

Diversity and Equity in the Neonatology Workforce

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American Academy
of Pediatrics

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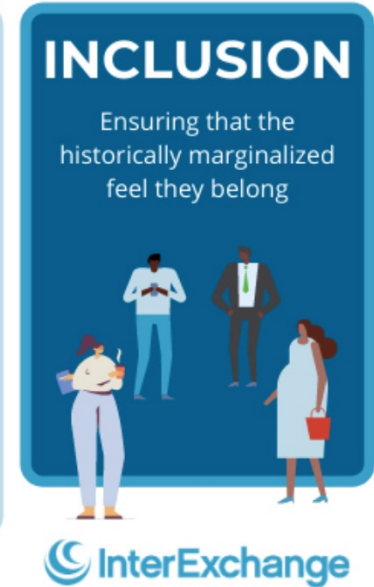
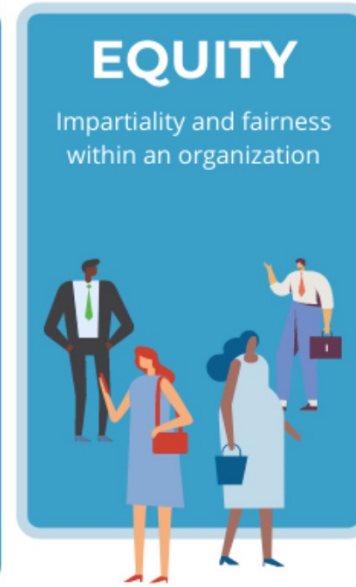
Disclosures

- I have no disclosures.
- I will not discuss unapproved or off-label uses.

- Terminology – AAP Words Matter
<https://www.aap.org/en/about-the-aap/american-academy-of-pediatrics-equity-and-inclusion-efforts/words-matter-aap-guidance-on-inclusive-anti-biased-language/>

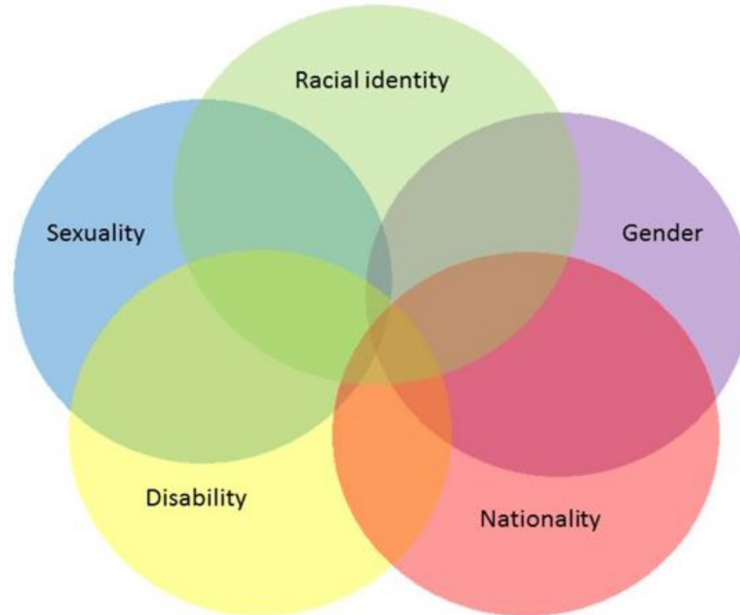
Outline

- Racial and Ethnic
- Gender
- In medicine/pediatrics
- In neonatology
- Improvement initiatives



Impact of Intersectionality

“the interconnected nature of social categorisations such as race, class, and gender, regarded as creating overlapping and interdependent systems of discrimination or disadvantage”



Racial and Ethnic Diversity and Equity

In Medicine



US Census Terminology

Race

White – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. **59%**

Black or African American – A person having origins in any of the Black racial groups of Africa. **12%**

American Indian or Alaska Native – A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment. **<1%**

Asian – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. **6%**

Native Hawaiian or Other Pacific Islander – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. **<1%**

Ethnicity

81%

19%

”not Hispanic or Latino”
 “Mexican, Mexican Am., Chicano”;
 “Puerto Rican”;
 “Cuban”;
 “another Hispanic, Latino, or Spanish origin” – 30+

AAMC Terminology

"Underrepresented in medicine (URiM) means

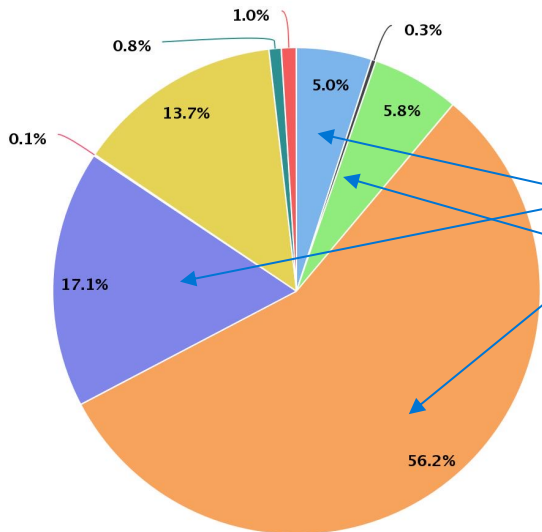
those racial and ethnic populations that are underrepresented
in the medical profession
relative to their numbers in the general population."

AAMC 2004

- Self-identification: Black, Hispanic or Latino, American Indian, Alaskan Native, Hawaiian, Pacific Islander
- Avoid "Minority" – in US children, all groups <50%

Physicians, Medical Students

Figure 18. Percentage of all active physicians by race/ethnicity, 2018.



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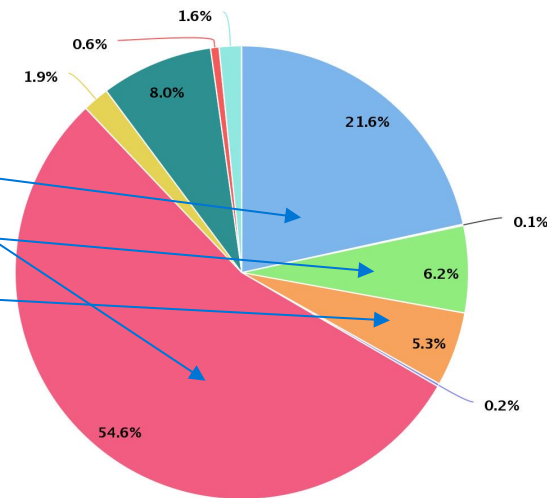
- American Indian or Alaska Native (2,570)
- Asian (157,025)
- Black or African American (45,534)
- Hispanic (53,526)
- Multiple Race, Non-Hispanic (8,932)
- Native Hawaiian or Other Pacific Islander (941)
- Other (7,571)
- Unknown (126,144)
- White (516,304)

Note: Figure 18 shows the percentage of active physicians by race and ethnicity as of July 1, 2019.

Source: Race and ethnicity are obtained from a variety of sources including DBS, ERAS, APP, MCAT, SMDEP, GQ, MSQ, PMQ, FACULTY, GME, STUDENT with priority given to the most recent self-reported source.

Figure 13. Percentage of U.S. medical school graduates by race/ethnicity (alone), academic year 2018–2019.

White
Asian
Black
Hispanic

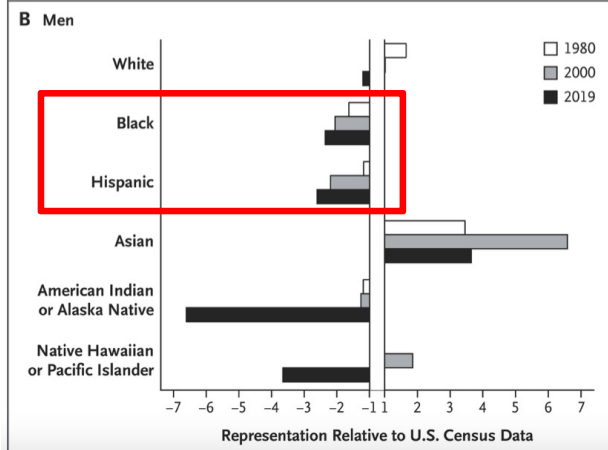
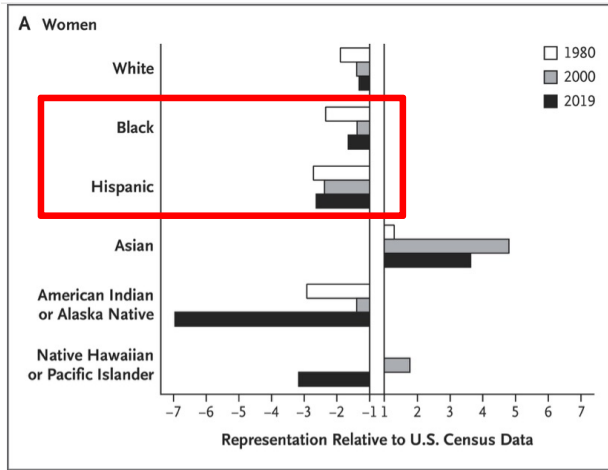


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- American Indian or Alaska Native (38)
- Asian (4,299)
- Black or African American (1,238)
- Hispanic, Latino, or of Spanish Origin (1,063)
- Multiple Race/Ethnicity (1,598)
- Native Hawaiian or Other Pacific Islander (9)
- Non-U.S. Citizen or Nonpermanent Resident (309)
- Other (380)
- Unknown Race/Ethnicity (124)
- White (10,879)

Note: Race/ethnicity "alone" indicates that an individual is reported in only one race/ethnicity category. The "Multiple Race/Ethnicity" category includes individuals who selected more than one race/ethnicity response. The "Non-U.S. Citizen or Nonpermanent Resident" category may include individuals with unknown citizenship.

Medical Students



No significant progress in increasing diversity of URiM over 4 decades

Stagnate for Hispanic women
Declines for Black & Hispanic men

	Black (12% US)	Hispanic (19% US)
2018	6.2% of graduates	5.3%
2019	3.2% increase	6.3% increase
2020	9.5% of matriculants	12%
2021	11.3% of matriculants	12.7%

Pediatric Trainees

URiM representation unchanged for residents, declined for fellows, **including neonatology

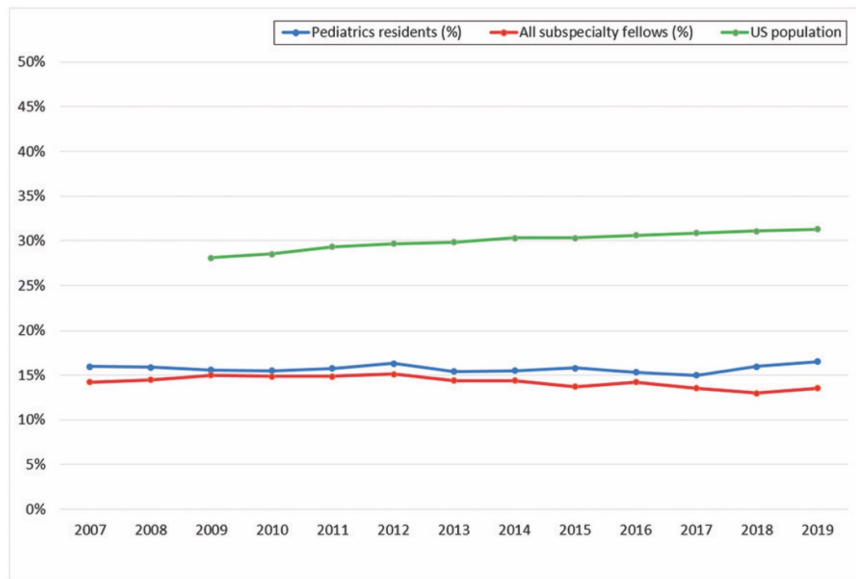


FIGURE 2
Percentage of URiM pediatric residents and fellows from 2007 to 2019 compared with US population.

Unknown 10% residents, 5% fellows. Multiple 1%, 4%

Comparison with US population, 2019

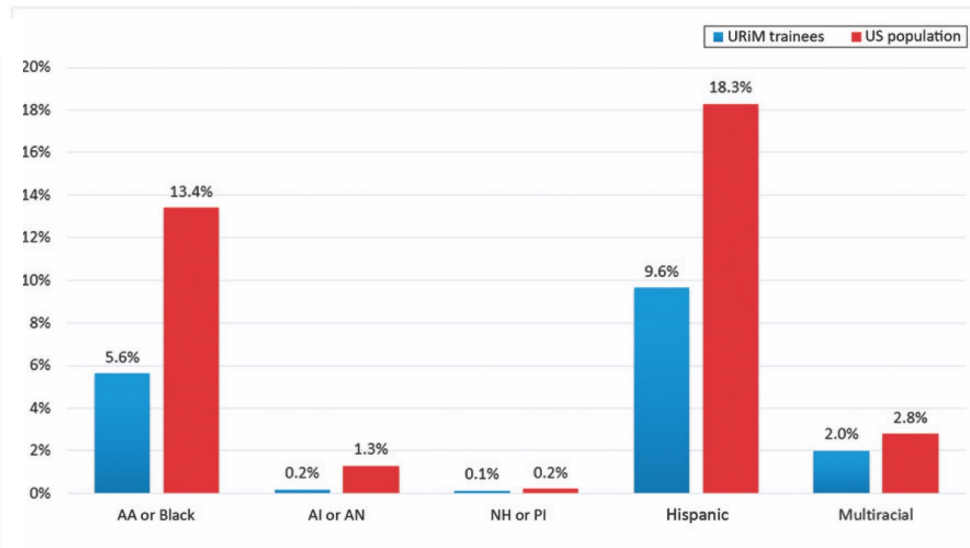
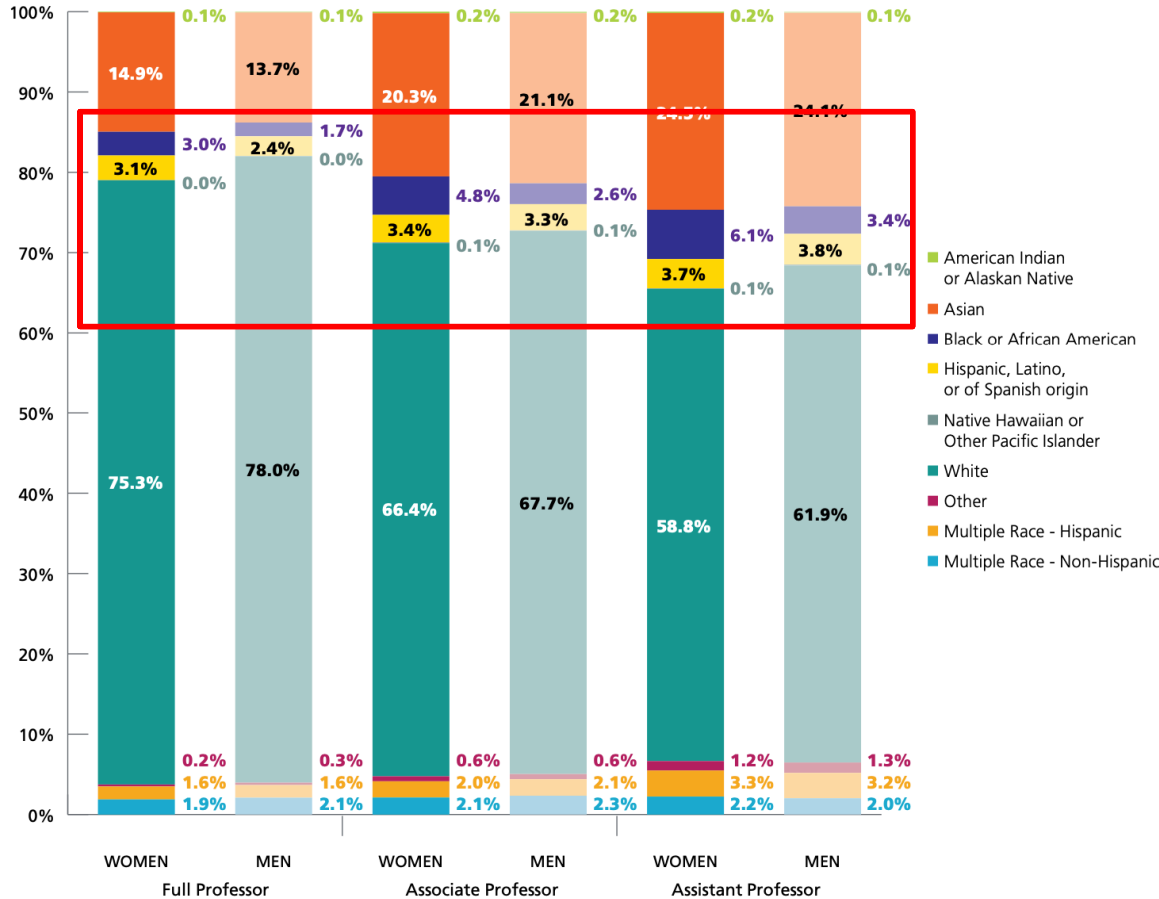


FIGURE 1
Percentage of URiM trainee representation compared with US population representation, 2019.

Med School Faculty Rank



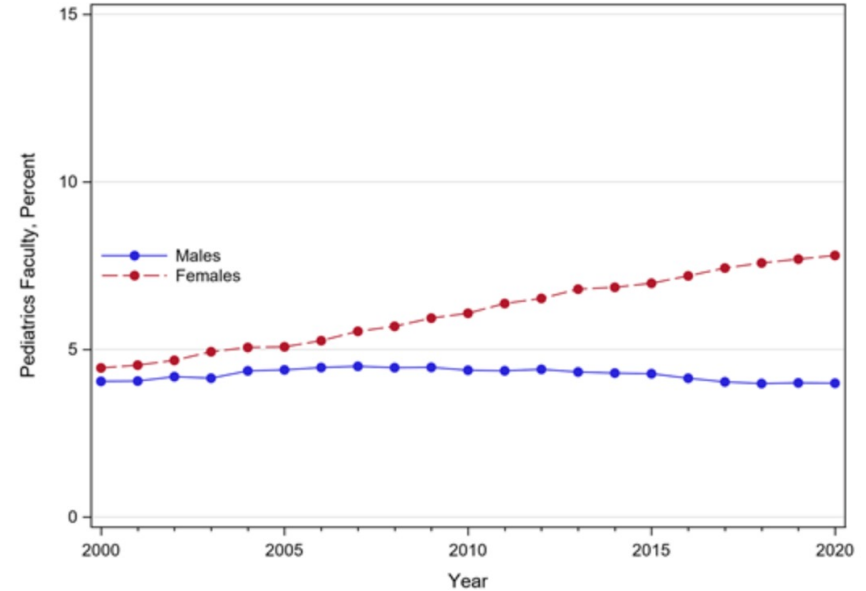
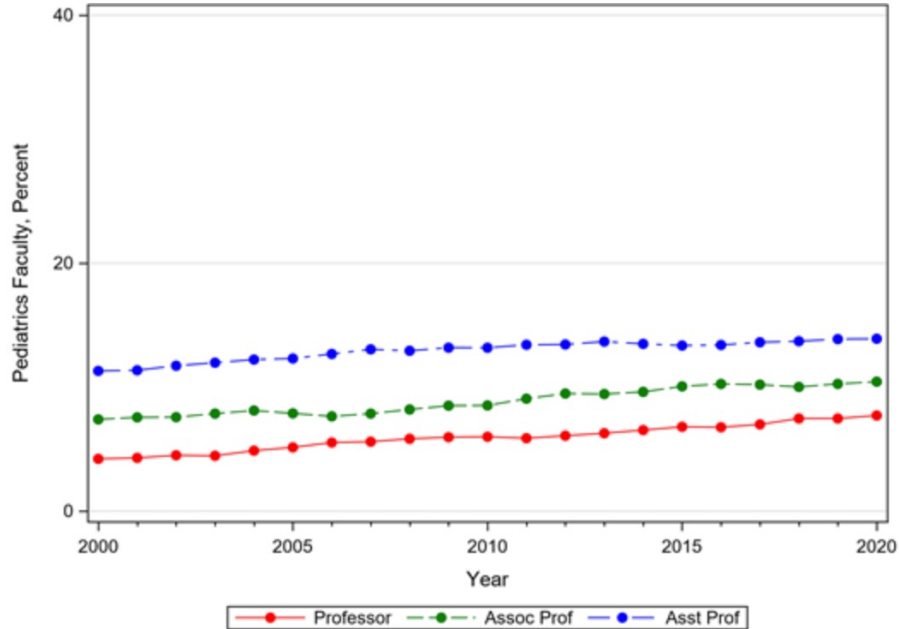
Blacks and Hispanics
more underrepresented
in 2016 than 1990

In every field (except
female OB/GYN)

At every rank

Pediatric Faculty

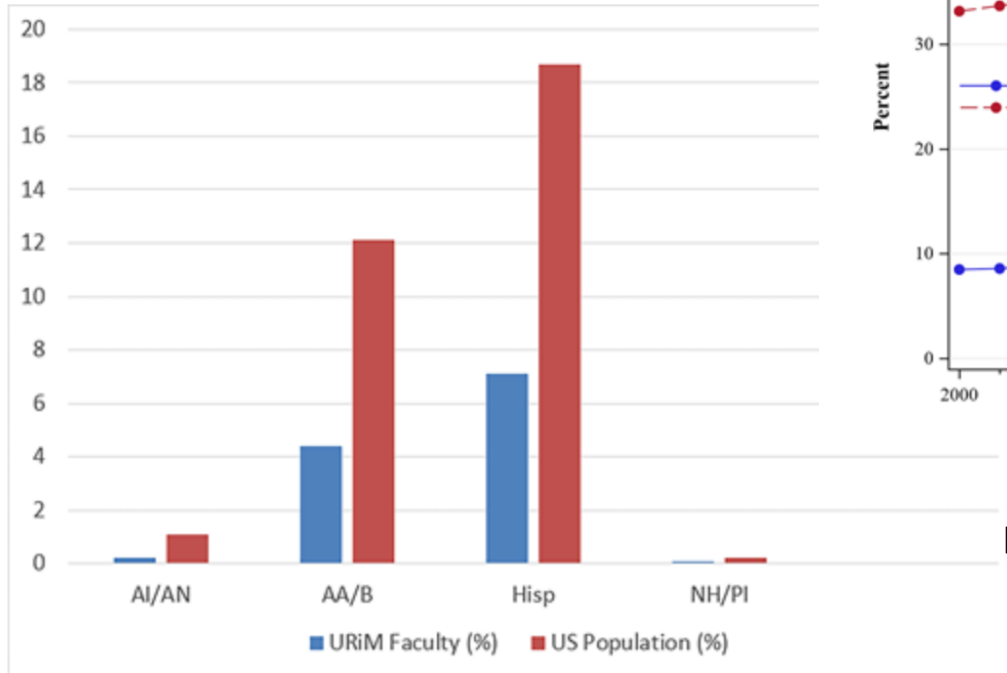
URiM representation increased modestly over 20 yrs



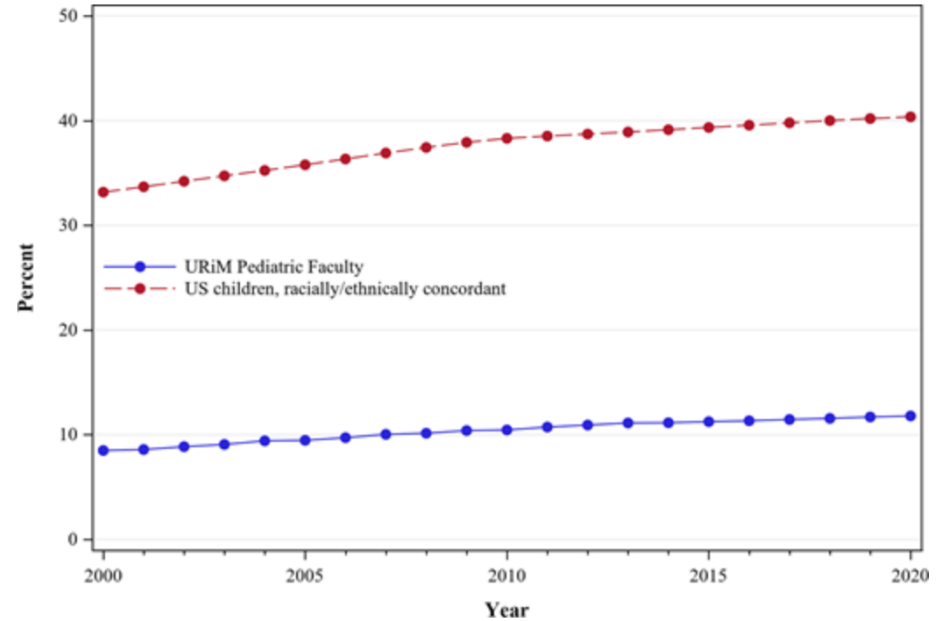
URiM male representation unchanged or declined

Pediatric Faculty

Comparison with US population



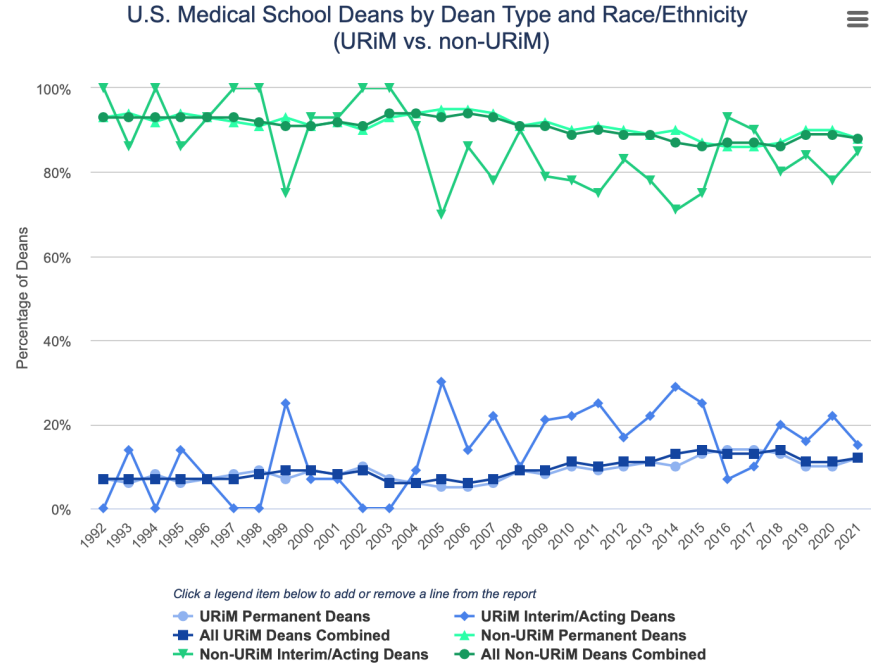
Comparison with US children



“the lack of faculty diversity reflective of the US population may have a critical impact on the ability to recruit/retain a diverse pediatric workforce and promote equitable care.”

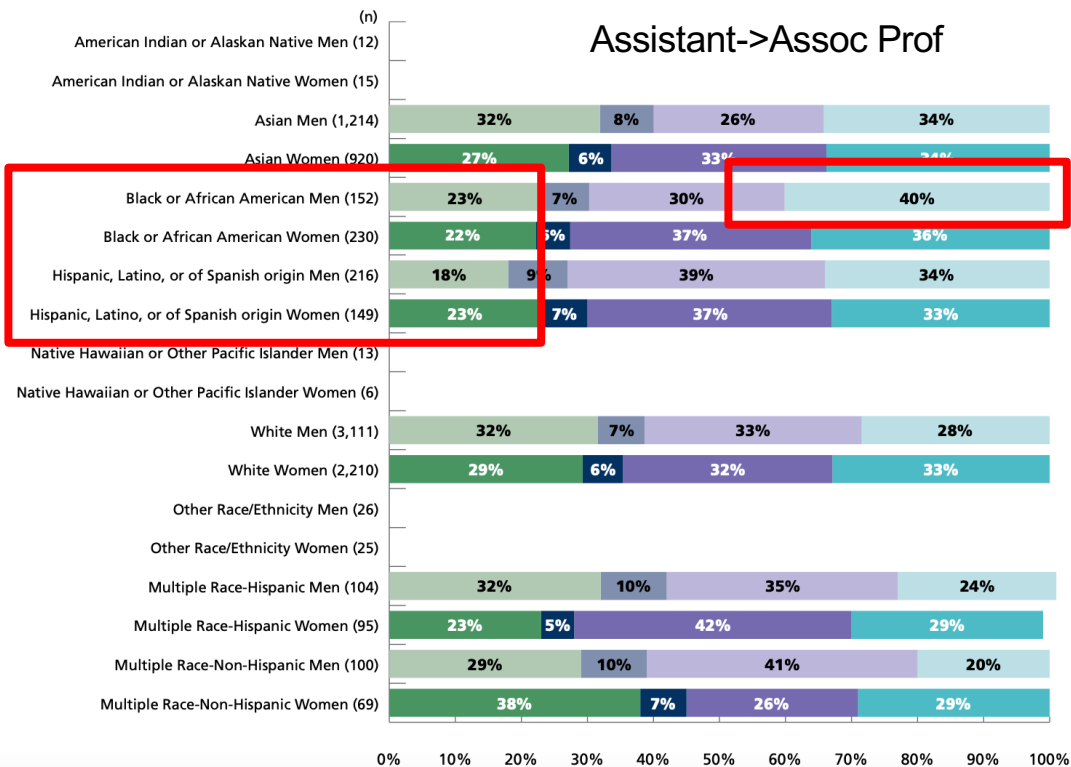
Academic Productivity, Leadership – URiM less

- URiM published 0.64 papers compared with white
- No adjusted difference in grant acquisition
- No significant or adjusted difference in senior leadership (17% white vs 10% URiM)

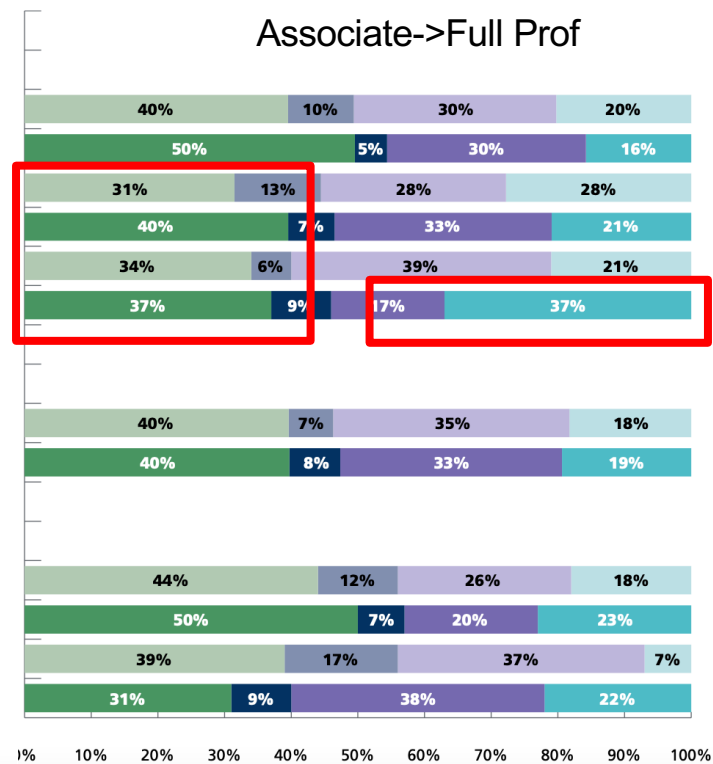


Promotions – URiM less, delayed

■ Promoted in Same Institution and Department
 ■ Promoted in Different Institution or Department
 ■ Not Promoted but Still in Academic Medicine
 ■ Not Promoted and Left Academic Medicine



■ Promoted in Different Institution or Department
 ■ Not Promoted but Still in Academic Medicine
 ■ Not Promoted and Left Academic Medicine



OR - UIM:White - Promotion to Full Professor – 0.53, Retention – 0.49

AAMC 2021, Kaplan 2018

Compensation – URiM less

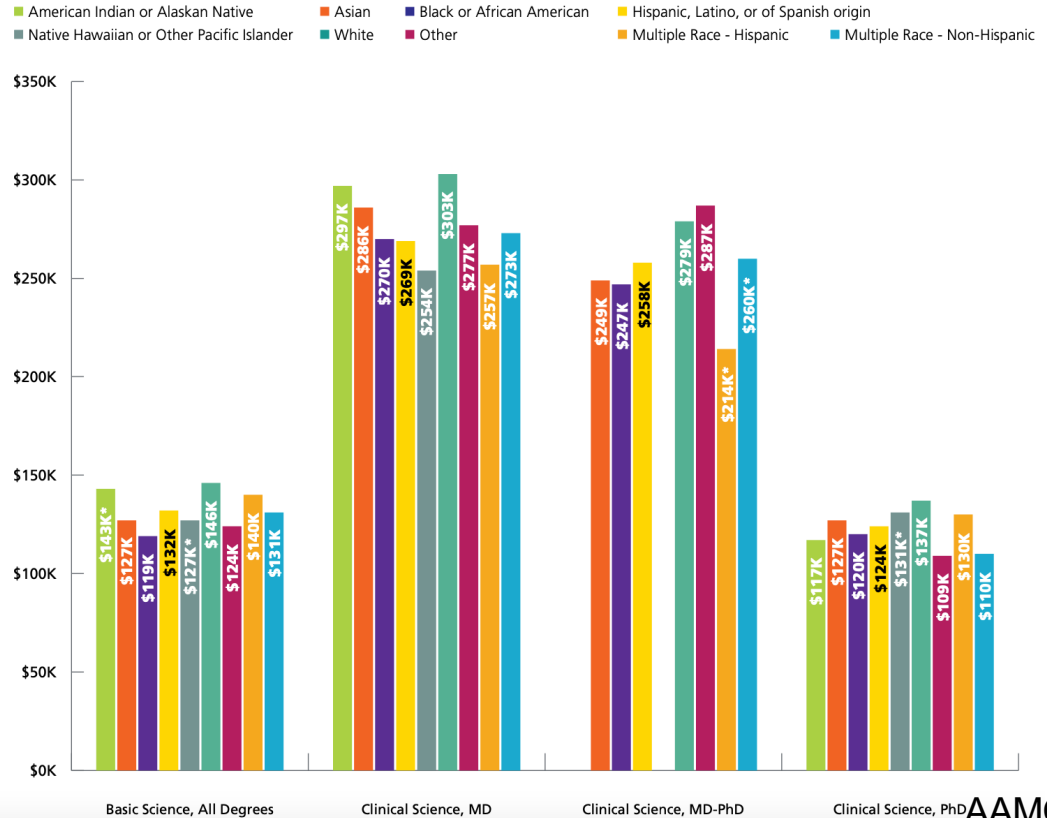
In most cases, white men
paid more than other groups

“Gender was the primary factor
driving compensation inequities;
men consistently made more than
women of the same
race/ethnicity.”

Clinical science MD example:

- White woman \$0.77
- Asian woman \$.74, man \$.98
- Black woman \$.73, man \$.93
- Hispanic woman \$.69, man \$.69

FIGURE 7. Median compensation for faculty by race/ethnicity, degree, and department type.



Racial and Ethnic Diversity and Equity

In Neonatal-Perinatal Medicine

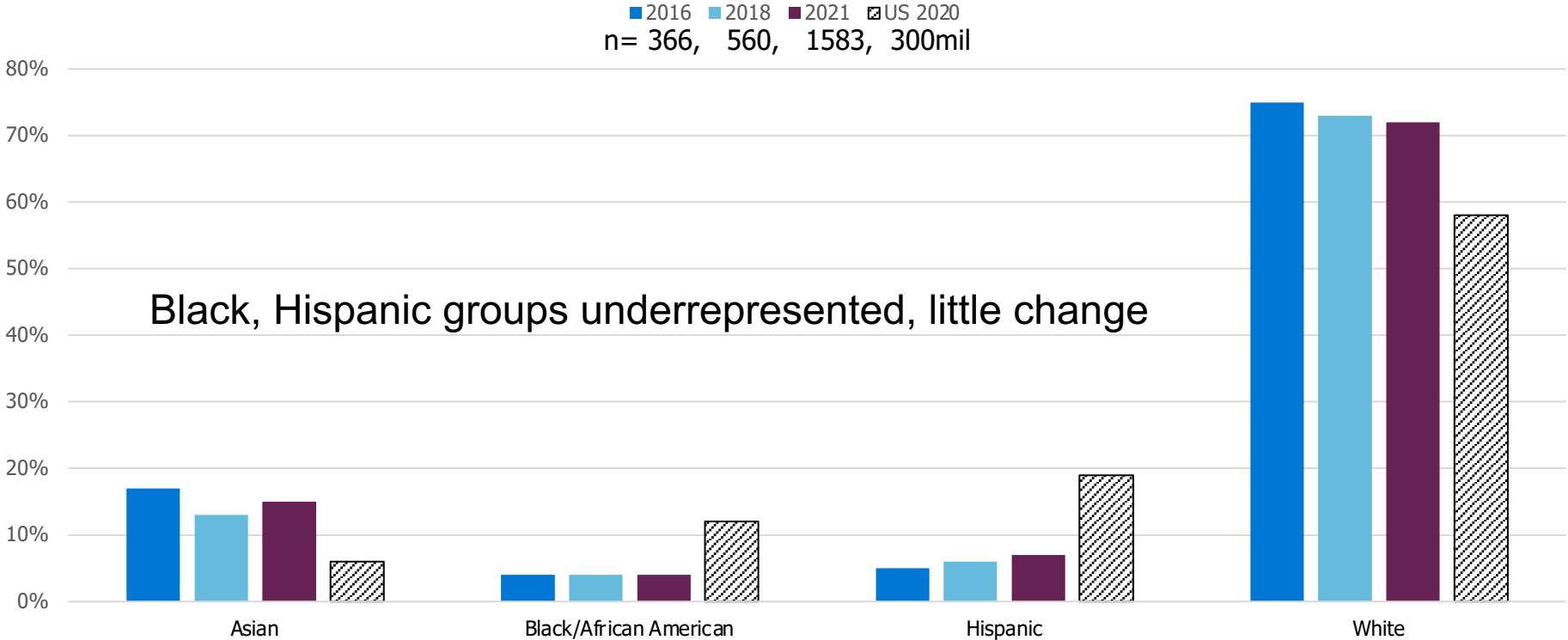


Where We Stand in Neonatology

- ACGME/AAMC data
 - Fellows 2007 – 2019: URiM 19% → 14%, $p < 0.001$
- ABP data
 - Certifications*
 - $n=4804 \leq 65$ years
 - $n=6525 \leq 75$ years
 - Collection started in 2018, not reported yet...
 - Race, ethnicity
 - Language proficiency besides English

AAP Workforce Survey Data

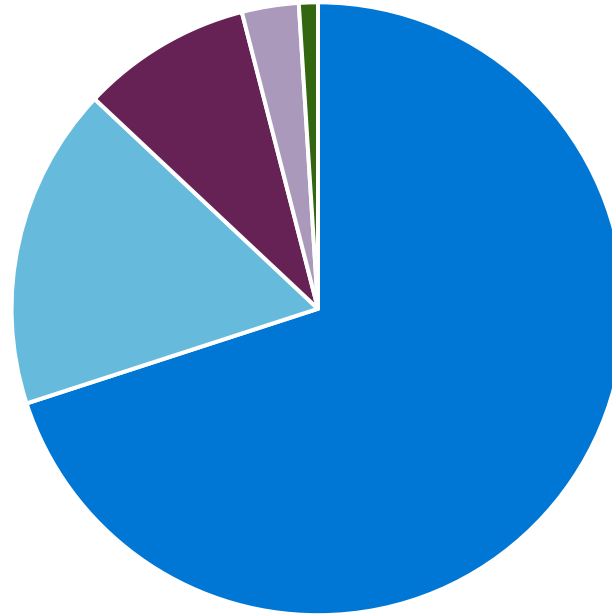
*Credit **Eric Horowitz**, Anisha Bhatia, Lauren Barone, Holly Ruch-Ross, Mark Hudak



* Middle Eastern/North African (3% 2021), American Indian or Alaska Native, Native Hawaiian or Pacific Islander, Other, Declined

NIH-funded Neonatologists

- 131 Neos in 2021
- 84 respondents
- 8 declined to answer



No Black,
Middle Eastern/North
African,
Native Hawaiian/Pacific
Islander

■ White ■ Asian ■ Hispanic ■ Other ■ American Indian or Alaskan Native

Equity in Neonatology

- 2018 Workforce Survey data, n = 335
- URiM (n=34), Asian (51), non-Hispanic White (250)

- URiM more likely
 - Work more weeknight shifts (48 URiM vs 40 Asian vs 36 white; p=0.016)
 - Practice in Southcentral or Southeast
 - International graduate medical education (Asian also)

- No significant adjusted differences in employer type, other clinical facets, leadership roles

Equity in Academia

Research	NH White	Asian		Black	
Research—weeks/year ^a	0 (0–10)	2 (0–10)	NS	0 (0–10)	NS
Percent with grant funding	21%	25%	NS	24%	NS
Annual grant funding ^a	\$87,000 (\$11,250–\$273,750)	\$100,000 (\$37,500–\$162,500)	NS	\$127,500 (\$18,500–\$700,000)	NS
Grant funding source(s)					
NIH funding	10%	14%	NS	21%	NS
Foundation funding	9%	10%	NS	12%	NS
Commercial funding	3%	6%	NS	9%	NS
Institutional funding	6%	8%	NS	12%	NS

	Factors	Odds ratio	p value
Primary investigator for NIH grant (AUC: 0.93)	Underrepresented in medicine (yes)	6.93 (1.56–30.72)	0.011
	Submitted a grant (yes)	6.82 (2.46–18.9)	<0.001
	Asian (yes)	2.59 (0.8–8.44)	NS
	Research (weeks per year)	1.11 (1.07–1.16)	<0.001
	Number of annual presentations	1.07 (1.01–1.13)	0.022
	Number of primary authorships	1.02 (1–1.04)	0.016
	Early career (yes)	0.18 (0.05–0.69)	0.012

- No adjusted difference in rank of full professor, research time, publications

Equity in Compensation

	Underrepresented in medicine (yes)	Dollars per year	p value
	Factors	Dollars per year	p value
Total cash compensation (R ² adjusted: 0.36)	Salaried (yes)	-\$63,475 (-\$15,628 to -\$111,323)	0.01
	Gender (female)	-\$42,503 (-\$25,843 to -\$59,165)	<0.001
	Academic affiliation (yes)	-\$37,686 (-\$18,208 to -\$57,165)	<0.001
	Region—Northeast	-\$36,155 (-\$14,271 to -\$58,039)	0.001
	Region—Mid-Atlantic	-\$34,451 (-\$13,003 to -\$55,899)	0.002
	Underrepresented in medicine (yes)	-\$27,688 (-\$991 to -\$54,384)	0.042
	Asian (yes)	-\$20,217 (-\$43,198 to \$2764)	NS
	Research (weeks/year)	-\$912 (-\$171 to -\$1654)	0.016
	Years post fellowship (5-year blocks)	\$10,553 (\$6887 to \$14,219)	<0.001
	Bonus (yes)	\$26,620 (\$9984 to \$43,255)	0.002

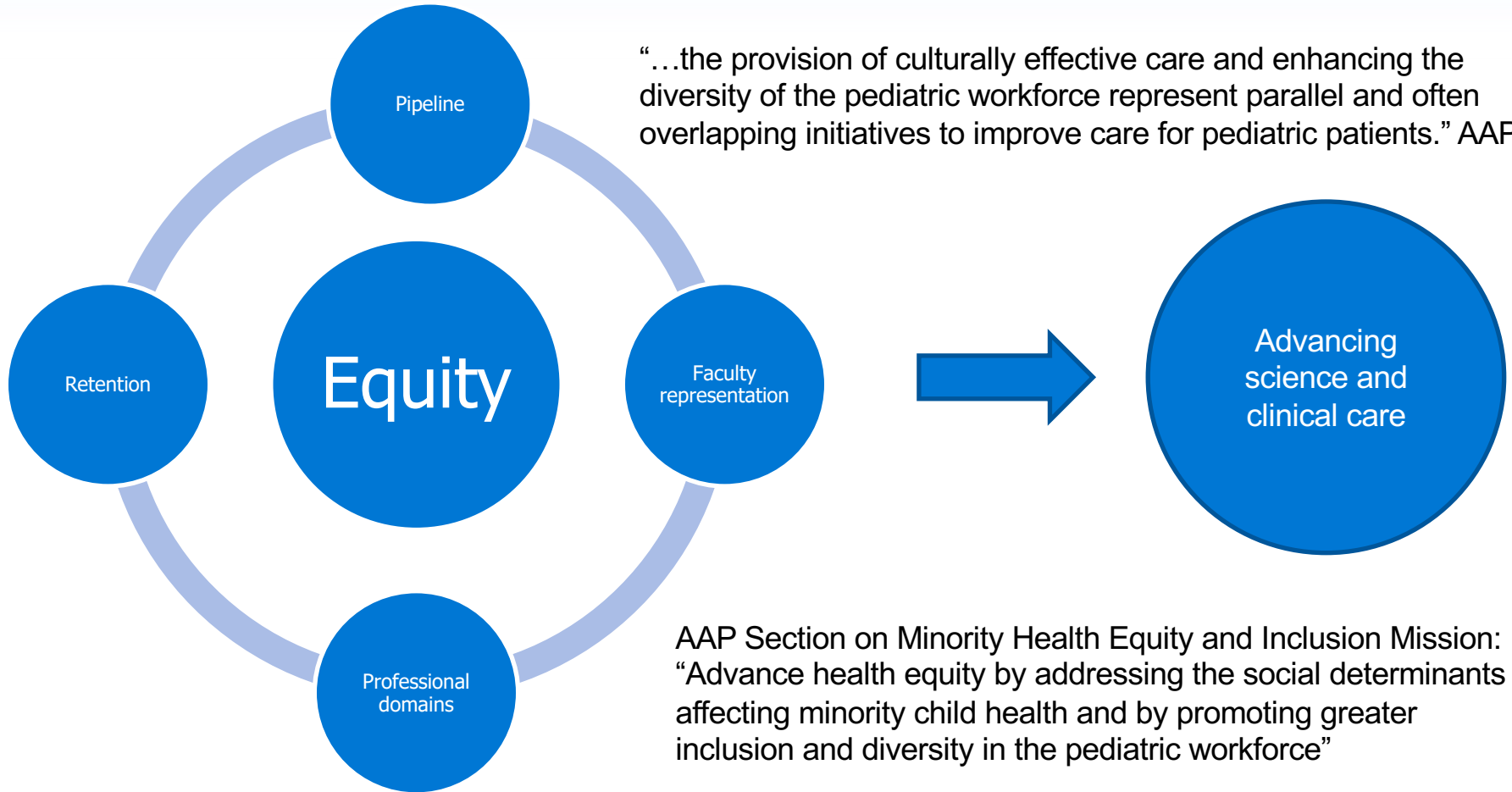
- 30 year gross earning difference = \$800K
- Invested = \$2 million

2021 Analysis

- AAP 2022 NCE plug! Horowitz et al
- Geographic differences persisted (South east and central)
- No meaningful differences in compensation or clinical, scholarly, leadership, administrative aspects

Where and Why is Diversity so Important?

“...the provision of culturally effective care and enhancing the diversity of the pediatric workforce represent parallel and often overlapping initiatives to improve care for pediatric patients.” AAP



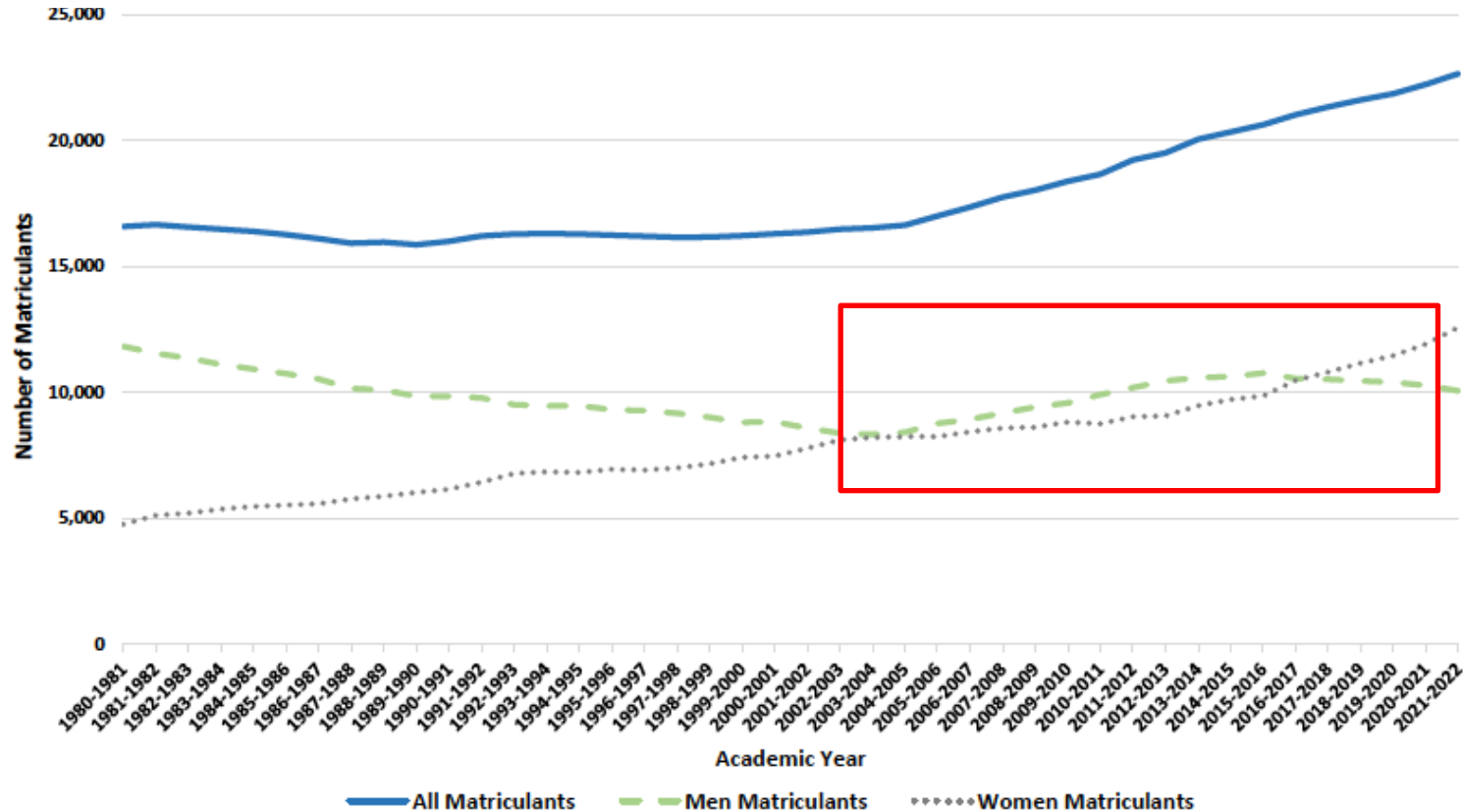
AAP Section on Minority Health Equity and Inclusion Mission:
“Advance health equity by addressing the social determinants affecting minority child health and by promoting greater inclusion and diversity in the pediatric workforce”

Gender Diversity & Equity

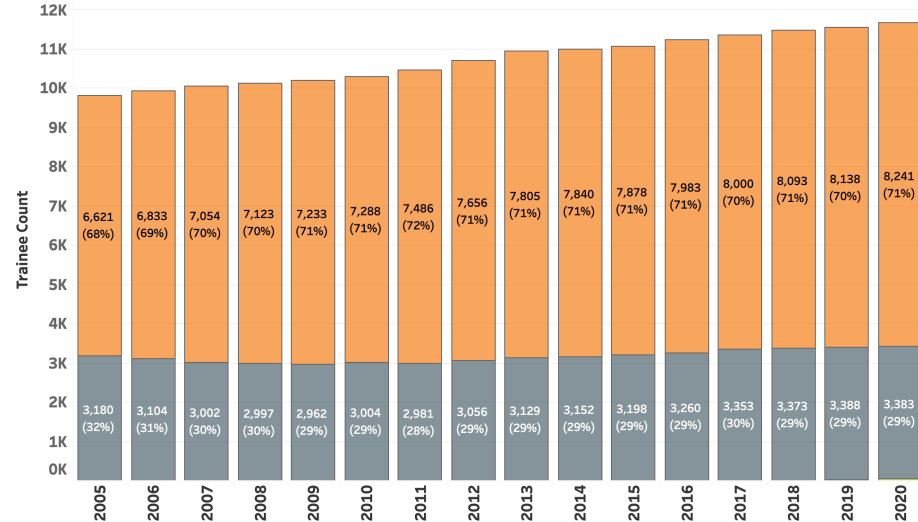
In Medicine



Medical School Matriculants >50% Women

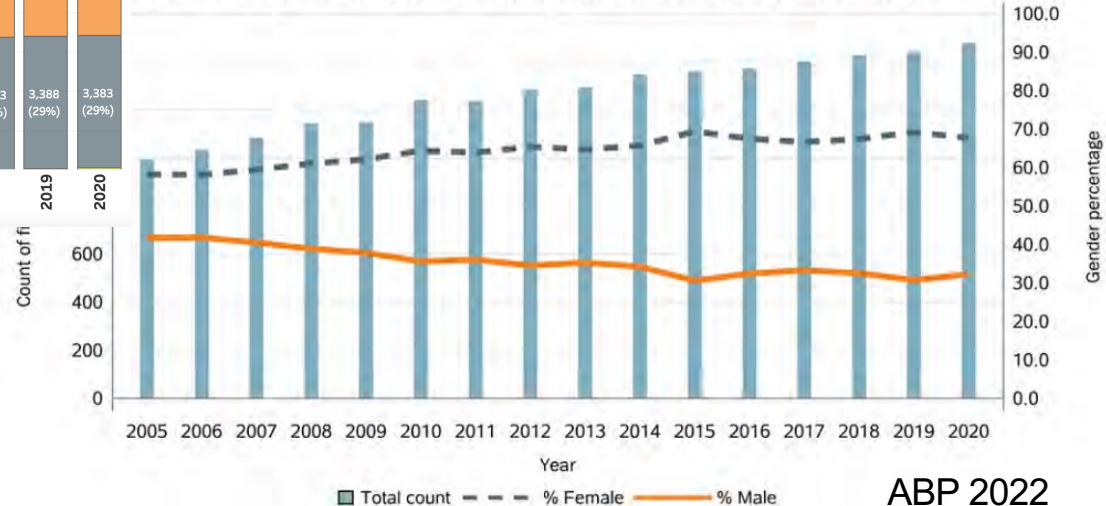


Pediatric Trainees >70% Women

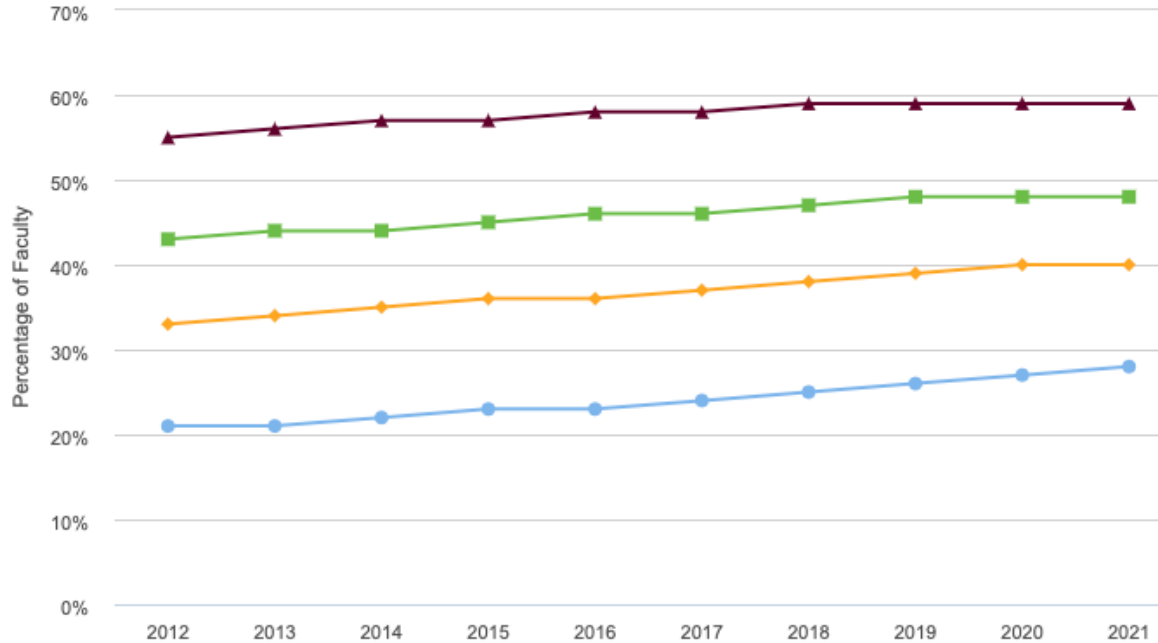


Residents

Legend
■ Female
■ Male



Medical School Faculty

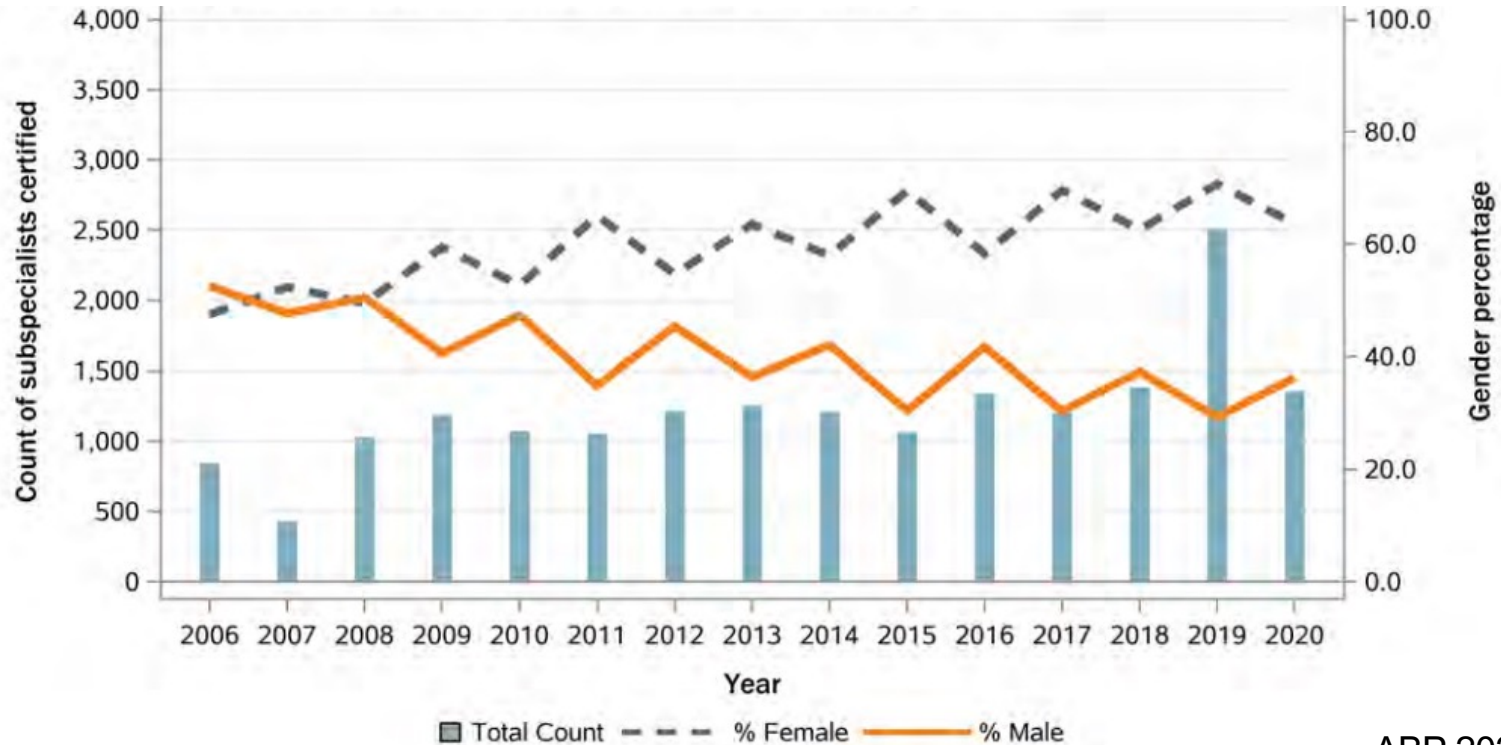


Click to add or remove line from report

- Professor
- Associate Professor
- Assistant Professor
- Instructor

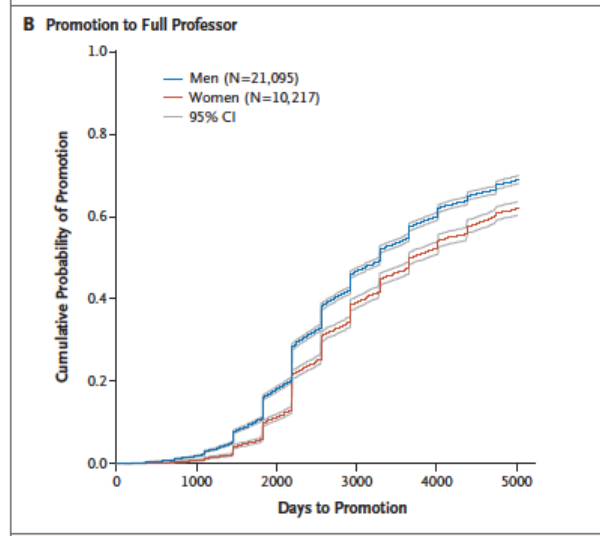
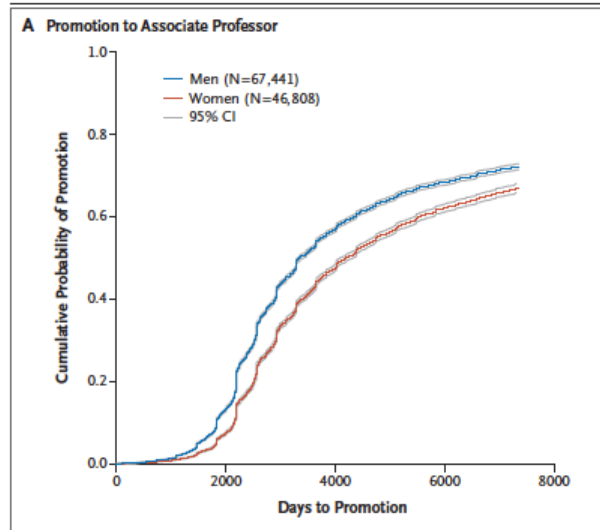
In **Pediatrics**,
women are
63% Faculty
57% Associate
34% Full

Pediatric Attendings >60% Women



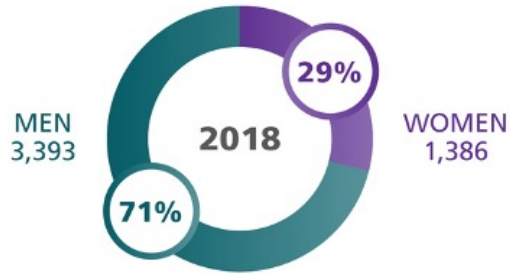
Promotions - Women less likely and slower

- Women more likely to be appointed at Assistant (1.12)
- Less likely to be promoted to:
 - Associate (adjusted HR 0.76)
 - 18% women, 24% men (7yr)
 - Median delay to Associate of 214 days
 - Full (0.77), 32% women, 27% men



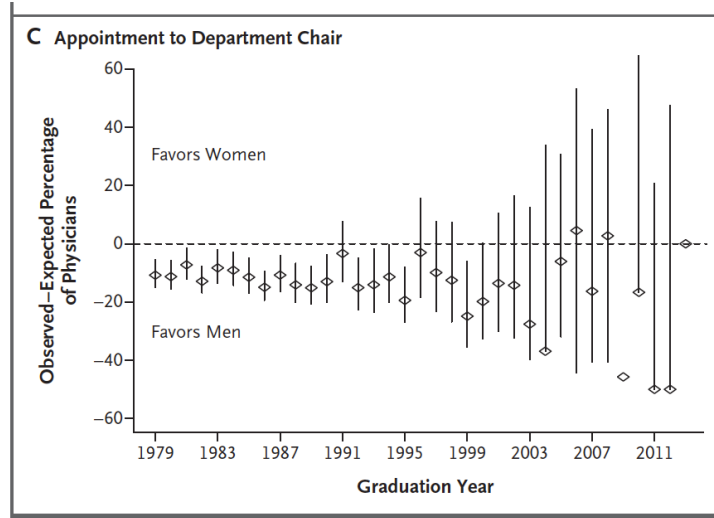
Leadership Positions – Women hold less

CURRENT DATA



Division Chief, all: 2.5x less

Department Chair: 54% less



2018
Since 2009, the number of women deans increased by about one each year, on average.



Dean: 4.5x less

Recognition – Women receive less

- Invited commentaries
 - OR 0.79, adjusted
 - 42% in high impact Peds journals
- Speakerships - 45% (AAP 2015-18)
- Awards
- Introductions
 - 49% informal when man introduced woman (72% man-man)
 - 17% by first name (3% men)
- Recommendation letters
 - 16% shorter, 4x less likely to mention publications
 - Language differences



Scholarly Work – Women make less gains

- Publications
 - Holding 1st or last author positions - Pediatrics: 61% first author, 44% last
 - Especially in high impact journals - 26-36%
 - Fewer citations – 33-50%
- Editorial boards and reviewers – 40%
- Grants
 - Award rates are similar, but women receive smaller amounts
 - First time NIH: women = 44%, \$39K less
 - **R01 Women \$15K MORE
 - Less participation on review panels
 - NIH Study sections: women 37% chairs, 39% reviewers

Puri et al 2020 Pediatrics, Trends in Gender Distribution Among Authors of Research Studies in Pediatrics: 2015–2019

Chatterjee et al 2021 JAMA, Gender Disparity in Citations in High-Impact Journal Articles

Fishman et al 2017 J Peds. Gender differences in the authorship of original research in pediatric journals

Oliveira et al 2019 JAMA, Comparison of National Institutes of Health grant amounts to first-time male and female principal investigators

Volerman et al 2021 JAMA, Representation of Women on National Institutes of Health Study Sections

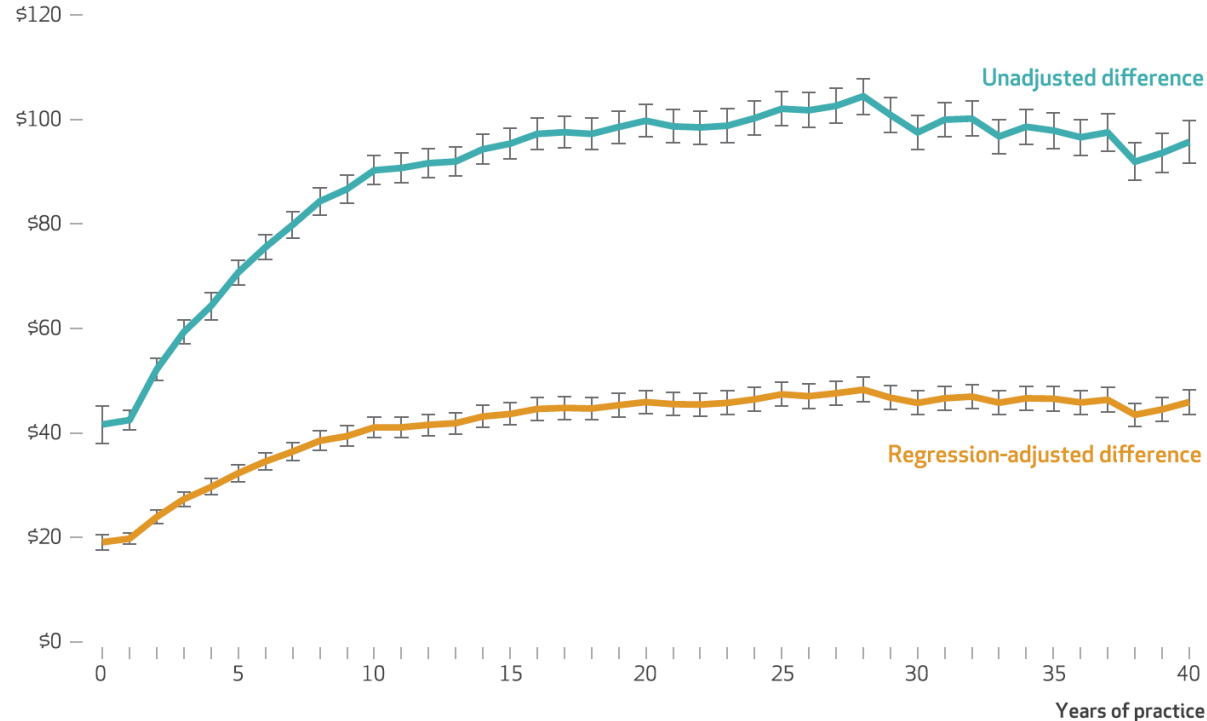
Compensation – Women earn a lot less

Whaley et al 2021, 80K physicians on Doximity 2014-19

EXHIBIT 1

Differences in income between male and female physicians in the US, by years of practice

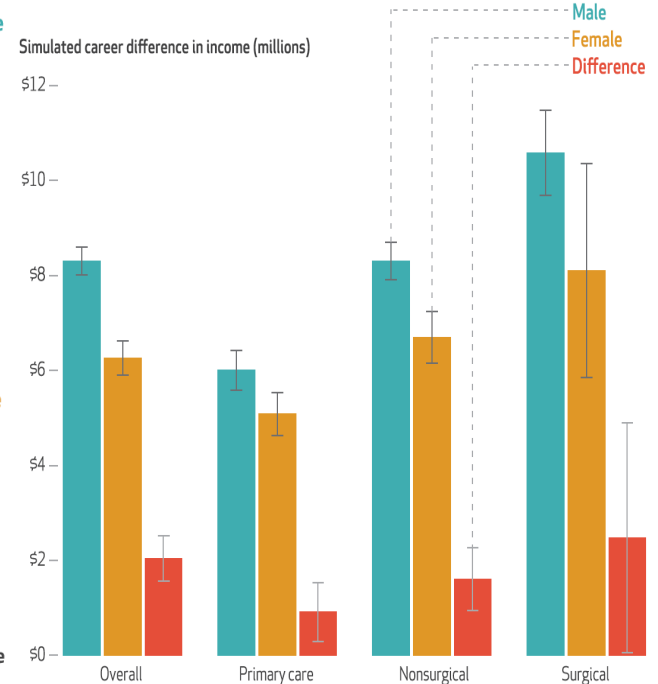
Difference in income (thousands)



\$2 million over 40 year career

EXHIBIT 2

Simulated career differences in income between male and female physicians in the US, by specialty

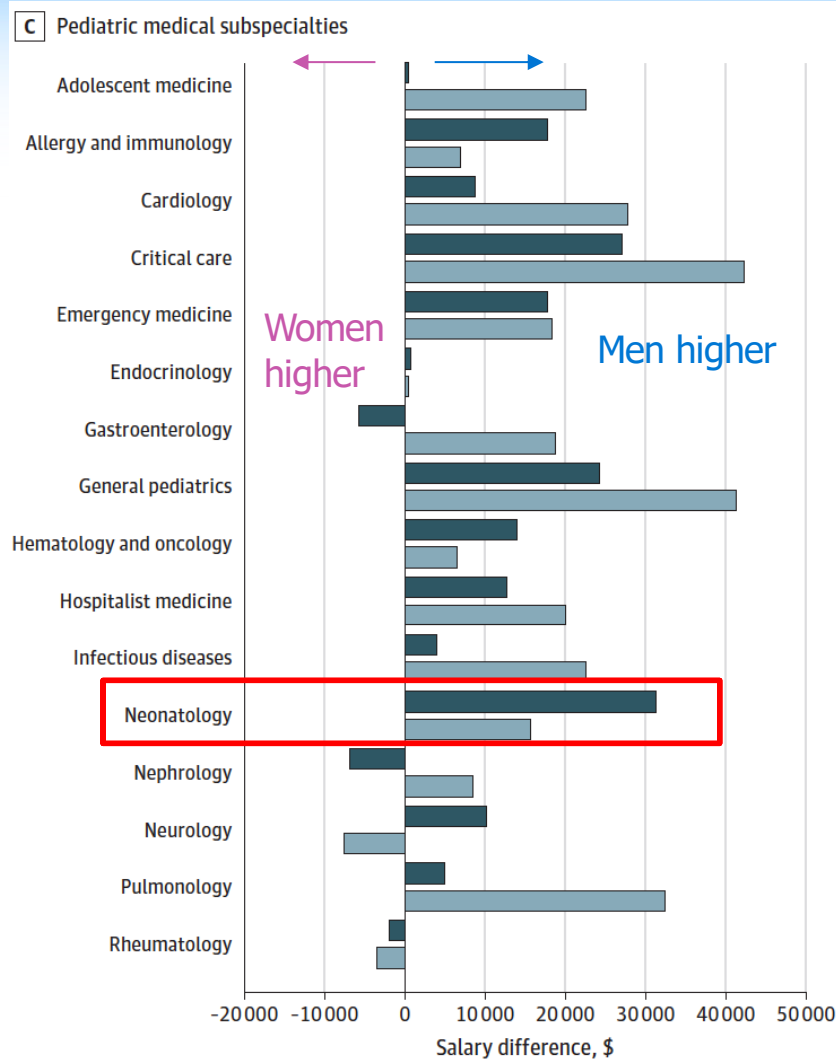
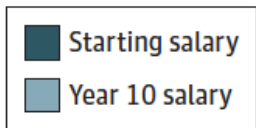


Women Lower Starting Salaries

Subspecialty	Difference, median (IQR), \$ [%] ^b	
	Starting salary	Year-10 salary
Adult medical	29 854 (22 673 to 39 432) [11]	21 504 (15 900 to 34 621) [8]
Adult surgical	64 124 (56 849 to 109 613) [17]	99 385 (83 737 to 127 805) [20]
Pediatric medical	9632 (620 to 18 008) [4]	18 841 (6957 to 24 215) [7]
All subspecialties	26 800 (12 816 to 40 980) [10]	22 890 (15 808 to 49 781) [9]

- Gap increases by year 10
- \$214K less 10yr earning potential
- 1 year delay in promotion reduces 10yr earning potential \$26K

Even in Pediatrics



Gender Diversity & Equity

In Neonatal-Perinatal Medicine

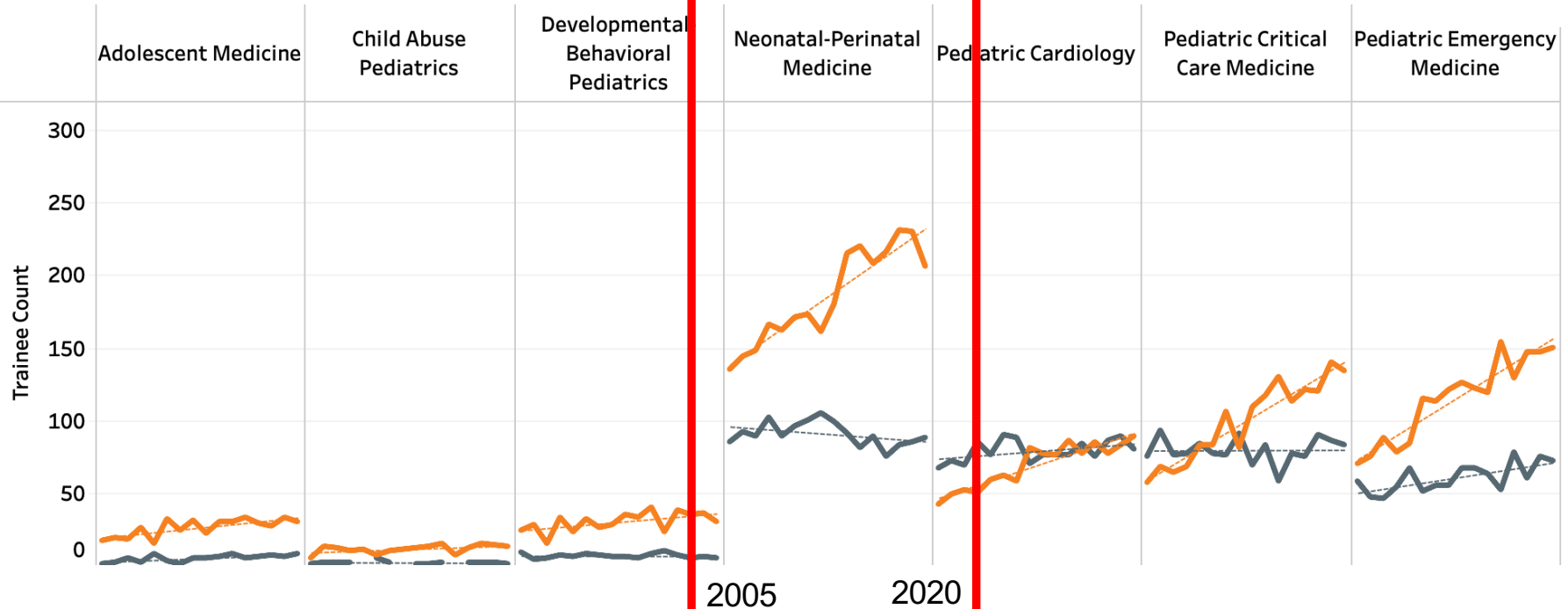


Neonatal-Perinatal Medicine Fellows

>70% female in last 10 years

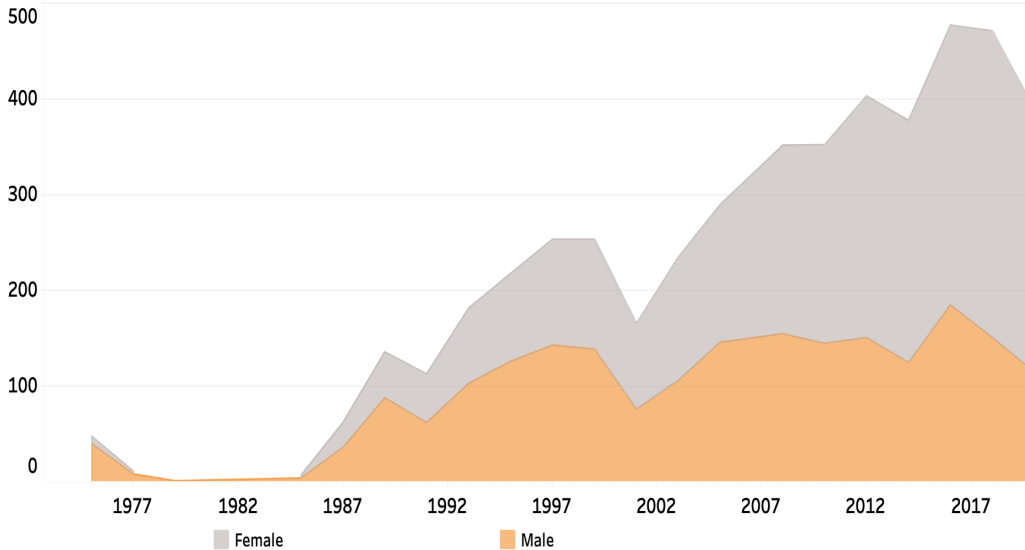
Legend

- Female
- Male



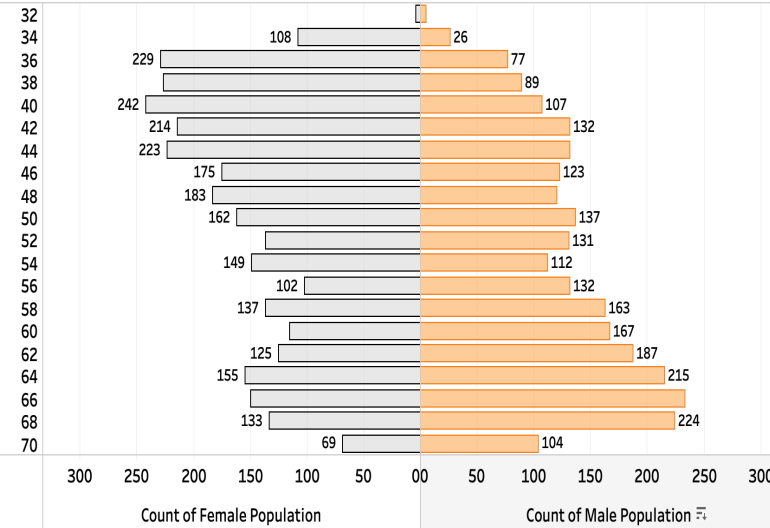
Neonatal-Perinatal Certifications

Certifications in Neonatal-Perinatal Medicine by Gender



62-71% female over last 10 years
56% overall

Age/Gender Distribution (Age 70 and Under) of Those Certified in Neonatal-Perinatal Medicine



ABP data

AAP Workforce Survey

Journal of Perinatology (2019) 39:359–365
<https://doi.org/10.1038/s41372-018-0304-7>

FEATURE

Neonatologist salary: factors, equity and gender

Eric Horowitz¹ · Henry A. Feldman² · Renate Savich³

- Academic + private practice
- 2016
- n=360 (15%)

Table 1 Characteristics of full-time board eligible/certified neonatologists in the United States

Variable	Categories	N (%)
Years post fellowship ^a	<5 Years	75 (20)
	5–10 Years	56 (15)
	10–15 Years	43 (12)
	15–20 Years	34 (9)
	20–25 Years	53 (14)
Years in current practice ^a	>25 Years	105 (29)
	<5 Years	128 (35)
	5–10 Years	50 (14)
	10–15 Years	52 (14)
	15–20 Years	32 (9)
Practice type ^b	20–25 Years	32 (9)
	>25 Years	72 (20)
	Health system employee	180 (49)
	Private practice	131 (36)
	Government	50 (14)
Academic track ^b	Other	4 (1)
	Academic	237 (65)
	Non-academic	129 (35)
Academic rank ^a	Instructor	8 (4)
	Assistant	89 (40)
	Associate	51 (23)
	Professor	75 (34)

Gender ^a	Female	168 (47)
	Male	192 (53)
Race ^b	Asian	59 (17)
	Black/African American	15 (4)
	White	252 (75)
	Other	12 (4)
Ethnicity ^b	Hispanic/Latino	19 (5)
	Medical training ^b	286 (80)
Compensation ^c –median (IQR)	American medical graduate	
	International medical graduate	71 (20)
	Salary (\$)	256,000 (213,608–315,000)
Total cash compensation (\$)	Bonus (\$)	7200 (0–26,500)
	Moonlighting (\$)	20,000 (8000–36,500)
	Total cash compensation (\$)	280,000 (225,000–355,750)

Data were collected as ^aordinal variable; ^bnominal variable; ^ccontinuous variable; and ^ddummy ordinal variable (0 or 1). Distribution around median listed as interquartile range (IQR)

Factors Influencing Base Compensation

Neonatologist salary: factors, equity and gender

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Table 4 Generalized linear model—factors influencing base compensation

Factors	Impact (%)	Impact (\$) ^a	P value
Region—North Central ^b	5.00	12,813	0.02
Work with physician assistants ^b	4.02	10,286	0.004
In-house call ^b	3.35	8579	0.005
Years post fellowship (5-year blocks) ^c	2.71	6927	<0.001
Administrative time—weeks/year ^c	0.24	612	<0.001
Daily rounding—critical care patients ^c	0.18	452	0.07
Clinical time—weekdays (daytime) ^{a,c}	0.05	125	<0.001
Medical education—weeks/year ^c	−0.26	−661	0.001
Work with neonatal hospitalists ^b	−1.97	−5030	0.10
Eligibility for annual bonus ^b	−3.48	−8911	0.002
Gender (female vs male) ^d	−3.68	−9425	<0.001
Large central metropolitan county ^b	−4.44	−11,359	<0.001
Academic (vs non-academic) ^d	−5.86	−14,996	<0.001
Region—Mid-Atlantic ^b	−6.12	−15,673	<0.001
Region—Northeast ^b	−6.72	−17,193	<0.001

 R^2 adjusted = 0.45556

All correlations of estimates are between −0.3 and 0.3, except for Work with Physician Assistants and Region—Northeast which had a value of −0.348

^aImpact (\$) calculated from Impact (%) × median compensation (\$256,000)

^bVariable analyzed as a binomial dummy variable with potential value of 0 or 1

^cVariable analyzed as continuous

^dVariable analyzed as nominal binomial

Gender = \$9425/yr, compounded

Deeper Dive into Gender Differences

Journal of Perinatology
<https://doi.org/10.1038/s41372-020-00897-4>

ARTICLE

Equity for women in medicine—neonatologists identify issues

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		All	Male	Female	
<ul style="list-style-type: none"> 2018 n=341 55% female 	Years post fellowship				
	5 years or less	18%	12%	23%	<0.001
	6–10 years	18%	10%	24%	
	11–15 years	14%	16%	13%	
	16–20 years	8%	8%	8%	
	21–25 years	9%	7%	11%	
	26–30 years	15%	22%	10%	
	31–35 years	10%	15%	6%	
36 years or more	7%	10%	5%		

^aMedian value (interquartile range).

Table 1 Gender comparison of key clinical setting variables.

	National average (<i>n</i> = 341)	Gender		<i>p</i> value
		Male (<i>n</i> = 155)	Female (<i>n</i> = 186)	
Employer type				
Hospital or healthcare system	73%	72%	75%	NS
Contracted: private single subspecialty group	14%	18%	11%	
Contracted: private multispecialty group	11%	9%	13%	
Military or federal government	1%	1%	1%	
Other	0%	1%	0%	
Academic or nonacademic affiliation				
Academic	72%	70%	73%	NS
Nonacademic	28%	30%	27%	
Characteristics of primary nursery for clinical duties				
Level 4 (regional neonatal intensive care unit)	54%	52%	56%	NS
Level 3 (neonatal intensive care unit)	44%	46%	42%	
Level 2 (special care nursery)	2%	3%	2%	
Clinical duties^a				
Clinical service—weeks/year	18 (12–26)	20 (13–30)	16.5 (12–25)	NS
Weekday daytime clinical shifts per year	90 (60–120)	90 (65–130)	85 (60–120)	NS
Weeknight clinical shifts per year	40 (22–60)	40 (21–60)	38 (24–60)	NS
Weekend daytime clinical shifts per year	24 (15–34)	24 (15–34)	24 (14–32.5)	NS
Weekend night time clinical shifts per year	15 (10–24)	15 (10–25)	15 (11.75–24)	NS
Clinical hours/year	1935 (1444–2672)	1932 (1413–2740)	1937.5 (1478–2626.5)	NS
Average daily census^a				
Total rounding census	20 (16–28.5)	22 (16–30)	20 (16–28)	NS
Call type provided				
In-house	39%	35%	42%	NS
From home	33%	34%	33%	
Both in-house and from home	25%	27%	23%	
No call	3%	3%	2%	
Years post fellowship				

Leadership & Academic Rank Differences

Table 2 Gender comparison of key leadership and compensation factors.

	National average (n = 341)	Gender		p value
		Male (n = 155)	Female (n = 186)	
Institutional administrative title(s)				
Committee member (group/division/ department)	34%	34%	33%	NS
Committee chair (group/division/ department)	18%	21%	15%	NS
Committee member (institutional)	33%	32%	33%	NS
Committee chair (institutional)	10%	15%	6%	0.005
Medical/Program director	40%	43%	37%	NS
Division chief/Group president	14%	23%	7%	<0.001
Department chair	4%	5%	3%	NS
Executive officer	3%	7%	0%	<0.001
Academic rank				
None	5%	5%	4%	NS
Instructor	7%	5%	8%	NS
Assistant professor	37%	27%	46%	0.002
Associate professor	28%	30%	27%	NS
Full professor	23%	34%	15%	<0.001

As a tenure track

Leadership & Academic Productivity Models, adjusted

Table 4 Regression models of factors influencing leadership and publications.

Target variable	Factors	Odds ratio	<i>p</i> value
Title of division chief or group president (AUC: 0.84)	Gender (male)	2.81 (1.35–6.14)	0.005
	Publications (>10)	2.43 (1.14–5.17)	0.022
	Years post fellowship (5-year blocks)	1.43 (1.2–1.74)	<0.001
	Clinical (>12 weeks/year)	0.4 (0.19–0.86)	0.02
	Research (>15 weeks/year)	0.24 (0.06–0.79)	0.017
Title of institutional committee chair (AUC: 0.81)	Gender (male)	2.92 (1.3–6.97)	0.009
	Years post fellowship (5-year blocks)	1.35 (1.13–1.63)	0.001
	Medical education (weeks/year)	1.06 (1.02–1.1)	0.004
	Presentations	1 (1.05–1)	0.053
	Primary authored publications	1 (1.04–1)	0.053
	Weekday clinical time (weeks/year)	0.96 (0.92–1)	0.043
	Group size (<6 neonatologists)	0.26 (0.07–0.76)	0.012
First or senior authorships (adjusted R^2 : 0.22)	Grant funding (yes)	17.81 (10.34–25.29)	<0.001
	Research (>15 weeks/year)	12.74 (4.66–20.81)	0.002
	Gender (male)	6.71 (0.81–12.6)	0.025
	Years post fellowship (5-year blocks)	4.24 (2.93–5.55)	<0.001

Adjusted R^2 : 0.41. Using ordinary least squares on log-transformed total cash compensation, estimates were converted to dollar amounts by applying the percentage change on the median total cash compensation in 2018 (\$280,000).

Academic Productivity – Women make less gains

- Publications
 - Men had twice as many primary authored publications as women
 - Same number of submissions
- Medical education time – men had 2 wks, women 0
- No gender difference in:
 - Research time
 - Grant funding, type, application

Compensation - Women are paid less

Unadjusted total cash comp difference= \$75K/yr

Adjusted difference = \$35K

Compounded 30 yr =

\$3.5 million

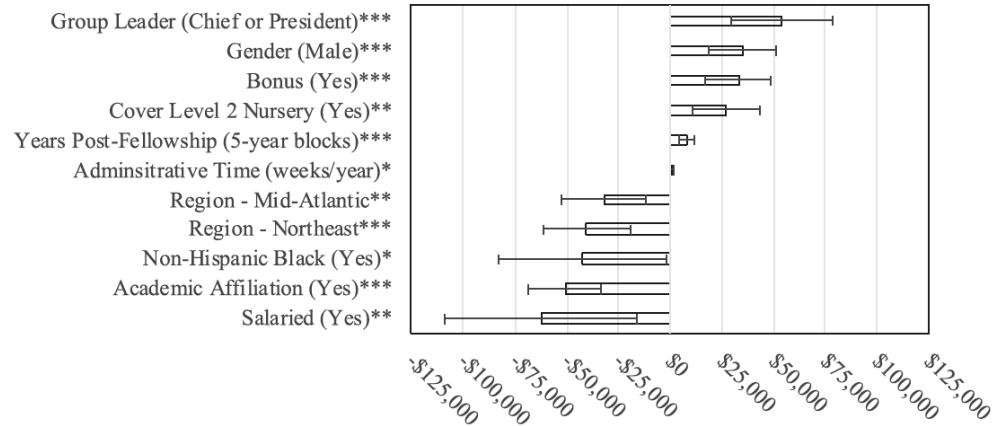
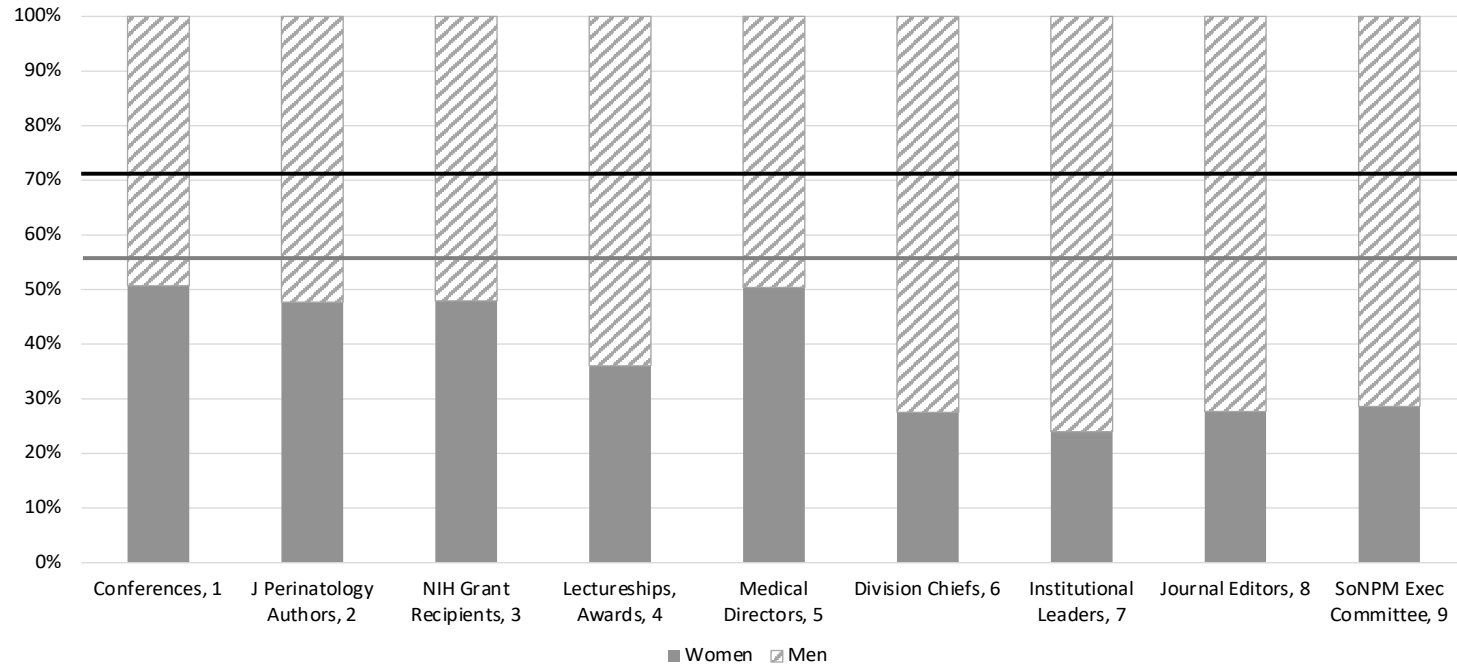


Fig. 1 Regression results of factors influencing total cash compensations (2018 US\$). Estimated dollar value of factors independently influencing total cash compensation. **p* value < 0.05; ***p* value < 0.01; ****p* value < 0.001.

Gender Representation in Various Professional Domains

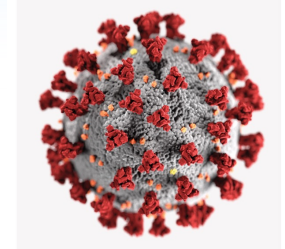


2018-2021 data

Women in Neonatology Equity Initiative



COVID-19 Amplified Gender Disparities



The National Academies of
SCIENCES · ENGINEERING · MEDICINE

CONSENSUS STUDY REPORT

THE IMPACT OF COVID-19
ON THE CAREERS OF WOMEN IN ACADEMIC
SCIENCES, ENGINEERING, AND MEDICINE



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SCHOLARLY PERSPECTIVES

COVID-19 Threatens Progress Toward Gender Equity Within Academic Medicine

Woitowich, Nicole C. PhD; Jain, Shikha MD; Arora, Vineet M. MD, MAPP; Joffe, Hadine MD, MSc

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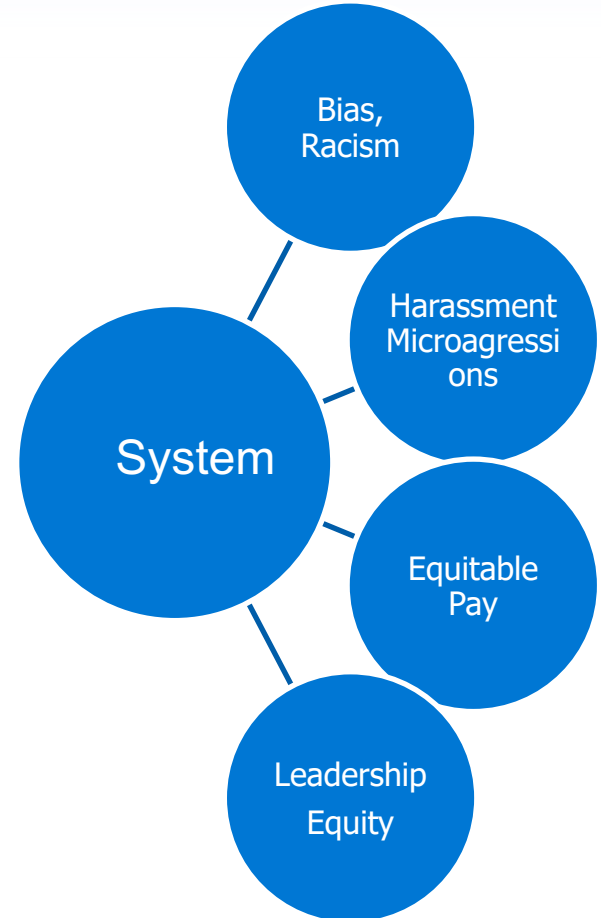
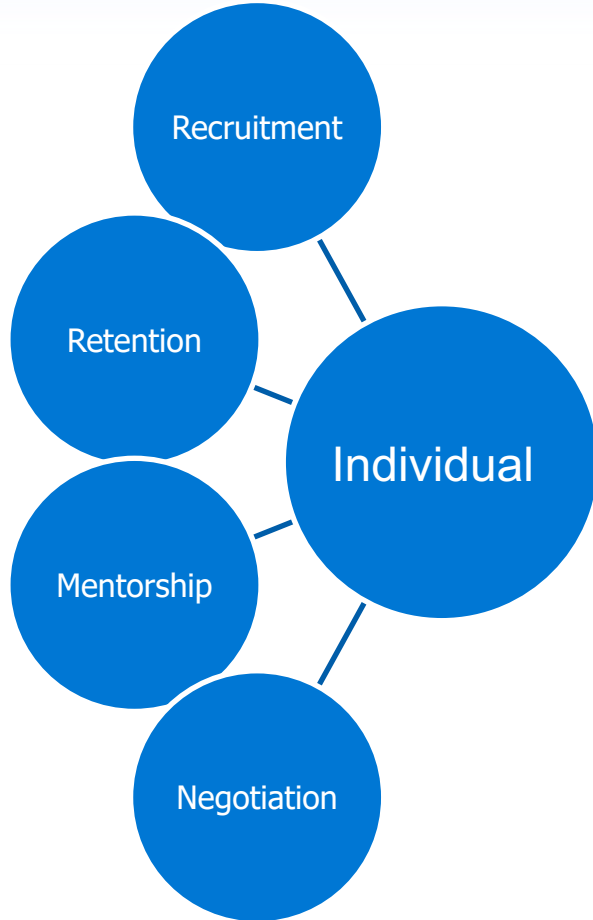
doi: 10.1097/ACM.00000000000003782

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Improvement Initiatives



Solutions for Change



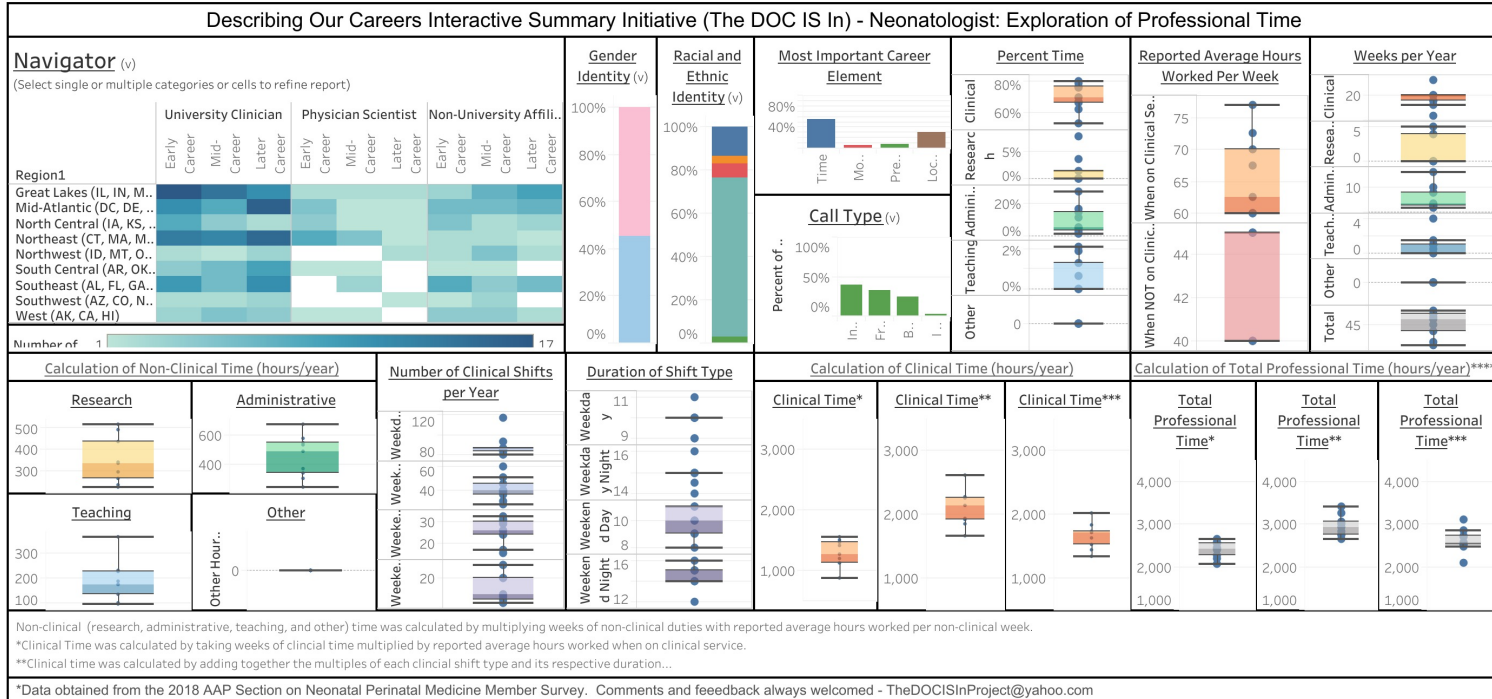
Awareness Example: DOC IS In

Instructions and Definitions

Professional Time

Peer Review

Methods



Advocacy Example: ALF Resolutions

- Combatting Racism in Graduate Medical Education Through Accreditation Council for Graduate Medical Education (ACGME) Curriculum Changes - #4, 2021
- Accountability through Measurement—Improving Diversity and Inclusivity in Pediatrics Through Metric-Driven Data to Better Address Members' Needs - #6, 2021
- AAP Support for Gender Pay Equity for its Members - #7, 2021
- Transparency of Equity, Diversity and Inclusion Outcomes for Medical School Pediatric Departments - 2022

Call to Action Statements – Gender Equity

- **AAP** – “As a collective group, we believe that the profession of medicine should collaboratively and intentionally address the numerous, multifaceted issues that hinder women physicians from reaching their full potential and ability to positively influence the profession of medicine, including by the following:”
- **AAMC** – “Academic medicine has suffered as a result of systemic discrimination and can no longer ignore the large impact that gender inequities have created. Now is the time to act. Member institutions and societies must renew their efforts to end exclusionary and discriminatory practices that operate across infrastructure, governance, operations, policies and processes, and workforce development. For the health of the academic medicine community, and for the patients who count on us, we can, we must, and we will achieve gender equity.”
- **American College of Physicians** – “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.”
 - **Neonatology** – “By leading systemic and sustained change toward equity, the SoNPM will maximize the engagement and potential of all neonatologists and **ultimately advance the science of our field and the care of our patients.**”

Intervention: Salary Equity Tools

FIRST STEPS ORGANIZATIONS CAN TAKE TO INITIATE A SALARY EQUITY EFFORT

- Establish consensus and commitment among institutional leadership about dedicating effort and resources to understanding and addressing salary equity locally.
- Scan the environment to assess whether other efforts are already underway to address salary equity in pockets of the institution or to address equity more broadly.
- Announce to the campus community that salary equity is an institutional strategic priority to demonstrate leadership commitment.
- Convene a group of diverse stakeholders across ranks and mission areas to begin exploring salary equity.
- Identify the various sources of compensation and personnel data (such as gender, race/ethnicity, and allocation of effort) available to your institution for local salary equity analyses.
- Conduct information sessions for faculty and leaders about compensation plans to ensure there is a consistent foundational understanding of compensation practices at your institution.

SALARY EQUITY

1. Establish diversity, equity, and inclusion as an organizational goal with oversight by senior leadership.
2. Task a multidisciplinary group of physicians, staff, and leaders with ongoing assessment and monitoring of salary equity and with identifying and addressing drivers of compensation disparities.
3. Track the representation of women and people from different races/ethnicities across units, in leadership roles, among new hires, and among academic and organizational promotions, and assess the impact of equity initiatives on these metrics.
4. Examine recruitment practices, and audit salary offers and startup packages to identify opportunities to improve pay equity through changing processes.
5. Conduct mandatory unconscious bias training with organizational leaders, in-house recruiters, academic promotion committees, and individuals who serve on job interview or external search committees.
6. Educate leaders about paying attention to situations where bias can emerge, such as during job negotiations, performance evaluations, and sponsorship.
7. Develop formal sponsorship programs and networking opportunities to promote professional advancement for faculty who are marginalized and underrepresented in medicine.
8. Explore underlying challenges to compensation and productivity that may result from increased domestic responsibilities (e.g., not being able to earn bonus pay for extra call, having inflexible work hours), and implement solutions that increase opportunities for all (e.g., allowing remote attendance at meetings and institutional support for caregiving).
9. Provide employees with gender-neutral parental leave and return-to-work policies to support the professional success of new parents.
10. Publicly report salary data and equity initiatives to close pay gaps. Track and share progress to enhance accountability and garner trust.

Key Takeaways

- Much work needed to improve racial and ethnic diversity
 - Evaluations for inequities
- Gender disparities exist in nearly all facets of the workforce
 - Even in Peds, in Neonatology
- May be small, but time point and compounding matter

The health of our workforce is key to the health of our patients

Women's Equality Day

- To commemorate the 19th Amendment – adopted August 26, 1920

“The right of citizens of the United States to vote shall not be denied or abridged by the United States or by any State on account of sex.”





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