 55.3 hours per week, compared with 41.5 hours per week for women. As children got older, hours worked did not differ between men with and without children, whereas women with children continued to work fewer hours than women without children (74). An analysis of U.S. Census data found that female physicians in dual-physician households had lower incomes and worked fewer hours outside the home than female physicians in single-physician households. The study also found that among all female physicians, the average number of paid work hours decreased as the male spouse's paid work hours increased, possibly reflecting the professional adjustments made by female physicians to tend to household responsibilities (75).

Expanding Opportunities for Women in Leadership

Although women now make up half of all U.S. graduates and many women hold faculty positions, they advance to senior faculty ranks at lower rates than their male peers. Female physicians constitute 38% of full-time medical school faculty but only 21% of full professors, 15% of department chairs, and 16% of deans (6). Moreover, women in senior faculty are disproportionately concentrated in roles that fulfill educational and institutional public image and are less likely to occupy general leadership, clinical, research, and corporate strategy roles (76).

Critical barriers to women's advancement in academia and other leadership positions include lack of role models; lack of female mentors; lack of tracking or monitoring systems; and implicit bias and interference of the classic tenure track pace with pregnancy, child

care, elder care, and other family responsibilities. Imposter syndrome—chronic feelings of inadequacy and fear of being discovered as an intellectual fraud because of self-doubt surrounding job skills—is known to affect women more than men (77). It may bar women's success if it causes them to pass up career development opportunities.

Gender disparities in promotion rates seem to contribute to the current leadership gap. For example, promotion rates for first-time assistant professors over a period of 10 years were 37% for men versus 31% for women (78). The University of Arizona at Tucson's GRACE (Generating Respect for All in a Climate of Academic Excellence) Project concluded that women at the College of Medicine were significantly less likely to have been asked to serve as leaders, even though leadership aspirations did not differ between women and men (79). The results also showed significant differences in perception of treatment at the College of Medicine by men and women. An examination of salaries revealed that after adjustment for faculty rank, years in rank, track, degree, specialty, section heads, and department or center heads, women were earning 11% less than men.

Publication in medical journals is often an important measure of academic productivity and highly emphasized in the academic promotion process. A study that looked at original articles from 6 prominent medical journals between 1970 and 2004 found that the proportion of women among the U.S. physician-authors of original research increased from 5.9% to 29.3% of first authors and from 3.7% to 19.3% of senior authors (80). The study concluded that although more women were in academic medicine then than in 1970, women still comprised a minority of senior authors. They suggested that it may be appropriate to consider awarding career development milestones independent of the number of years since medical school or since a first faculty appointment because many women have a delayed productive period of their career, which conflicts with traditional tenure tracks.

Guidance from mentors, coaches, sponsors, and connectors is critical for success in academic medicine (81). In 1 systematic review of 39 studies, mentorship in academic medicine was found to have an important influence on career guidance, career choice, research productivity, and personal development. Mentorship can also help female physicians attain a better work–life balance by navigating institutional culture, policies, and expectations surrounding committee responsibilities, the tenure clock, resources and opportunities, and socialization (82). Women perceived much more difficulty finding mentors than their male peers (83).

The **Appendix Table** highlights potential best-practice solutions to many common challenges encountered by female physicians. The cases are current, real-life examples that our Committee members or their acquaintances have experienced.

Across many disciplines, a diverse workforce has been shown to be more productive and effective. ACP makes the following recommendations to achieve gender equity in physician income and advancement.

Positions

1. ACP affirms that physician compensation (including pay; benefits; clinical and administrative support; clinical schedules; institutional responsibilities; and where appropriate, lab space and support for researchers) should be equitable; based on comparable work at each stage of physicians' professional careers in accordance with their skills, knowledge, competencies, and expertise; and not based on characteristics of personal identity, including gender. Physicians should not be penalized for working less than full-time.

A 2016 study that controlled for external factors, including age, faculty rank, and specialty, found that on average female academic physicians made $227 783, compared with $247 661 for male physicians, a gap of $19 878. For internists, female physicians made $191 338, compared with $207 497 for male physicians, a gap of $16 159 (4). This pay gap extends beyond the academic realm: Another study of physicians in all settings found that female physicians made $163 244 on average, compared with $249 164 for male physicians after adjustment for other factors, such as specialty, hours worked, and practice type (12). This gap is seen as soon as physicians leave their residency program and begin their careers (47). As it continues to grow throughout the years, it can reach the range of at least a million dollars (84). Moreover, the intersectionality of factors, including race and ethnicity, generally compounds the pay disparity (14, 15). Researchers have offered many possible explanations of why women make less than men, including choice of occupation, time taken away from work to parent, gender discrimination, and productivity levels. However, studies have found that the gap persists even after adjustment for "self-selected" factors (46–48).

ACP believes strongly that physicians should be compensated equally and fairly for comparable work at all stages of their professional careers in accordance with their skills, knowledge, competencies, and expertise regardless of characteristics of personal identity. These characteristics include race, gender, religion, nationality, sexual orientation, and gender identity. ACP believes that highlighting the gender pay gap is important because of the overwhelming data showing the existing disparity in total compensation.

Physicians who work part-time should not be penalized for that decision. Salary should be prorated fairly, but their timelines related to promotion and tenure should consider the part-time status. Full-time equivalent requirements in research programs and grants make it difficult for physician scientists to work part-time.

2. ACP supports transparency and routine assessment of the equity of physician compensation arrangements by all organizations that employ physicians.

Embracing a culture of transparency in compensation through implementation of reporting procedures and other best practices has been offered as a way to reduce pay disparities. Some argue that public disclosure of salaries would make it easier for regulators to identify and harder for employers to hide cases of discrimination. In addition, public availability of compensation would give negotiating leverage to employees, especially those susceptible to pay inequities; surveys have found that women are less likely to negotiate then men and that men report more successful negotiations (85, 86). One study examined pay disparities in states that have passed legislation outlawing pay secrecy in some capacity and found that these states were associated with increased earnings for women relative to men and a reduction in the gender wage gap (87).

Compensation in medicine is extremely complex and often opaque. Total compensation can include base salaries, stipends for other positions, various productivity standards, clinical and nonclinical support, and office and laboratory space. Transparency in physician compensation models is critical to understanding and closing the gender pay gap in medicine. The use of publicly available data about state employee's salaries to analyze gender differences in earnings among academic physicians highlights the importance of transparency in addressing the gender pay gap (4). The criteria for initial and subsequent physician salaries and compensation packages should be clearly defined. Making information about compensation public will help shed light on disparities that need to be addressed. This information will also empower physicians in initial and subsequent salary and resource negotiations.

All organizations that employ physicians should institute and report routine assessments of compensation practices (including benchmarks and performance metrics used to determine initial salary and increases) to ensure gender equity in salaries and overall compensation and fair compensation for comparable work. Organizational leaders should be held accountable for implementing transparent practices that allow for equitable compensation and advancement of all physicians.

Physicians in smaller independent practices are not immune to pay disparities. These practices should commit to examining how they compensate their partners and associates, male and female alike, to identify and make corrections to eliminate any gender pay bias. In addition, fee-for-service payment systems based on relative value units (RVUs), which may be the predominant form of payment for smaller independent practices, may contribute to the pay disparity and require further study and analysis, as discussed later in this paper.

3. ACP supports the goal of universal access to family and medical leave policies that provide a minimum 6 weeks of paid leave and calls for legislative or regulatory action at the federal, state, or local level to advance this goal. Such legislation should include minimum paid leave standards and dedicated funding to help employers provide such leave. Paid leave policies should ensure that all employees have increased flexibility to care for family members, including children, spouses, partners, parents, parents-in-law, and grandparents.

a. ACP opposes discrimination on the basis of reproductive status, for those who choose to have children biologically or via adoption and for those who choose not to have children.

b. Family and medical leave and paid leave policies should be a standard part of physicians' benefit packages, regardless of gender.

c. Residency and fellowship programs, academic medical centers, community hospitals, and physician practices should develop and implement paid leave policies to provide compensation to eligible male and female physicians and trainees for a minimum of 6 weeks to care for a newborn, newly adopted, or seriously ill child and to attend to other qualifying life events, such as care of seriously ill family members other than children.

d. Medical schools and residency and fellowship training programs should publish and distribute their family and medical leave policies to all applicants.

e. Accrediting bodies for medical education and training should establish policies regarding family and medical leave for students and trainees, supporting a minimum of 6 weeks to care for a newborn, newly adopted, or seriously ill child and to attend to other qualifying life events, such as care of seriously ill family members other than children.

f. Medical specialty boards should be flexible in their requirements for board eligibility in circumstances when trainees took family or medical leave.

ACP opposes discrimination against medical students, residents, fellows, and physicians on the basis of reproductive status, for those who choose to have children biologically or via adoption and for those who choose not to have children. Women make important contributions to the physician workforce, and policies that support their roles as mothers and caregivers are essential. In a large, cross-sectional survey of physician mothers, 77.9% reported perceived discrimination and more than a third reported maternal discrimination (29). Among those who reported maternal discrimination, 52.9% reported disrespectful treatment by nursing or other support staff, 39.2% reported not being included in administrative decision making, and 31.5% reported pay and benefits not equal to those of their male peers.

The United States is 1 of only 3 countries in the world that does not offer paid maternity leave and is

the only industrialized nation that does not have some form of standard paid parental leave for workers. Although FMLA allows for unpaid, job-protected leave by requiring employers of a certain size to provide 12 weeks of unpaid leave to care for a newborn, newly adopted, or seriously ill child, not all physician parents are able to use these protections. Their reasons include the size of their employer, duration of time worked at their current job, and financial constraints that do not allow for an extended period without pay. Further, paid leave policies, unlike FMLA, typically establish the minimum and maximum duration (days and weeks) that qualified persons would be eligible for *paid* leave; the level of compensation offered during that leave, often stated as a percentage of salary; and the qualifying life conditions—not only maternity or paternity care of a newborn or seriously sick child but also other life events, such as providing care to other seriously ill family members. Medical residents and fellows are protected under FMLA, but extended leave can affect their ability to meet requirements for initial certification or graduation. ACP calls on the Accreditation Council for Graduate Medical Education and medical specialty boards to reevaluate their criteria to allow for additional flexibility in these requirements when trainees need to take family or medical leave. More broadly, ACP calls on residency and fellowship programs, academic medical centers, community hospitals, and physician practices to develop paid leave policies to provide compensation for eligible physicians and trainees for a minimum of 6 weeks to care for newborn, newly adopted, or seriously ill children and to attend to other qualifying life events, such as care of other seriously ill family members.

Medical students are ineligible for federal parental leave protections because they are not employed by the institution. Instead, they are limited to such options as using vacation time, using time dedicated to elective study or residency interviews, or taking a medical leave of absence. In addition, taking parental leave can necessitate extending the duration of medical school, which adds to students' financial burden because they pay an additional year of tuition. The Liaison Committee on Medical Education, American Osteopathic Association, and Commission on Osteopathic College Accreditation should establish policies that support a minimum of 6 weeks' leave to care for a newborn, newly adopted, or seriously ill child and to attend to other qualifying life events, such as care of seriously ill family members other than children.

We acknowledge that an extended leave may result in the need to extend school or training and that institutions will face logistical challenges. Organizations that employ physicians, particularly small practices, will also encounter these challenges. Hidden barriers to parental and family leave must be addressed to avoid peers having to take on extra uncompensated duties or dissuading individuals from taking leave. This may be done by hiring temporary employees and back-filling or adjusting clinical workload and pay. We believe that resolving these issues is critical to ensure that all medical students, residents, fellows, and physicians can benefit from such policies.

4. ACP supports the provision of programs in leadership development, negotiation, and career development for all physicians and physicians-in-training.

Leadership development is key to ensuring inclusion, comprehensiveness, and accountability. Although all physicians and physicians-in-training could benefit from salary negotiation training and leadership development, women in particular are adversely affected in these spheres. A survey of female physicians across all specialties revealed that about one third have asked for a promotion and roughly half of those received it. Slightly more than 40% of female physicians surveyed attempted to negotiate a higher salary but only half were successful (68). ACP established its Leadership Academy in an effort to provide members with formal leadership training and resources to prepare them for leadership roles. Training in contract and total compensation negotiations and career advancement are also critical in helping our members feel empowered as they navigate these issues throughout their careers.

5. ACP supports the provision of regular and recurring implicit bias training by all organizations that employ physicians. Organizational policies and procedures should be implemented that address implicit bias.

Increasing awareness of how subtle differences in the evaluation of male and female physicians can impede recruitment, retention, and career advancement is essential to closing the gender leadership gap. Studies have shown that female physicians face higher levels of scrutiny in the workplace than male physicians (34, 35). Research has also found that female physicians are less likely to be properly introduced by their title at internal medicine grand rounds. An analysis of recordings of 321 introductions from 124 grand rounds made at Mayo Clinic locations in Arizona and Minnesota revealed that although women introduced speakers with their proper titles 96.2% of the time, male introducers addressed female speakers by their proper titles 49.2% of the time. The authors concluded that such subtle and unintentional acts delegitimize female physicians and can negatively affect career trajectories and satisfaction (35).

Education that increases awareness and provides bias reduction strategies has been found to improve implicit bias (88–90). Even short interventions are proven to bring awareness of implicit biases. A standardized, 20-minute educational intervention to instruct faculty about implicit biases and strategies for

overcoming them was found to have a positive effect on bias toward female leaders (91).

6. Academic institutions, health care organizations, physician private practice groups, and professional physician membership organizations should take steps to increase the number of women in practice, faculty, and leadership positions and structure equal access to opportunities, including:

a. Encouraging mentorship and sponsorship and providing training for faculty on how to be effective mentors and sponsors.

b. Coaching and development programs.

c. Flexibility in structuring career paths in academic medicine, health systems, and private practice and adopting flexible promotion and advancement criteria, including promotion tracks that reflect the wide range of responsibilities and unique contributions of female physicians.

d. Requiring the inclusion of female physicians as job candidates and members of search committees.

e. Ensuring diversity, including gender diversity, on all committees, councils, and boards through leadership development to ensure inclusion, comprehensiveness, and mechanisms for accountability.

Although women now make up half of the medical student population, they continue to be underrepresented in prominent leadership positions, particularly in academic medicine. Increasing the number of women in faculty and leadership positions will be critical to providing role models for students, residents, fellows, and junior faculty. It is also essential to closing the gender leadership gap and ensuring a diverse leadership team in academic medicine and within health care organizations and private practice groups. Research has begun to test ways to improve career success for female physicians. One randomized trial of female assistant professors from 27 different departments and divisions introduced a multilevel, 3-pronged intervention: professional development of female faculty, department task forces and department-wide change initiatives, and engagement of department chairs and chiefs and institutional leaders. For the first level, female faculty participated in manuscript-writing and leadership programs. For the second level, task forces were established in each division to come up with initiatives to improve the environment for career success for women. The third involved working with division and institutional leaders to create division-wide change and accountability. Although academic productivity and work self-efficacy increased in both groups, the average weekly number of hours worked decreased significantly more for the intervention group than the control group, leading the authors to conclude that the intervention taught participants to "work smarter" and brought about efficiencies. In the intervention group, those who participated more in the manuscript-writing and leadership programs had a 2-fold increase in peer-reviewed publications (8).

Effective mentorship can positively influence career advancement. Female physicians in academic medicine with mentors report more publications, more time spent on research activity, and greater career satisfaction than those without mentors (92). Yet, studies have revealed that fewer female physicians and residents have mentors than their male counterparts (82, 93, 94). Female physicians also report more difficulty in identifying mentors, particularly female mentors, because this group is often underrepresented in faculty and leadership positions (82, 94). Mentorship should be encouraged, and training in effective mentorship should be provided.

Encouraging and training physicians to be effective sponsors is equally important because, unlike mentors, sponsors use their positions of power to elevate mentees' work and further their careers. For example, institutional leaders could sponsor female academic physicians by naming them to highly visible and mission-critical positions, which would allow mentees to contribute a more diverse array of ideas and experiences, allow them to foster and refine their skills, and prepare them for executive leadership roles later on (95).

Flexibility in structuring career paths, including tenure clock extensions, are also important in ensuring a supportive environment that allows for promotion and advancement of female physicians in both academic medicine and private practice.

To improve the effectiveness of search committees in achieving gender diversity, it is essential to include female physicians not only as job candidates but also as members and leaders of search committees.

ACP's membership comprises a diverse population of internists, subspecialists of internal medicine, and medical students. ACP values diversity, including gender diversity, and views it as one of the organization's greatest strengths. ACP believes that a commitment to diversity strengthens its capacity to respond to the needs of members and their patients and strives to encourage internists and subspecialists of internal medicine from diverse groups to join ACP, participate in chapter activities, and seek positions of leadership. The full involvement of women and other traditionally underrepresented persons in leadership roles in professional membership organizations is essential to this goal. ACP encourages such societies to make a concerted effort to ensure diversity on all committees, councils, and boards.

ACP has a growing number of women in leadership roles, both at the staff level—including its chief executive officer, senior staff, other director and management roles, and at the *Annals of Internal Medicine*—and in governance. However, ACP, like other professional organizations, must continue striving to provide maximum leadership opportunities for women and other traditionally underrepresented groups to promote di-

versity. Current leaders should recognize their responsibility for succession planning, mentoring, and advancement of underrepresented groups and act on it.

7. Further research is needed on the reasons for and effect of gender pay inequity and barriers to career advancement and the best practices to close these gaps across all practice settings.

The evidence is clear that gender pay inequities exist in medicine and that women are underrepresented in leadership positions (3–6). Further, minority women face additional unique challenges in the workplace, such as a larger compensation gap and discrimination motivated by gender and race. ACP believes that more research is needed on barriers to career advancement and best practices to close these gaps, especially for minority women. In addition, few data are available on the effect of gender on compensation models across all settings, including physicians in private practice; employed physicians; those practicing in federally qualified health centers; and those working for federal agencies, including the Department of Veterans Affairs and Department of Health and Human Services. More research is needed on how RVU-based compensation may adversely affect female physicians, particularly those in independent practices that get most of their compensation under fee-for-service payment systems based on RVU-based payments per procedure or visit code, but also those in larger systems who may be compensated under salary arrangements that are adjusted by productivity (RVUs). Because most independent practices are paid predominantly on an RVU-based fee-for-service basis, such methods may place female physicians at a disadvantage for various reasons. Female physicians are paid the same as male physicians for identical RVUs but may have fewer billable RVUs per hour and per day if they spend more time with patients, resulting in lower compensation to them and the practice. If they work fewer hours because of family care demands, they also generate fewer RVUs. Payment based on RVUs benefits those who work longer hours and spend less time with patients, allowing them to generate more billable visits and procedures and with them, more RVU compensation. Even in a larger salaried system, the widespread presence of RVU-based productivity adjustments would benefit those who do more and spend less time in each encounter, potentially disadvantaging female physicians. An opportunity to examine this issue may arise as health care delivery moves toward value-based models of care. Further study is needed.

8. ACP opposes harassment, discrimination, and retaliation of any form based on characteristics of personal identity, including gender, in the medical profession.

A survey of practicing physicians revealed that 51.3% of female physicians reported workplace discrimination, compared with 31.2% of male physicians. Further, 15.2% of female physicians reported having filed a discrimination complaint with their employer, and 27.6% of these reported worsening conditions after the complaint, compared with 8.2% and 5.6%, respectively, of male physicians (29). Female physicians were also more likely than male physicians to report sexual harassment (30.4% vs. 4.2%).

ACP believes strongly that sexual harassment in the medical profession should not be tolerated. We must recognize that sexual harassment exists in the medical profession and work to destigmatize reporting and promote culture change. ACP also believes that there should be no discrimination for career opportunities in medicine based on characteristics of personal identity, including gender. All members of the medical profession should be given equal consideration in the workplace and educational and training environments and treated with integrity, honesty, and respect. Although female physicians have consistently demonstrated that they can perform at the same level as male physicians, gender discrimination still holds many back, which is unacceptable.

Conclusion

It is important to recognize the progress that has been made to ensure gender diversity in the physician workforce. However, despite this progress, gender inequities have contributed to the disproportionately low number of women achieving academic advancement and serving in leadership positions. The medical profession and our patients benefit greatly from a diverse physician workforce, and a concerted effort must be made to eliminate the inequities that exist in compensation and career advancement opportunities and provide a more inclusive environment to realize the full potential of all physicians in the workforce.

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Appendix Table. Case Studies

Position	Challenge	Potential Solution
Physician compensation should be equitable and not based on characteristics of personal identity, including gender. ACP supports transparency and routine assessment of the equity of physician compensation arrangements by all organizations that employ physicians.	Dr. W is a third-year resident in internal medicine who is exploring her career options after residency. She is very interested in returning to her hometown to serve the indigent where she was raised. She knows that there is a dearth of African American physician role models so is excited to return home. As she is discussing her contract with a colleague who is also interested in working for the same clinic with identical experience and position description, she is made aware that her contract offer is 30% less than that of her white male colleague.	Recognizing Dr. W's valid concerns, Dr. W's potential new boss looks into it and finds out that she is correct. The offer is changed so that she is offered the same as her male colleague. In addition, he begins routinely and transparently providing deidentified data about compensation, stratified for rank and time in rank, for both new hires and current faculty. This is shared with every faculty member during the hiring and annual faculty review process.
ACP supports the goal of universal access to family and medical leave policies that provide a minimum of 6 weeks of paid leave and calls for legislative or regulatory action at the federal, state, or local level to advance this goal.	Dr. H is an early-career physician. After she and her husband adopt an infant son, she takes 6 weeks of family leave. Upon returning, she is informed that the leave was unpaid because institutional policy treats adoption as family leave, which is unpaid. Had the leave been maternity leave, it would have been paid.	Dr. H and Dr. L, a colleague from pediatrics who experienced the same challenge, work with their employer to change the policy. The policy now allows for 6 weeks of paid leave for maternity leave, which includes adoption of a child. They are continuing to work on changes that will expand it to a parental leave policy that includes fathers.
ACP supports the provision of programs in leadership development, negotiation, and career development for all physicians and physicians-in-training.	Dr. J is a successful academic physician who has achieved the status of full professor and who serves as chair of the Department of Medicine as well as chair of the Board of Directors of a prominent national medical organization. Despite these remarkable accomplishments, she shies away from attention and often passes up opportunities for fear of being underqualified for the next step. She is concerned that a next step could be a glass cliff and does not want to worsen the cause for women in medicine by failing.	Dr. J believes that the best approach to her personal and organizational concerns will require multilevel interventions. She meets with her faculty development dean to review how other institutions have addressed the imposter syndrome and glass cliff barriers. They obtain information and actionable practices from other institutions and implement programs to improve the confidence, skills, and leadership qualities of individual faculty.
ACP supports the provision of regular and recurring implicit bias training by all organizations that employ physicians. Organizational policies and procedures should be implemented that address implicit bias.	Curious that the Department of Medicine Promotion and Tenure Committee has only 1 woman and 1 underrepresented minority, Dr. F, the new chair of the Department of Medicine, reviews promotion data for his department and finds that women and underrepresented minorities progress substantially more slowly than others.	After finding that women and underrepresented minorities progress substantially more slowly than others, Dr. F implements processes within the Department of Medicine that assure that each annual performance review of individual faculty members includes a discussion about promotion needs and timelines.
Academic institutions, healthcare organizations, physician private practice groups, and professional physician membership organizations should take steps to increase the number of women in practice, faculty, and leadership positions and structure equal access to opportunities.	Dr. T serves as the only woman department chair at an academic medical center. In addition to raising 3 children and caring for her aging mother, she is a well-known academic "triple threat" who maintains an active clinical practice, is an award-winning teacher and medical educator, and consistently secures NIH funding for her research on hypertension. The academic institution she works for has convened a search committee for its next dean. She is interested in becoming dean. Knowing the influence chairs can have, she is disappointed to learn that during an informal gathering that included many of the chairs, the chairs had not even considered her for the dean position because "they assumed she was too busy."	Dr. K is the dean of a medical school and calls for a review of diversity and inclusion status and policies in the institution, including a baseline needs assessment, installation of a Diversity and Inclusion Task Force whose composition specifically weights underrepresented minority and female faculty to review the survey data, current status of formal and informal processes that feed the leadership pipeline, organizational changes from this actionable data, and accountable metrics to track progress in the leadership and advancement for all faculty.
Further research is needed on the reasons for and effect of gender pay inequity and barriers to career advancement and the best practices to close these gaps across all practice settings.	Dr. G prides herself on being a highly sought-after internal medicine specialist because of the comprehensive, patient-centered care she provides to her patients. Many women patients seek care from her because she will take care of not only their medical problems but also their Pap smears and psychosocial issues. Her quality metrics and patient satisfaction ratings are the highest in her practice. During her annual performance review, she is notified that she will need to increase her productivity or take a pay cut because her RVUs are lower than those of her colleagues. She believes that this is due to the additional time she spends per patient visit.	Dr. G asks for her practice to consider tracking the additional gynecological and mental health care provided, as well as weighting quality metrics and patient satisfaction, for all members in her practice. She offers to work with her management and colleagues to find a compensation model that will acknowledge and incentivize these additional metrics. Her practice agrees because they want to retain physicians.

ACP = American College of Physicians; NIH = National Institutes of Health; RVU = relative value unit.