OBJECTIVES

• Describe harassment and gender-based career disparities in healthcare
• Highlight the case for equity and safety
• Discuss (and brainstorm) individual & institutional solutions
• Introduce TIME’S UP Healthcare and discuss synergies with the Mullan Institute for Health Workforce Equity and GW
THE PROBLEM
Why focus on women in healthcare?

Sexual Coercion

Promising professional rewards in return for sexual favors

Threatening professional consequences unless sexual demands are met

Unwanted Sexual Attention

Rape

Sexual assault

Unwanted groping or stroking

Public Consciousness
Gender Harassment

- unwanted sexual discussions
- nude images posted at work
- sexually humiliating acts
- sexual insults
  - e.g., "for a good time call...", calling someone a whore
- offensive sexual teasing
- offensive remarks about bodies
- sexist insults
  - e.g., women don't belong in science
- sabotage of women's equipment
- obscene gestures
- vulgar name calling
  - e.g., "slut," "bitch," "c**t"
- gender slurs
  - e.g., "pu**y"
- insults to working mothers
  - e.g., "you can't do this job with small kids at home"
(1) **gender harassment:** verbal and non-verbal behaviors that convey hostility, objectification, exclusion, or second-class status

(2) **unwanted sexual attention:** unwelcome verbal or physical sexual advances, which can include assault

(3) **sexual coercion:** when favorable professional or educational treatment is conditioned on sexual activity
Changes in the Professional Lives of Cardiologists Over 2 Decades

Sandra J. Lewis, MD, a Laxmi S. Mehta, MD, b Pamela S. Douglas, MD, c Martha Gulati, MD, MS, d Marian C. Limacher, MD, e Athena Poppas, MD, f Mary Norine Walsh, MD, g Anne K. Rzeszut, MA, h Claire S. Duvernoy, MD, i on behalf of the American College of Cardiology Women in Cardiology Leadership Council

ABSTRACT

The American College of Cardiology third decennial Professional Life Survey was completed by 2,313 cardiologists: 964 women (42%) and 1,349 men (58%). Compared with 10 and 20 years ago, current results reflect a substantially lower response rate (21% vs. 31% and 49%, respectively) and an aging workforce that is less likely to be in private practice. Women continue to be more likely to practice in academic centers, be pediatric cardiologists, and have a noninvasive subspecialty. Men were more likely to indicate that family responsibilities negatively influenced their careers than previously, whereas women remained less likely to marry or have children. Men and women reported similar, high levels of career satisfaction, with women reporting higher satisfaction currently. However, two-thirds of women continue to experience discrimination, nearly 3 times the rate in men. Personal life choices continue to differ substantially for men and women in cardiology, although differences have diminished. (J Am Coll Cardiol 2017;69:452-62) Published by Elsevier on behalf of the American College of Cardiology Foundation.
Cardiologists

- 65% of women reported discrimination
  - 96% related to gender
  - 37% related to parenting responsibilities
- Women were less likely to be married or have children
  - Those that did were responsible for childcare
  - 57% of men’s partners provided all childcare

Lewis, et al. JACC 2017
Clinician-researchers

- 30% of women reported sexual harassment experiences, compared to 4% of men
  - Half reported a negative impact on confidence as a professional and reported these experiences negatively affected career advancement

Jagsi et al. JAMA 2016
Little change over time
Worst in medicine
Overlooked, tolerated
Under and poorly measured
Stalled on litigation
Effects compounded by race/ethnicity
NOT JUST HARASSMENT

The system that supports harassment is one of inequity
RETENTION & PROMOTION

- 46% Applicants
- 47% Matriculants
- 46% Residents
- 21% Full Professor
- 38% Faculty
- 16% Deans
LEADERSHIP

Plenty of moustaches but not enough women: cross sectional study of medical leaders.

BMJ 2015;351:h6311

19% mustaches

UNEXPLAINED $19,878 DIFFERENCE IN SALARY
# Compensation

Medical specialties with the **LARGEST** wage gaps between **MEN** and **WOMEN** in 2017

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Men 2017</th>
<th>Women 2017</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hematology</td>
<td>$392K</td>
<td>$314K</td>
<td>20% LESS</td>
</tr>
<tr>
<td>Occupational Medicine</td>
<td>$301K</td>
<td>$242K</td>
<td>20% LESS</td>
</tr>
<tr>
<td>Urology</td>
<td>$434K</td>
<td>$349K</td>
<td>20% LESS</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>$543K</td>
<td>$442K</td>
<td>19% LESS</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>$465K</td>
<td>$378K</td>
<td>19% LESS</td>
</tr>
</tbody>
</table>

Medical specialties with the **SMALLEST** wage gaps between **MEN** and **WOMEN** in 2017

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Men 2017</th>
<th>Women 2017</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colon and Rectal Surgery</td>
<td>$387K</td>
<td>$331K</td>
<td>14% LESS</td>
</tr>
<tr>
<td>Pediatric Infectious Disease</td>
<td>$203K</td>
<td>$173K</td>
<td>15% LESS</td>
</tr>
<tr>
<td>Pediatric Cardiology</td>
<td>$292K</td>
<td>$249K</td>
<td>15% LESS</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>$259K</td>
<td>$221K</td>
<td>15% LESS</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>$484K</td>
<td>$412K</td>
<td>15% LESS</td>
</tr>
</tbody>
</table>

**WOMEN EARNED $105K LESS, ON AVERAGE**
COMPENSATION

Salary Differences Between Male and Female Registered Nurses in the United States.

JAMA. 2015;313(12):1265-1267.
White  Asian  Underpresented Minorities in Medicine  Multiple Race  Other
sexual harassment has stronger relationships with women's well-being than other job-related stressors. Negative effects extend to witnesses, workgroups, and entire organizations.
WHY DOES THIS CULTURE PERSIST?
Science faculty’s subtle gender biases favor male students

*PNAS 2012 109 (41): 16474-16479*
Agentic traits valued

Career advancement sought

Agentic women penalized

Women behave communally
Interventional cardiologists

WHY?
- “Old boys’ club” culture
- Lack of female role models
- Gender discrimination/harassment
- Few job opportunities over a lifetime

COMPETENCE/LIKEABILITY DILEMMA

HEIDI vs “HOWARD”

...she is competent
  BUT
I don’t want to work for her.
I don’t really like her.

...he is competent
  AND
... I want to work for him.
.... I really like him.
Sex Differences in the Pursuit of Interventional Cardiology as a Subspecialty Among Cardiovascular Fellows-in-Training

Celina M. Yong, MD, MBA, MSc, a,b Freddy Abnousi, MD, MBA, MSc, b,c Anne K. Rzeszut, MA, d Pamela S. Douglas, MD, e Robert A. Harrington, MD, b Roxana Mehran, MD, f Cindy Grines, MD, g S. Elissa Altin, MD, c Claire S. Duvernoy, MD, h for the American College of Cardiology Women in Cardiology Leadership Council (ACC WIC) and the Society for Cardiovascular Angiography and Interventions Women in Innovations (SCAI WIN)
Five categories of attributes were identified as barriers to selecting an IC career. They are shown here according to beta value for the factor contribution, which means that the factors with the highest beta values contributed more to deselecting IC. This 5-factor model explains 62.4% of variance in the original variables accounted for by the factors. IC = interventional cardiology.
How Medicine Became the Stealth Family-Friendly Profession

Female doctors are more likely than other professionals to have children and keep working. The reasons offer lessons for other jobs.
Female Doctors Choose Specialties With Fewer Hours

For doctors under 45, the specialties with shorter average workweeks attract more women, and those with longer hours have more men.

WHAT DO WE GAIN BY FIXING IT?
THE BUSINESS CASE

How diversity correlates with better financial performance

McKinsey 2015
THE BUSINESS CASE

Diversity has a positive impact on many key aspects of organisational performance  
McKinsey 2015

- Improve decision making
- Win the war for talent
- Increase employee satisfaction
- Enhance the company’s image
- Strengthen customer satisfaction
Patients treated by female surgeons had lower odds of death 30 days post-op and no difference in length of stay, complications, or readmission rates vs. male surgeons.
Patient–physician gender concordance and increased mortality among female heart attack patients

Brad N. Greenwood\textsuperscript{a,1}, Seth Carnahan\textsuperscript{b}, and Laura Huang\textsuperscript{c}

\textsuperscript{a}Carlson School of Management, University of Minnesota–Twin Cities, Minneapolis, MN 55455; \textsuperscript{b}Olin Business School, Washington University in St. Louis, St. Louis, MO 63130; and \textsuperscript{c}Harvard Business School, Harvard University, Boston, MA 02163

Edited by Michael Roach, Cornell University, Ithaca, NY, and accepted by Editorial Board Member Mary C. Waters July 3, 2018 (received for review January 3, 2018)

We examine patient gender disparities in survival rates following acute myocardial infarctions (i.e., heart attacks) based on the gender of the treating physician. Using a census of heart attack patients admitted to Florida hospitals between 1991 and 2010, we find higher mortality among female patients who are treated by male physicians. Male patients and female patients experience similar outcomes when treated by female physicians, suggesting that unique challenges arise when male physicians treat female patients. We further find that male physicians with more exposure to female patients and female physicians have more success treating female patients.

issues are salient in the medical setting. We posit that these challenges exacerbate the difficulty of diagnosing and treating AMIs, such that physician–patient gender concordance contributes to better patient outcomes. We further argue that the benefits of gender concordance will be strongest for female patients due to the difficulty of diagnosing and treating AMIs in female patients. We find empirical support for these ideas, documenting that gender concordance between the patient and physician influences measurable, substantive outcomes like patient survival and length of stay during an AMI. Furthermore, this relationship is much stronger for female patients. Results suggest that medical providers may need to account for the possible challenges physicians (particularly male physicians) face when treating AMI patients of the opposite gender.
Fig. 1. Gender concordance and patient survival: results from Table 2, column 3, 90% confidence interval displayed. Estimates include controls and hospital quarter fixed effects. Covariates held at sample means. $n = 581,797$. 
HOW DO WE FIX THIS?
INTERNAL DRIVERS

• Visible prioritization from highest leadership
  • *Including repairing the leaky pipeline*

• Accountability to the community and stakeholders

• Targets for change known and progress shared

• “Champions” of change
The Path Forward: Calling On All Leaders to Be Ethical

Medical schools, hospitals, and healthcare organizations

- Calling on leaders in 4 key “gatekeeper” categories to:
  - Make workforce gender equity an ethical imperative
  - Prioritize and properly fund initiatives to close gender equity gaps

Medical societies

- Avoid critical thinking errors

Medical journals

- Use a systematic process and specific metrics to evaluate disparities

Funding sources

- Implement strategic interventions
Recruitment, Promotion and Retention of Women in Academic Medicine: How Institutions Are Addressing Gender Disparities

Phyllis L. Carr, MD, Christine Gunn, PhD, Anita Raj, PhD, Samantha Kaplan, MD, MPH, and Karen M. Freund, MD, MPH

aMassachusetts General Hospital, Women’s Health, Yawkey 4B, Boston, MA 02114

bBoston University School of Medicine, Department of Medicine, Women’s Health Unit, Boston, MA 02118

cUniversity of California, San Diego, 10111 North Torrey Pines Rd, MC-0507, La Jolla, California 92039

dBoston University School of Medicine, 72 East Concord St., Boston, MA 02118
Figure 1.
Programs in Recruitment, Promotion, and Retention by Social Level
Advancing women in science, medicine, and global health

Gender equity is not only a matter of justice and rights, it is crucial for producing the best research and providing the best care to patients. If the fields of science, medicine, and global health are to hope to work towards improving human lives, they must be representative of the societies they serve. The fight for gender equity is everyone's responsibility, and this means that feminism, too, is for everybody—for men and women, researchers, clinicians, funders, institutional leaders, and, yes, even for medical journals.

— The Lancet

The February 9, theme issue on advancing women in science, medicine, and global health, contains new international evidence on forms of gender bias in funding; women's attrition in clinical training programmes; the extent to which universities worldwide have actualised their public commitments to gender and ethnic diversity; and the relationship between women's leadership in science and the production of sex/gender-related research.

New analysis and commentary establish the importance of feminist and masculinity theories, and problematise organisational strategies for increasing gender diversity in medicine and science. The importance of intersectionality, learning from the Global South, and the under-recognition of women's experience of harassment and abuse are key themes.

Collectively, the theme issue lays out robust evidence to inform an action plan for institutional leaders to confront gender bias, improve diversity and inclusivity, and drive change. Strategies to redress inequalities are not just women's issues—they require the full participation of everyone in deeper explanations and solutions.
NIH apologizes for its failure to address sexual harassment in science

By LEV FACHER @levfacher and MEGAN THIELKING @meegophone / FEBRUARY 26, 2019
Half of women stated a “lack of opportunity” as the primary barrier to a career in IC.

Capranzano et al. Eurointerv 2016

Yong et al. JACC: Cardiovasc Interv 2019
EXTERNAL DRIVERS

- Donors
- Funders of research and educational programs
- Public and patients
- Academic and professional organizations
- TIME’S UP Healthcare
An initiative of the TIME’S UP Foundation, a 501(c)3 organization

- 50 founding members
- 14 advisors
- Medicine, nursing, research, healthcare administration, non-profit, and service
- Over 40 signatories, and growing...
• Raise awareness and knowledge about inequity and harassment and their effect on healthcare
• Make equity, inclusion, and safety central, visible, and urgent priorities
• Unify efforts across healthcare organizations and disciplines
• Improve standards for institutional responses to inequity and harassment
• Provide support for moving from structures to processes to outcomes
• Support & improve protections for targets of harassment