Closing the Gender Pay Gap in Medicine

A Roadmap for Healthcare Organizations and the Women Physicians Who Work for Them

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Editor
Amy S. Gottlieb
Associate Dean for Faculty Affairs
and Professor of Medicine and Obstetrics and Gynecology
University of Massachusetts Medical School – Baystate
Chief Faculty Development Officer
Baystate Health
Springfield, MA
USA

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Amy S. Gottlieb, MD, FACP
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Contributors

Valerie M. Dandar, MA Director, Medical School Operations, Association of American Medical Colleges, Washington, DC, USA

Kevin Eide, MDiv Associate Vice President, Financial Planning and Analytics, Medical College of Wisconsin, Milwaukee, WI, USA

Kimara Ellefson Vice President, Human Resources and Faculty Affairs (Interim), Medical College of Wisconsin, Milwaukee, WI, USA

Amy S. Gottlieb, MD, FACP Associate Dean for Faculty Affairs and Professor of Medicine and Obstetrics and Gynecology, University of Massachusetts Medical School – Baystate, Springfield, MA, USA

Chief Faculty Development Officer, Baystate Health, Springfield, MA, USA

Diana M. Lautenberger, MA Director, Faculty and Staff Research, Association of American Medical Colleges, Washington, DC, USA

Kristin Morales-Lemieux, MBA Senior Vice President and Chief Human Resources Officer, Baystate Health, Springfield, MA, USA

Brita Roy, MD, MPH, MHS Assistant Professor of Medicine, Yale School of Medicine, New Haven, CT, USA

Assistant Professor of Epidemiology, Yale School of Public Health, New Haven, CT, USA

Director of Population Health, Yale Medicine, New Haven, CT, USA

Patricia A. Washienko, JD Freiberger and Washienko LLC, Boston, MA, USA

Chapter 1
Introduction: How Healthcare Organizations Can Benefit from a Road Map to Close the Gender Pay Gap

Amy S. Gottlieb

For the first time in history, the number of women exceeds the number of men in US medical schools. In fact, for four decades, women have represented a significant proportion of medical school graduates and currently account for almost half of graduate medical trainees (i.e., residents and fellows) and over a third of active physicians nationally [1]. Despite these numerical gains in representation, women physicians continue to experience well-documented disparities in opportunity and compensation within our profession [2–10]. These inequities are interrelated, and addressing one successfully necessarily implies understanding and mitigating the others.

In the United States, women physicians earn 75 cents on the dollar compared with their male counterparts, even after accounting for specialty, geography, time in practice, and average hours per week worked [10]. This pay gap is significantly greater than the one reported for women workers as a whole [11] and has shown little improvement over time [9, 10, 12, 13]. Compared with other occupations, physicians experience one of the largest gender pay gaps in the country [14].

Women physicians earn less than men in every specialty and at every academic rank [9, 10]. Salary inequity is more pronounced among employed physicians [10], which is particularly concerning given the industry-wide trend toward hospital and health system employment instead of practice ownership [15]. Additionally, salary differences between men and women physicians begin right out of training and persist after controlling for every imaginable contributing factor [8, 16, 17]. If national trends apply, women physicians of color likely experience even greater pay disparities [18]. Amidst this concerning landscape, there has been a proliferation of commentary, in both the lay press and academic literature, identifying ways in

A. S. Gottlieb (✉)
Associate Dean for Faculty Affairs and Professor of Medicine and Obstetrics and Gynecology, University of Massachusetts Medical School – Baystate, Springfield, MA, USA

Chief Faculty Development Officer, Baystate Health, Springfield, MA, USA

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which men and women are perceived, treated, and compensated differently within the medical profession. What has been missing, however, is a robust discussion about how to rectify the situation.

Inequitable pay is a challenging juggernaut as it likely represents a convergence of all forces that diminish women's professional value within our healthcare institutions. As Fig. 1.1 depicts, multiple factors contribute to how we as a profession (and as a nation) got to the point where we compensate half our workforce significantly less than the other half. Thus, it is critical to identify, acknowledge, and address these contextual forces as we set about correcting the practice of paying equally talented women physicians less than their male counterparts. Relying on robust evidence, we must thoughtfully and methodically dispel false narratives that seek to justify the gender pay gap and potentially derail fruitful approaches to eliminating disparities. Ultimately, however, compensation is a business endeavor. As such, there needs to be a road map for operationalizing equity within the finance, human resources, and compliance structures of our healthcare organizations. Our contributing authors – experts in the fields of compensation, employment law, human resources, and gender equity – have taken up that mantle in the following chapters. Each of us intends this book to be a step-by-step guide for organizations seeking to examine their policies and revise their practices to close the gender pay gap among their physician workforce.

Our road map begins with an evidence-based discussion of how gender-based differences in performance assessments, specialty choice, domestic responsibilities, negotiation, professional resources, sponsorship, and clinical productivity

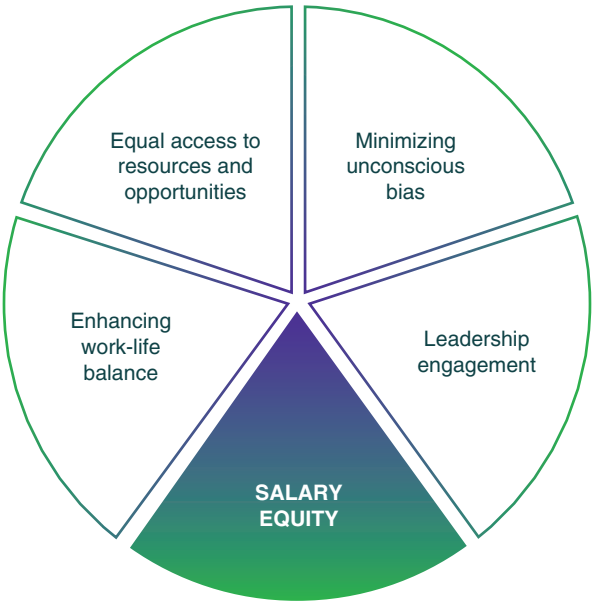

Fig. 1.1 Understanding compensation disparities. (Reprinted with permission from Dandar et al. [9])

accumulate across women's careers in medicine and impact evaluation, promotion, and therefore compensation in the healthcare workplace. Next, we describe traditional physician compensation models and explore how these pay programs support conventional practice styles that disproportionately monetize characteristics more commonly displayed by male physicians. Since organizational leaders seeking to narrow the gender pay gap must be aware of the legal context surrounding this type of endeavor, Chap. 4 provides a robust review of relevant statutory imperatives like the Equal Pay Act, Title VII of the Civil Rights Act of 1964, and state laws that prohibit gender discrimination in employment. Importantly, this chapter explains nuances of how claims under each statute differ in scope and impact and also addresses how the Stark Law, Anti-Kickback Statute, and Internal Revenue Code impose restrictions on physician compensation.

Salary equity initiatives require intentionality, vision, and longitudinal planning. Organizations must employ change management models and techniques to create governance structures, anticipate responses to pay initiatives, and communicate compensation goals and progress. Building on these change management principles, Chap. 5 describes how to install infrastructure and conduct robust salary studies to identify baseline inequities, ensure reliable analysis, and facilitate organizational trust and forward movement in closing the gender pay gap. Chap. 6 details specific strategies healthcare enterprises can adopt to support the culture change necessary to identify and address biased workplace expectations that may be unintentionally sustaining the disparities discovered in salary studies. Lastly, the road map culminates with a chapter describing the efforts of one medical institution that has successfully made the journey from identifying compensation equity as a high-priority, organizational objective to creating the infrastructure, assessments, and policies necessary to support this enterprise mission.

It is likely that few in our industry would argue with the moral imperative of paying people equally for equal work and most understand that harnessing the talent of the entire workforce is a sound business practice [19–21]. It is how to achieve these goals that overwhelms institutions and their leaders. Helping healthcare enterprises plan courses of action and identify potential pitfalls so they can be understood and mitigated is essential to eliminating the gender pay gap in medicine. For finance, human resources, and other business leaders in healthcare, the road map detailed in this book will break down the component parts of compensation methodology to reveal their unintentional impact on salary equity and then lay out processes and procedures that support new approaches to generate fair and equitable outcomes. For Deans and CEOs, the following chapters will serve as a resource for transformational leadership anchored in change management principles that address institutional culture and provide momentum toward salary equity through enhanced communication and accountability. We thank you all, in advance, for your commitment to closing the gender pay gap in medicine and for inviting us to share our knowledge and experience with you.

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Chapter 2
Organizational Culture, Practices, and Patterns of Interaction that Drive the Gender Pay Gap in Medicine: Second-Generation Gender Bias and Other Complexities

Brita Roy and Amy S. Gottlieb

As we seek to eliminate the gender pay gap in medicine, we must consider the context in which this disparity arises. In order to be successful and sustainable, a new approach to compensation should identify, understand, and ultimately address all potential drivers of inequity. A priori, one might reasonably believe that the pay gap between men and women in medicine is explained by the types of choices women make in medical training and the workplace, e.g., decisions about which specialty to pursue, how many hours to work per week, and how to allocate their professional time. Although this narrative may seem plausible, it is inaccurate, and current research refutes it [1–4].

B. Roy (✉)
Assistant Professor of Medicine, Yale School of Medicine, New Haven, CT, USA

Assistant Professor of Epidemiology, Yale School of Public Health, New Haven, CT, USA

Director of Population Health, Yale Medicine, New Haven, CT, USA
e-mail: brita.roy@yale.edu

A. S. Gottlieb
Associate Dean for Faculty Affairs and Professor of Medicine and Obstetrics and Gynecology, University of Massachusetts Medical School – Baystate, Springfield, MA, USA

Chief Faculty Development Officer, Baystate Health, Springfield, MA, USA

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In 2018, E.A. Apaydin and colleagues published the most robust study to date on drivers of the gender pay gap in medicine [1]. The authors surveyed 656 physicians in 30 practices in six states about their annual incomes, demographics, professional time allocation and foci, compensation models, and practice types. Two hundred sixty-three men and 176 women participated in the study, resulting in a 67% response rate. Investigators identified a raw income difference between men and women of almost $100,000 per year (men earning more than women). Men indeed worked more hours, did more procedures, and provided less primary care than women. However, after adjustment for these and all other possible contributing factors, a $27,000 pay gap remained.

There is evidence that an unexplained income gap starts at the beginning of a woman physician's career trajectory and increases over time: Lo Sasso and colleagues examined salaries of approximately 17,000 physicians starting clinical positions immediately after completion of residency training in New York State and reported unadjusted sex-based differences of $24,400 in 1999 and $48,200 in 2017 [2]. Hypothesized mediators such as specialty choice and work-life balance preferences did not explain 39% of the difference. Additionally, the unexplained portion increased over the 1999–2017 time period. What is driving the residual compensation disparity observed in the Apaydin and Lo Sasso studies and prior investigations? This chapter describes the organizational culture, practices, and patterns of interaction within medicine today that are the engines behind this pay gap.

Second-Generation Gender Bias

In the twenty-first-century workplace, federal statutes, state laws, and organizational policies prohibit overt acts of discrimination. However, implicit expectations and unconscious gender stereotypes continue to dictate a professional culture that inadvertently benefits men and disadvantages women [5–8]. In medicine, male physicians are expected to be decisive, assertive, and independent and therefore are readily afforded authority, respect, and opportunity. Women physicians, however, must balance long-standing social expectations to be nice, caretaking, and other-focused while carrying out the requisites of being a competent clinician, researcher, educator, and/or administrative leader. Considered "second-generation gender bias," these cultural assumptions are not intentional or overt. However, they impact how women are evaluated, promoted, and therefore compensated in the healthcare workplace. Although equal numbers of men and women now matriculate into medical school, biases threaten the equity typically associated with numerical parity, systematically limiting women's professional advancement in medicine via career choices, job prospects and negotiations, greater domestic responsibilities, and leadership opportunities (Fig. 2.1).

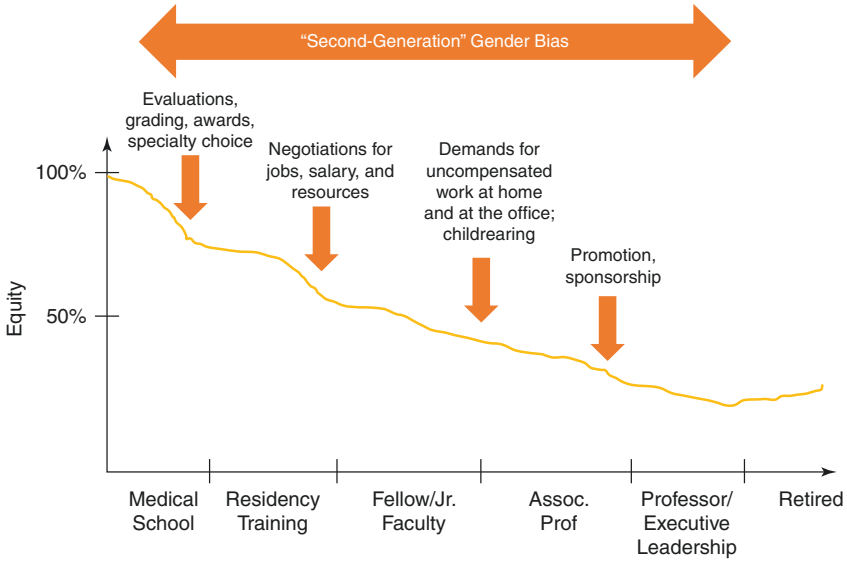

Fig. 2.1 How second-generation gender bias cumulatively erodes equity and opportunity throughout women's careers in medicine

Evaluations, Awards, and Recognition

Beginning in medical training, implicit gender expectations influence performance assessment. Although a systematic, multi-institutional study of gender bias in medical school has yet to be performed, existing literature suggests inequities. A retrospective review of medical student theses over 13 years at a single institution reported that, although women authored 51% of research theses, they were less likely than their male counterparts to receive highest honors [9]. This disparity persisted after controlling for multiple factors associated with achieving high honors including completing a fifth year of school, pursuing a joint masters in health science degree, securing competitive research funding, and working with a mentor with a history of three or more thesis honorees. Additionally, a survey of 2395 medical students from 105 schools reported that women received higher grades in obstetrics and gynecology and psychiatry and lower grades in surgery, historically a male-dominated specialty [10]. Taken together, this research implies that second-generation gender bias in medical school exists and results in accolades amidst traditionally female endeavors and less recognition in stereotypically male domains like surgery and research.

Specialty "Choice"

Unconscious stereotypes and gender norms experienced in medical school may deter women from pursuing procedural specialties. Women report machismo or an "old boy" attitude observed among surgeons and more sexual harassment in general surgery clerkships than their male counterparts [11]. Compared with men, women are discouraged by the lack of same-sex role models in surgery. The effects of these experiences may be confounded by the decision to have a family and the expectation that subsequent demands will hamper career plans [11, 12]. Although most men and women report feeling surgeons have poor work-life balance, women are more likely to cite this reason for not pursuing a career in the specialty [11]. Additionally, cognitive specialties may be perceived to have better work-life balance. To that end, implicit cultural expectations may discourage women from considering an array of medical specialties and urge them toward pediatrics, family practice, and obstetrics and gynecology [13].

Women are currently overrepresented in non-procedural, less remunerative specialties. This phenomenon may seem to explain the observed gender pay gap. However, research that has controlled for specialty, practice, and workload variables still uncovers disparities [1]. Furthermore, studies examining pay distributions *within* non-procedural specialties demonstrate that gender disparities in pay exist. For example, among primary care physicians, general internists, internal medicine residency program directors, and hospitalists, women are paid significantly less than men within the same field [14–16]. Among general internists, white women earned $36,609 (19%) less and black women earned $56,452 (29%) less than white men physicians after accounting for similar work effort and provider and practice characteristics [14]. These findings suggest that disparities in compensation are compounded along gender lines: not only are women overrepresented in lower-paid specialties, but also they are paid less within those specialties.

Clinical Productivity Measures

Physician compensation in the United States is largely based on clinical productivity, and this traditional approach to salary determination potentially disadvantages women. Specifically, clinical productivity is measured in work relative value units (wRVUs), and in aggregate, women physicians have been shown to produce fewer wRVUs [17]. This disparity is explained only in part by the difference in number of hours worked. Women physicians have been observed to spend more time with patients, reflecting patient-centered communication styles and increased focus on psychosocial lines of inquiry compared with male colleagues [18]. Although women physicians have demonstrated achievement of better patient health outcomes, their clinical volume is potentially compromised by such patient focus and attention to broader determinants of health [19, 20]. However, perhaps because patient-centered communication is a gender-congruent expectation, women physicians do not get the same amount of "credit" for patient-centeredness on subjective patient experience

surveys as their male colleagues, calling into question the validity of using patient ratings as a marker of healthcare delivery excellence [21]. These findings beg the question, are healthcare organizations defining "productivity" correctly or are we unintentionally penalizing women for the care they deliver?

Domestic Responsibilities

Women physicians assume more domestic responsibilities compared with their male counterparts, which may take away time from clinical duties, grant applications, manuscript preparation, and opportunities for networking and professional development [22]. Women physician-researchers early in career are more likely than men to have spouses or partners who work full-time [23]. Among those who are partnered with children, women physicians spend 8.5 more hours than men physicians on domestic responsibilities and are more likely to take off work when disruptions in childcare occur. Among physician couples with children under the age of two, men work 55 hours per week, compared with 41 hours per week for women [24]. As children get older, there is no difference in hours worked between men with and without children, while women with children work fewer hours than women without children. Even among dual-physician households without children, men work on average 57 hours per week, compared with 52 hours per week for women. Additional data from the US Census reveals that female physicians in dual-physician households have lower incomes and work fewer hours outside the home than female physicians in single-physician households [25]. Moreover, among all female physicians, the average number of paid work hours decreases as the male spouse's paid work hours increase, signaling female physicians may be making professional adjustments to tend to household responsibilities.

Childbearing and the "Mommy Tax"

More women physicians are having children during residency training, and research reveals they are insufficiently supported during this major life event [26]. A study of 15 graduate medical education training programs found that only half have policies providing paid childbearing or family leave time, and the mean duration of total paid maternity leave time is 6.6 weeks, which is lower than the mean of 8.6 weeks provided to faculty at the same academic institutions [27]. (Both are below the 12 weeks currently recommended by the American Academy of Pediatrics.) In addition, many residency programs require women to make up call and condense scheduling shifts prior to the start of maternity leave. Such increased work hours and short leave time may be detrimental to maternal and child health. Women who take maternity leave may also experience delays in completion of residency because of medical specialty boards' strict requirements about number of months of training [28, 29]. Because residency and fellowship programs align with an academic calendar, beginning July first of each

year, any delay in residency graduation may result in missing an annual cycle for initiating fellowship training, potentially impacting a woman's competitiveness or eligibility for fellowship (and long-term earning potential).

Less than one-third of women attending physicians have maternity leave included in their most recent contracts [30]. Additionally, more than half report losing $10,000 in income because of maternity leave with no significant difference between procedural and non-procedural fields. Women physicians in procedural specialties are more likely to report negative impact on referrals associated with maternity leave, being required to complete missed shifts, and owing money to their practice. More than one-third of women with children report experiencing maternal discrimination, with 90% attributing the discrimination to being pregnant or taking maternity leave and 48% to breastfeeding [31]. Women describe being excluded from administrative decision-making and being passed over for leadership positions because of pregnancy or upon returning from maternity leave [32]. Other financial consequences of having children include the necessity of switching to part-time work, leaving academic or private practice due to a hostile work environment, and being denied salary increases or bonuses due to maternity leave despite meeting productivity goals. Data from the Bureau of Labor Statistics support these claims, revealing that women with children earn less than women without children [33].

The "Likability Paradox" and its Downstream Effects

Implicit gender norms underlie our collective tendency to use unfavorable adjectives when evaluating women in the workplace compared with men of equal qualification [34]; to designate women job applicants as less competent, hirable, and mentorable than men with the same resume [35]; and to address women physicians by their first names and male physicians as "Doctor" [36]. These unconscious assumptions also influence how work is assigned, valued, and compensated within organizations and are the likely engine behind women's stalled career advancement and the gendered career paths we continue to observe in healthcare and other industries.

Letters of recommendation for medical school faculty positions differ systematically by gender [37]. Letters written for women tend to be shorter and lack specificity and detail about the record of the applicant. They are also twice as likely to include negative phrases or phrases that raise doubt. Presumably, these factors are partly responsible for the fact that women in academic medicine receive fewer resources at the start of their career. Among junior biomedical researchers, women's start-up packages have been shown to be $539,000 less than men's [38], even after accounting for differences in degree, experience, or institutional characteristics.

Based on traditional gender norms of prioritizing others over self-interest, women are not expected to advocate for themselves [6, 7, 39], and there are well-described social penalties when asking for salary and resources [40, 41]. Although likely unintentional and unconscious, such organizational and interpersonal consequences compromise women's ability to obtain equitable and appropriate compensation.

Gender-based differences in salary and resources at the beginning of academic women physicians' professional trajectory initiate a cascade of events that impacts advancement and compounds pay disparities over a career, resulting in large salary inequities among the most senior faculty [42]. When women receive smaller start-up packages and less protected time for research, they may have inadequate time to prepare manuscripts for publication and secure grant funding. Though the rates of publications in high-impact journals authored by women have increased over the past few decades, a gender gap remains, with less than one-third of citations authored by women [43, 44]. Gender-based differences in publication rates during early career have profound implications for subsequent citation of women's work [45].

Gender differences also exist in the granting of career development awards by the National Institutes of Health: fewer than half of K08 and K23 recipients are women [46]. Among first-time R01 applicants, women physician-investigators are less likely to be successful than men. Additionally, among career development awardees, fewer women than men successfully obtain R01 funding at 5 and at 10 years, even after controlling for type of and year of K award, specialty, funding institute, and institution tiers. R01 applications submitted by women principal investigators (PI) are scored lower than applications submitted by men, despite similar narrative evaluation of methodology [47]. Moreover, women PIs receive lower scores on priority, approach, and significance, even after adjustment for level of experience, funding outcome, priority score, and interactions among PI sex, experience level, and funding outcome. Indeed, among all R01s awarded to MDs and MD/PhDs, less than one-third are led by women principal investigators [48]. Advancement in academic medicine (and perhaps healthcare writ large) is largely driven by publication in high-impact journals and the amount of independent grant funding obtained. As such, these phenomena likely contribute to the observed gender disparities in organizational and academic promotion.

Less Sponsorship for Women

Sponsorship differs from mentorship in its focus on career advancement and spotlighting highly talented individuals. Despite decades of near equal numbers of men and women graduating from medical school, only 18% of medical school deans, 18% of department chairs, and 25% of professors are women [49]. Similarly, women represent only 13% of chief executive officers, 29% of chief operating officers, and 23% of chief financial officers in healthcare [50]. Women receive less sponsorship than men, which limits their visibility, credibility, and upward mobility within organizations [51–55]. Lack of sponsorship may also underlie the tendency of women to pursue advancement in areas that are consultative or supportive, like human resources or faculty affairs, rather than those with budgetary or managerial responsibility, like chief operating officer or associate dean for clinical affairs, that are incubators for the highest rungs of leadership and compensation [50, 56–58]. Additionally, women are asked to assume greater responsibility for organizational service and citizenship tasks. Time and effort to accomplish these endeavors are typically not tracked and therefore are not evaluated or compensated [59–61].

Summary

Implicit gender bias, sometimes referred to as second-generation gender bias, leads to disparities in performance evaluation, allocation of resources, and workplace expectations for women in medicine compared with male colleagues with equal training and specialization. Such unconscious gender stereotypes contribute to stalled advancement and lower compensation. Understanding second-generation gender bias and its myriad manifestations within an organization's structure and practice is the necessary first step to addressing pay equity.

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Chapter 3
How Compensation Is Determined and Potential Pitfalls for Pay Equity

Kristin Morales-Lemieux

Compensation is derived from cash and noncash components and is commonly described using the terms total cash compensation and total remuneration. Total cash compensation includes base salary, bonuses and incentives, and other cash payments such as stipends for administrative duties and clinical call. Total remuneration includes total cash compensation plus employee benefits such as the employer-paid portion of health and dental coverage and retirement contributions. It is the total remuneration, together with the work effort required to perform the duties of a position, that must be evaluated in order to understand and compare compensation levels. In this chapter, we will look briefly at physicians as owners and then focus in detail on compensation models commonly used for employed physicians. In each circumstance, we will discuss how these models work differently for men versus women physicians and the inequities that can occur as a result.

Employee Versus Owner

For the first time in history, the number of physicians working as employees has outpaced those who identify themselves as practice owners. According to an American Medical Association (AMA) study published in 2019, 47% of practicing physicians are employees, while only 46% own their practices. This phenomenon is particularly relevant for women physicians: only 34% are practice owners compared with 52% of men. Furthermore, the AMA study included only physicians working 20 or more hours per week, potentially underrepresenting the percentage of

K. Morales-Lemieux (✉)
Senior Vice President and Chief Human Resources Officer,
Baystate Health, Springfield, MA, USA
e-mail: Kristin.Morales-Lemieux@baystatehealth.org

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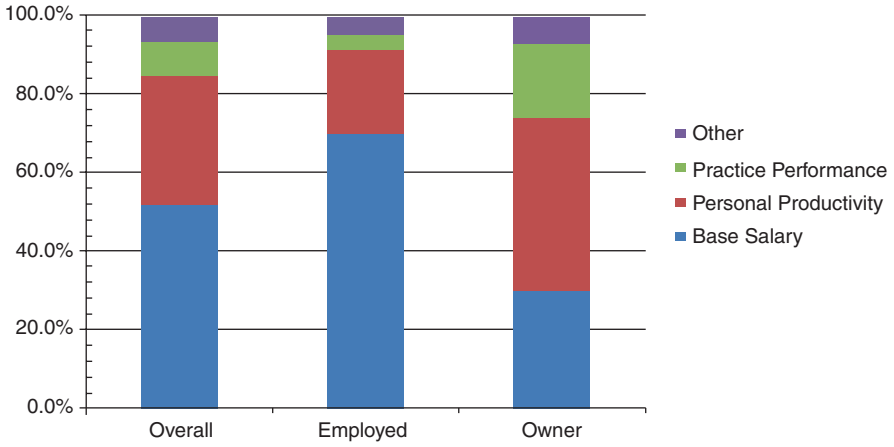

Fig. 3.1 Composition of physician compensation. (Adapted from [3])

employed women physicians [1]. Since physician-owners of practices report higher earnings overall, the lower representation of women in this sector likely contributes to the observed gender pay gap [2]. While detailed studies have not been conducted to determine the engine behind the higher number of male physicians in ownership roles, practice ownership has always been less common among younger physicians. With 22% of women physicians under the age of 40 compared with 12% of male physicians, age-related demographics may be a driver of this ownership disparity [1]. Additionally, women tend to practice in specialties with relatively high rates of employed physicians (e.g., pediatrics).

For practice owners, physician compensation tends to focus less on base salary and more on bottom-line performance. While employed physicians receive an average of 70% of their compensation in base salary, only 30% of physician-owners' compensation is derived from this source [3] (Fig. 3.1).

The compensation formula in private practice may seem bias-free in its focus on bottom-line performance; however, the allocation of administrative and management duties as well as practice-style differences between male and female physicians impacts individual productivity and therefore compensation. We will discuss these phenomena in greater detail later in the chapter.

Employed Physician Compensation Models

Given that the majority of US physicians work as employees, this chapter will focus on common compensation models for employed physicians to identify how their components may contribute structurally to gender-based salary inequities. There

are a number of plans in the market, and most include a base salary and a cash-based incentive. Less common compensation models include the profit/loss-based plans and capitation and risk-based compensation models, which we describe briefly below.

Profit/loss-based plans closely mirror a physician-owner's compensation structure by paying physicians based on revenue generated by professional activities minus costs associated with overhead to run a practice and to cover benefits. This model has become less popular as physicians seek employment [4]. Profit/loss-based plans may also disproportionately disadvantage women physicians by focusing heavily on revenue-producing activities and apportioning a heavy expense load onto part-time practice hours, potentially contributing to the gender pay gap since more than 22% of women physicians report working part-time compared with only 5% of male physicians [5].

Capitation and risk-based compensation models have begun to infiltrate markets in which health systems are moving away from fee-for-service insurance payment arrangements. Under a capitation compensation model, physicians are paid according to the number of patients attributed to them in insurance panels at an amount that reflects the profitability of the insurance contract rather than the units of billable service they produce. Similarly, in risk-based or shared-savings compensation models, some or all of the physician's compensation is derived from managing the cost of care in patient populations to generate savings over the insurance contract's budget. These savings, in turn, are distributed to physicians and comprise all or part of their total compensation. While these plans have been slow to take hold, they may mean good news for women physicians who have been shown to perform better than their male counterparts in quality measures and adherence to evidence-based guidelines [6–9]. Such factors are success drivers in alternative payment scenarios, and faster adoption of physician compensation models that reward these achievements could work to narrow the gender wage gap.

Base Salary and Incentive Compensation

Despite healthcare's gradual shift from fee-for-service-based reimbursement to value-based, risk-sharing payment arrangements, compensation structures for employed physicians remain heavily reliant on base salary plus productivity-related incentives. According to the AMA, 92% of total cash compensation among employed physicians in the United States is attributed to base plus personal productivity [3]. The remaining 8% of total cash is derived from administrative stipends, quality, safety, patient satisfaction, and sharing in risk-based contract surpluses (see Fig. 3.1). Because of this model's prevalence, we will focus the majority of the following analysis on it.

Base Salary

As stated above, the largest portion of total cash compensation for employed physicians is base salary, representing nearly 70% of total. Therefore, understanding the methodology used to establish and maintain base salaries is critical to closing the gender pay gap.

Organizations generally utilize commercially available benchmarking data from national consulting firms and professional associations to determine physician pay scales. Doing so provides institutions guidance on competitive wage requirements and also furnishes data to assist in determining fair market value and commercially reasonable compensation for employed physicians, information necessary to maintain compliance with federal fraud and abuse laws governing financial relationships between physicians and hospitals. Some examples of common benchmarking data sources include the Medical Group Management Association (MGMA), the Association of American Medical Colleges (AAMC), Sullivan Cotter, and Integrated Healthcare Strategies. Physician salary benchmarking surveys are released on an annual basis and stratify compensation levels based on specialty and market percentiles. They often include thousands of respondents for each specialty area and provide salary information by specialty according to geographic regions and practice types. Within base salary ranges, however, there is often a considerable difference between the dollar amounts at the low and high ends of the range, allowing organizations a wide berth in making compensation determinations.

In addition, physician pay ranges are influenced by supply and demand in individual marketplaces. In regions where patient demand is high for certain types of care (e.g., primary care), organizations can find themselves competitively bidding for physician hires against other healthcare enterprises. This increased competition can result in physician pay scales that are at the top of, or at times exceed, the benchmarking data.

Where individual physicians fall within established pay ranges depends on a variety of factors that may be vulnerable to gender bias. Salary expectations and vigorousness of negotiations during initial hiring are significant in determining both current salary and future earnings. It is here that we see a potential sandtrap for women who may have lower expectations of what an ideal salary should be, may lack confidence in their skills as negotiators, or may be penalized for negotiating. Research reveals that the pay gap between women and men physicians begins right out of training and these initial disparities have considerable long-term financial impact [10–12]. In an investigation of general surgery residents published in 2019, women had, on average, a $30,000 per year lower salary expectation than their male counterparts. The estimated effect of this difference in negotiated pay for the first position out of residency would translate into $900,000 of earnings across a physician's career. Among the same group of residents, 19% of women reported they had the skills necessary to negotiate their pay, while 32% of their male counterparts stated they had the tools to achieve the salary they desired [12].

Evidence reveals that women engage in salary negotiations as frequently as men, and so a personal reluctance to negotiate is not the likely driver behind gender disparities in base salary [13, 14]. However, numerous studies have shown that women experience backlash in the workplace when they exhibit self-advocating behaviors that are traditionally associated with being male. Implicit cultural expectations about how women should behave impede their ability to negotiate successfully, and as such, the burden of salary inequity lies beyond the control of individual women to fix. Instead, organizations will need to address this systematically.

Most institutions rely on the following criteria to establish individual physician base salary within the benchmarked pay ranges. These metrics may also unintentionally drive gender-based compensation inequities.

Years of Experience

Many organizations place physicians higher within pay ranges to reflect their experience, which is typically measured both in terms of number of years practicing medicine and working for the organization. Since 22% of practicing women physicians are under 40 years old, compared with only 12% of practicing men under 40, women as a whole are disadvantaged in terms of achievable salary based on this metric [1].

Prior Earnings

While somewhat related to experience, the recognition of prior earnings in setting base salaries is a distinct contributor to base salary consideration and may have a disproportionate impact on pay inequities. The initial salary negotiated by physicians entering the workforce can have lasting effects on future earnings because of the consideration given to past salaries in developing future offers. Recent legislation enacted in the Commonwealth of Massachusetts and several other states, including California, seeks to mitigate this phenomenon by making it impermissible for organizations (or their agents) to discuss current and past pay during salary negotiations for new employees [15]. This legislation was crafted specifically to address the gender bias inherent in salary history and the impact it could have on lifetime suppression of wages for women across all occupations, including physicians.

Professional Reputation

Physicians with national-level recognition in their fields, large referral networks, or considerable patient followings are often rewarded with higher base salaries because of the value they bring to their employer organization. Academic rank, research impact, medical education accomplishments, clinical contributions, and recognition

in one's discipline support a professional reputation that often translates into higher salary. For women, the myriad of barriers to achievement in these arenas, as described in other chapters, limit the salary benefit that accrues to this driver of compensation.

Leadership

Physicians who rise to academic and institutional leadership roles typically receive higher compensation. While women account for 36% of practicing physicians in the United States, they comprise only 13% of healthcare CEOs and 18% of departmental chairs and deans [16–18]. Because women in healthcare experience stalled organizational and academic advancement, as detailed in other chapters, they disproportionately reside in roles with lower earning potential.

Productivity

While productivity considerations weigh heavily into incentive compensation models, they may also contribute to the determination of base salary. Physicians may be slated into compensation ranges based on where they fall in the corresponding productivity range. For example, an individual producing at the 25th percentile of her specialty's clinical benchmark could be designated to receive base compensation at the 25th percentile. Time away from the office for parental leave and other domestic responsibilities can diminish women's ability to equal their male counterparts' clinical and academic productivity. In addition, the practice pattern of women physicians may impact the number of patients seen (and therefore clinical productivity as traditionally defined). This phenomenon is explored further in the productivity-based incentives discussion below.

Citizenship

Citizenship or service-related activities include attending department meetings and grand rounds, participating in committees and other organizational initiatives, coordinating call schedules, and mentoring faculty, trainees, and staff. Many of these endeavors require significant time and effort, typically without compensation, and present specific challenges for women physicians. In the workplace, women are expected to volunteer for these organizational service tasks more than their male colleagues, potentially taking time away from compensable and promotable work [19–21]. Furthermore, women who do opt out of such activities because of additional responsibilities at home may have their commitment to the organization questioned.

Organizations vary in how often they analyze and adjust physician base salaries, potentially creating long periods of time without merit or market-based

adjustments. With the average direct financial loss per employed physician, defined as the net revenue each physician produces minus the expenses of operating a practice (including salary and benefits of the physician and support staff, supplies, rent, etc.), estimated to be approximately $200,000 per year, employers may be reluctant to increase physician salaries on a routine basis [22]. (This number does not account for the value employed physicians bring to their employers in terms of ancillary services they order, referrals they make, etc.) Although one option could be to hold base salary at risk and make downward adjustments when performance and productivity requirements are not met, concerns about losing physician employees to competitors make this tactic less appealing. The reluctance to redistribute salary dollars based on performance or market forces could maintain inequities in pay longer than we might see in occupations where workers are regularly evaluated on performance and receive wage adjustments in recognition of achievements and marketplace dynamics.

Incentive Compensation

For most physicians, incentive compensation is an important component of total cash compensation, comprising an average of 25% for employed physicians and 63% for physician practice owners [3]. By nature, incentive compensation is at risk and variable based on individual and group performance. Typically, it is composed of multiple components, with the largest opportunity generally reflective of an individual productivity goal (see Fig. 3.1). In many organizations, employed physician productivity is synonymous with clinical productivity and is measured through the use of work relative value units (wRVUs), which assign a numerical value to every billing code based on the Centers for Medicare and Medicaid Services (CMS) schedule used to calculate Medicare fees. Other types of clinical productivity-based goals are patient visit goals, gross or net revenue goals, and other quantifiable unit-of-service or financial metrics. These measurements are less popular in employed environments as the wRVU is largely insulated from factors outside of the direct control of physicians such as payer mix, patient scheduling, and the organization's efforts around billing and collections. Physician-owners are much more likely to have their productivity incentive based on actual practice collections.

Productivity-based incentive plans can create challenges for physicians who spend disproportionate amounts of time engaging in activities that are not drivers of wRVUs or other sources of revenue (e.g., research funding). Examples include consulting with colleagues, teaching and mentoring, performing administrative service-related tasks like managing a team's call schedule, and non-visit-related patient interactions such as telephone calls and emails. According to Medscape's 2019 Physician Compensation Survey, women in both primary and specialty care reported dedicating fewer hours per week to direct patient care than their male counterparts and more hours per week on administrative duties [2]. Because these activities are often invisible, cannot be easily quantified, and are generally not

direct revenue generators, they are often undervalued and non-compensable. Additionally, reduced time in direct patient care has a cumulative effect on overall compensation levels as clinical productivity often represents the majority of incentive compensation and, as mentioned above, may be a component of base salary too. The tendency of women physicians to spend more time with patients, focusing on shared decision-making, disease prevention, and education rather than the number of patient encounters, further exacerbates the divide in productivity achievement [23].

In some organizations, one must attain a certain threshold of individual productivity to qualify for non-productivity-based incentives. In this scenario, a physician must generate a minimum number of wRVUs in order to qualify for any incentive payments. Such a requirement could leave a physician who is achieving high levels of quality, patient satisfaction, and participation in organizational initiatives without any financial reward for her efforts if she failed to achieve the required clinical productivity.

As physician practices and health systems begin to transition from a fee-for-service environment to a population-health-based payment system where quality and total medical cost are valued over quantity of services provided, incentive plans are starting to move beyond simple clinical productivity-based measures. Examples of alternate measures are quality scores (e.g., Healthcare Effectiveness Data and Information Set (HEDIS), healthcare-acquired infection (HAI) rates) and patient panel growth goals. Since women physicians have been shown to generate higher quality and patient outcomes (e.g., readmission and mortality rates), these new approaches to compensation could be beneficial [6]. Unfortunately, movement is slow, with the percentage of physicians participating in alternative payment models approximately 10% nationally [2].

Compensation structures for employed physicians are also not changing to keep pace with the evolution of healthcare economics, and this lag continues to leave women in the lower ends of the pay ranges. While alternative payment models represented 34% of healthcare dollars paid to providers in 2017 by commercial plans, Medicare, and Medicaid, physicians report only 8% of compensation based on criteria other than base pay and productivity-based incentives (see Fig. 3.1) [3, 24]. Given the evidence supporting superior quality and clinical outcomes, modifying compensation strategies to reward women's performance commensurate with percentage contribution to revenue in these spheres could be one avenue to narrowing the gender pay gap.

Impact of Part-Time Work on Salary

A greater percentage of women physicians work in part-time capacities than male physicians [5]. In general, employers prorate salaries for less than full-time work. For example, if the base salary for a full-time equivalent (FTE) position is $250,000

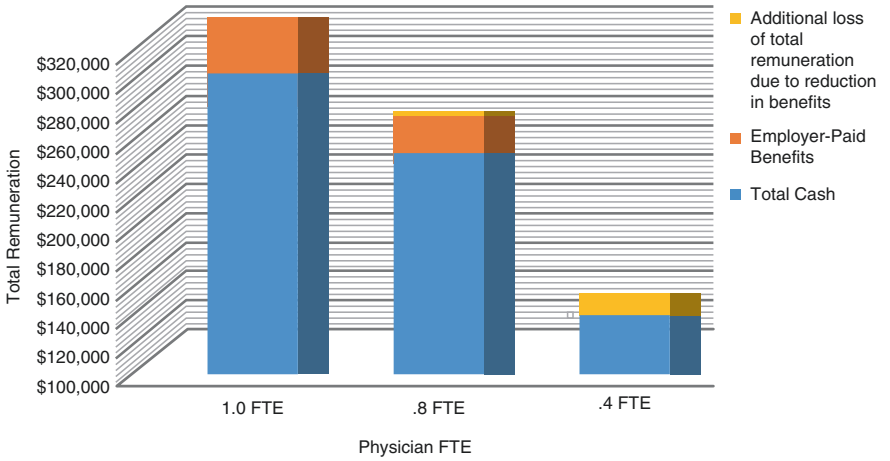

Fig. 3.2 Scenario assumes physician total cash compensation at a 1.0 FTE is $275,000 ($250,000 base salary and $25,000 incentive). FTE is defined as "full-time equivalent." (1.0 FTE is 40 work hours per week, .8 FTE is 32 work hours per week, and .4 FTE is 16 work hours per week.) Benefits include employer retirement contribution (5% of base salary at or above .5 FTE), educational programs ($5000 per year prorated to FTE at or above .5), and health and dental with employer paying 80% of total premium ($25,000 and $1000, respectively) at 1.0 FTE, 50% at .8 FTE, and no benefit eligibility below .5 FTE

per year, a physician working 32 hours per week (.8 FTE) would have a base salary of $200,000. However, as illustrated in Fig. 3.2, lowering base salary has an additional impact on the calculation for incentive compensation and may also affect noncash benefits (e.g., having to contribute a greater percentage of salary to an employer group health plan or reducing the employer contribution toward retirement). Moreover, despite part-time compensation, a women physician may still be held to full-time on-call responsibilities, attendance at required meetings, and completion of administrative duties. Administrative work may be done outside of the office and, as a result, is invisible to leaders, undervalued, and under-compensated.

Other Additions to Pay

In addition to standard pay programs, organizations may compensate specific activities like extra call responsibilities or holiday/weekend coverage. Because these activities require work during evening hours, weekends, or vacations and women physicians shoulder more domestic responsibilities than their male colleagues, it can be challenging for women to take advantage of them at a rate equivalent to men [25, 26].

Noncash Remuneration

Remuneration, other than cash, comprises an increasingly significant component of the total compensation package as the cost of health insurance, education, and retirement increases. The ability of physicians to take full advantage of the packages offered by employers has an effect on their total remuneration. Examples of noncash benefits include health, dental, and vision insurance, short- and long-term disability income replacement, life insurance, continuing medical education or postgraduate degree reimbursement, paid leave, childcare and eldercare benefits, fitness and financial wellness benefits, and loan forgiveness. While these programs are generally offered to all employees, proration based on a physician's status as a full- or part-time worker can have significant impact on the benefit received, oftentimes disproportionate to the reduced work effort. Figure 3.2 illustrates this disproportionate reduction in total remuneration by displaying a common scenario: a physician's total cash is decreased by an amount equivalent to the reduction in FTE. Moreover, the smaller percentage of benefits the employer pays to a physician working as a 0.8 FTE decreases total remuneration further. The financial impact of part-time work is magnified when the physician reduces her time to 0.4 FTE and is no longer eligible to participate in any physician benefit programs. Because the percentage of women physicians working part-time exceeds that of men, the effect of reduced FTE on total remuneration compounds gender-based pay inequities observed in total cash compensation.

Summary

The differences in the way men and women work, the unique challenges women face in the workplace, and the slow movement in transitioning compensation calculations to reflect metrics of success in value-based care perpetuate gender-based inequities in physician compensation. These inequities can be difficult to uncover and are often woven into the fabric of the plans through emphasis on traditional measures of contribution and productivity, unconscious bias affecting how work and compensation are assigned, and disproportionate reductions in total remuneration for part-time work.

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Chapter 4
Regulatory and Legal Considerations Regarding Salary Equity

Patricia A. Washienko

Gender-based pay disparities and legislative efforts to redress them are not new phenomena. In 1870, the US Congress passed a bill that prohibited gender pay discrimination for new clerks in federal jobs [1]. (The law was rarely enforced [2].) In 1942, the National War Labor Board adopted General Order No. 16, which mandated that employers pay equal compensation to women hired to replace male workers conscripted to fight in World War II [3]. In 1945, when the War Labor Board was dissolved, the Women's Equal Pay Act, which would have prohibited employers from paying women less than men for work of "comparable quality and quantity," was introduced [4]. It did not pass.

The federal gender discrimination and pay equity laws in effect today were enacted in the civil rights era. In 1961, President John F. Kennedy established the Presidential Commission on the Status of Women, which was charged with developing recommendations for achieving pay equity (and chaired by Eleanor Roosevelt) [5]. As Arthur J. Goldberg, Secretary of Labor, observed in congressional hearings that followed:

> The origin of the rate differential for men and for women performing comparable jobs is the false concept that a woman intrinsically deserves less money than a man. This outmoded concept, rooted in a psychological downgrading of women's skills, has been amply demonstrated to be false in every field of endeavor, and we simply cannot afford to give it credence in this modern space age. It is indefensible from every standpoint. To state this concept should suffice to refute it, but this has not proven to be true. Discrimination in wage payment on the basis of sex continues to exist, and this subcommittee is performing an invaluable public service in publicizing its extent and its complete lack of justification [6].

In 1963, Congress enacted the Equal Pay Act (EPA), which requires employers to pay to men and women in the same workplace equal pay for equal work [7, 8]. The Education Amendments of 1972 significantly broadened the reach of the EPA,

P. A. Washienko (✉)
Freiberger and Washienko LLC, Boston, MA, USA
e-mail: pwashienko@fwlawboston.com

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making it applicable to executive, professional, managerial, and administrative jobs, which had previously been excluded [9, 10].

In 1964, Congress enacted the Civil Rights Act of 1964, Title VII of which bans employers from discriminating on the basis of race, color, religion, sex, or national origin, except where sex is a bona fide occupational qualification for the job [11]. (Given the critical role Title VII plays in pay equity litigation, it is somewhat ironic that the category "sex" was not originally included in the proposed bill but was added as an amendment at the last minute, according to some in an attempt to prevent its passage [12, 13].) In 2009, Congress enacted the Lilly Ledbetter Fair Pay Act [14] to reverse a decision of the US Supreme Court, *Ledbetter v. Goodyear Tire & Rubber Co., Inc*. [15], that had severely limited Title VII's protections by narrowly construing the law's statute of limitations in pay disparity cases.

The EPA and Title VII, both as amended, are the bedrock federal laws prohibiting gender-based pay disparities and retaliation against those who object to them. Both laws apply nationally, although the contours of the protections of each law may vary by federal circuit unless the Supreme Court has ruled on an issue.

Virtually every state has also enacted laws to prohibit gender discrimination and gender-based pay disparities. As set out more fully below, many of them provide more expansive and robust protections than those set out in the federal laws: by covering more businesses and organizations in the definition of "employer," for example, or by providing for more severe penalties. Plaintiffs (i.e., aggrieved persons advancing claims in litigation) may advance both state law claims and federal claims in litigation.

Chapter Overview

- Section I of this chapter will outline the EPA and Title VII and provide a primer on the legal elements necessary to establish claims under both laws (including retaliation claims), identify the defenses available to employers, and highlight their differences and strengths. (*Although Section I provides an overview, these laws are much more complicated than can be conveyed in a single book chapter. This information should not be construed as legal advice.*)
- Section II will review select state laws.
- Section III will identify special laws governing financial relationships between healthcare institutions and entities that provide designated health services and how they potentially impact physician compensation via safe harbor provisions, as well as IRS regulations governing a healthcare institution's 501(c)(3) status. (*Although Section III also provides an overview, these laws are much more complicated than can be conveyed in a single book chapter. This information should not be construed as legal advice.*)
- This chapter will conclude, in Section IV, with a warning and recommendation to employers: conduct an audit and find a way to fix gender-based pay inequities now. The risk of doing otherwise is significant, and liability can be staggering.

A Primer on Federal Law: The Equal Pay Act and Title VII

The Equal Pay Act (EPA)

The EPA provides that:

> No employer having employees subject to any provisions of this section shall discriminate, within any establishment in which such employees are employed, between employees on the basis of sex by paying wages to employees in such establishment at a rate less than the rate at which he pays wages to employees of the opposite sex in such establishment for equal work on jobs the performance of which requires equal skill, effort, and responsibility, and which are performed under similar working conditions, except where such payment is made pursuant to (i) a seniority system; (ii) a merit system; (iii) a system which measures earnings by quantity or quality of production; or (iv) a differential based on any other factor other than sex [16].

To prevail on a claim for violation of the EPA, a plaintiff must prove that the employer employed the plaintiff and a male employee in the same establishment [17] in jobs requiring substantially equal skill, effort, and responsibility [18]; that the two jobs are performed under similar working conditions; and that she [19] received less total compensation [20] than a male employee doing substantially equal work [21]. The jobs need not be identical, but the content of the jobs must be "substantially equal" – a fact-specific inquiry that has caused considerable litigation [22]. *Critically, a plaintiff need not establish the employer had an intent to discriminate* [23]. Note that if the lower-paid job requires *greater* skill, effort, or responsibility than is required for the performance of the more highly paid job, the EPA may still apply; the fact that the two jobs are not substantially equal will not render the EPA inapplicable in these circumstances [24].

Even if a plaintiff is able to establish all of the required elements of her Equal Pay Act case, an employer may nevertheless defeat her claim by proving one of four affirmative defenses: that the pay differential is attributable to (i) seniority, (ii) merit, (iii) quantity or quality of production, or (iv) "any other factor other than sex" [16]. An employer must submit evidence from which a reasonable fact finder could conclude that the proffered reasons *actually* motivated the wage disparity – not just that the reasons could justify it.

The vague category "any other factor other than sex" has been particularly troublesome, as employers have used it to justify salary disparities on the basis of, among other things, "market forces" [25] and factors not adopted for legitimate business reasons [26, 27]. The circuit courts of appeal are split as to whether employers can rely solely on a female employee's prior salary as an "any other factor other than sex" affirmative defense [28]. In March 2019, the House of Representatives passed a new law, the Paycheck Fairness Act, to ensure that employers relying on the "factor other than sex" defense may not pay men and women doing substantially equal work different wages unless the wage differential is justified by a job-related reason, such as education, training or experience, and consistent with business needs [29, 30]. It is not clear if the Act will pass the Senate or be signed into law.

The fact that the employer has asserted an affirmative defense is not fatal to a plaintiff's EPA claim; she may nevertheless prevail if she rebuts the affirmative defense, which she can do by demonstrating that the defenses are "pretextual" – i.e., an illegitimate justification for a gender-based differential rather than a real and legitimate reason for the pay disparity (and often a post hoc effort to explain/justify a gender-based differential) [31]. The defendant at all times retains the burden of proving a legitimate reason for the discrepancy in pay [32].

Retaliation

The EPA also provides a cause of action for retaliation, making it unlawful "to discharge or in any other manner discriminate against any employee because such employee has filed any complaint or instituted or caused to be instituted any proceeding under or related to this Act, or has testified or is about to testify in any such proceeding …" [33]. Oral complaints are sufficient to trigger anti-retaliation protections of the EPA [34]. Although the Supreme Court has not decided whether the EPA's anti-retaliation provision applies to complaints made to the employer rather than the government [35], a number of federal courts of appeal have held so, concluding that the law should be construed broadly [36].

Retaliation claims are generally easier to prove than discrimination claims, as a plaintiff need not establish the elements of the equal pay claim itself, and the affirmative defenses are not implicated. Rather, *a plaintiff need only establish that she engaged in protected activity (i.e., complained about pay inequity), the employer took materially adverse action against her, and causation* [37]. Causation may be inferred when the adverse employment action closely follows the protected activity; if there is a significant delay, causation may be established with other evidence such as continuing animus or inconsistent or shifting explanations [38].

Coverage, Statute of Limitations, and Collective Action

The EPA applies to virtually all employers, regardless of size [39]. A claim must be filed within two years of the discrimination/retaliation or three years in the case of a "willful" violation, but *a claim arises each time an employee receives lower pay than male employees doing substantially similar work – i.e., every paycheck* [40]. Significantly, under the EPA, "similarly situated" employees have the right to pursue their claims as a "collective action" [41]. Because multiple plaintiffs are involved, the liability employers face can be substantial: two recent EPA collective action cases settled for $8.2 million and $19.5 million, respectively [42]. The attention drawn to gender-based pay inequity by the collective EPA (and Title VII) action brought by the US National Women's Soccer Team against the United States Soccer Federation, Inc. is likely to encourage more EPA actions, collective and otherwise [43].

Damages

Under the EPA, a prevailing plaintiff is entitled to recover the pay that she should have received for equal work, doubled as liquidated damages [44]. (As noted above, particularly in a collective action, these damages quickly add up.) The damages recoverable for a retaliation claim are greater, including employment, reinstatement, promotion, the payment of wages lost, and an additional equal amount as liquidated damages [45]. There is a split in the circuits as to whether punitive damages may also be awarded for a retaliation claim [46]. Attorneys' fees will be awarded to a successful claimant for both an equal pay and a retaliation claim [41]. In addition to the employer, an individual (e.g., an owner or officer) may also be personally liable for a gender-based pay disparity if s/he had the capacity to exercise control over the plaintiff [47].

The Road Ahead

The Equal Employment Opportunity Commission (EEOC) has, since 2012, included equal pay protections as one of its substantive area priorities that guide its enforcement activities [48]. Consistent with that priority, in 2016, the EEOC began to require employers to provide information about pay data in its EEO-1 reports, to be better able to track pay disparity [49, 50]. The EEOC has also started to prosecute lawsuits specifically aimed at gender pay equity [51]. Private attorneys are increasingly litigating EPA cases: one management-side employment law firm that monitors the number of gender discrimination cases filed nationally reports that since 2016, over 250 pay equity cases have been filed in the United States [52].

Title VII

Title VII makes it "an unlawful employment practice for an employer … to discriminate against any individual with respect to … compensation" *because* of sex [53]. In other words, a Title VII plaintiff (unlike an EPA plaintiff) must prove intent. She may do so using direct evidence (which typically consists of "clearly sexist, racist, or similarly discriminatory statements or actions by the employer" [54, 55] that make animus explicit) or indirect evidence, which allows a jury to infer that gender bias is motivating the pay disparity. Since overtly discriminatory statements are rare in most workplaces, most Title VII plaintiffs rely on indirect evidence.

In *McDonnell-Douglas Corp. v. Green*, the US Supreme Court articulated a framework to help courts and jurors evaluate cases in which plaintiffs have only indirect evidence of discrimination [56]. Under this three-stage framework, plaintiffs must establish a *prima facie* case of discrimination; defendants must then offer a legitimate, nondiscriminatory reason for the pay disparity [57]; and plaintiffs must then establish intent to discriminate [58, 59].

To establish her *prima facie* case, a Title VII plaintiff must show she is paid less than a member of the opposite gender in a similar job [60, 61]. Her comparator need not be in an equal job, but he must be "similarly situated in all relevant respects" [62], a burden that is not all that much lighter. The employer's obligation to articulate a legitimate, nondiscriminatory reason for the pay disparity is not a difficult burden [63], and the affirmative defenses to an EPA claim also suffice as legitimate, nondiscriminatory reasons for a Title VII claim [64, 65].

At the third stage, a Title VII plaintiff must show that, regardless of the reasons offered, her employer intentionally discriminated against her. She may do so by showing either that the proffered reason was a pretext for discrimination (i.e., an illegitimate justification) or that her gender was another motivating factor for the decision [66]. An employee can prove pretext by showing the employer's proffered reason was "(1) factually baseless, (2) not the employer's actual motivation, (3) insufficient to motivate the action, or (4) otherwise pretextual" [67].

Retaliation

Like the EPA, Title VII also prohibits retaliation [68]. Its elements are the same: protected activity, materially adverse action, and a causal connection [69].

A cause of action for retaliation under Title VII lies whenever an employer responds to protected activity in such a way "that a reasonable employee would have found the challenged action materially adverse, which in this context means it might well have dissuaded a reasonable worker from making or supporting a charge of discrimination" [70]. There is no requirement that the retaliation is job-related, and Title VII's anti-retaliation protections extend to not only former employees but also certain third parties [71, 72]. To prevail on a retaliation claim, a plaintiff must prove that the unlawful retaliatory act would not have occurred but for the plaintiff's protected activity [73]. A showing that the employer's reasons for its action are pretextual – i.e., illegitimate – can establish "but for" causation [74]. *As with EPA retaliation claims, Title VII retaliation claims are often easier to establish than the underlying discrimination, and a plaintiff may prevail on a retaliation claim even if she does not prevail on an underlying discrimination claim, should she bring one* [75]. Perhaps as a result, the total number of Title VII retaliation charges filed at the EEOC increased 86% from 1997 to 2018, climbing from 16,394 to 30,556 [76].

Coverage, Statute of Limitations, and Class Actions

Title VII's protections apply to employers with fifteen or more employees [77]. An employee seeking to prosecute a claim under Title VII must file an administrative charge within 180 days of the "unlawful employment practice"; however, that deadline is extended to 300 days if a state or local agency enforces a law that prohibits employment discrimination on the same basis [78]. She may also proceed in court,

so long as she has filed the administrative charge and initiates the litigation within 90 days of receiving a right to sue letter [79]. In response to Supreme Court decision holding that a claim of discriminatorily low pay began when the pay decision was initially made, Congress enacted the Lilly Ledbetter Fair Pay Act to clarify "that a discriminatory compensation decision … occurs each time compensation is paid pursuant to the (discriminatory decision)" [80]. *Thus, every discriminatorily low paycheck triggers a statute of limitations* [81].

Title VII claims may be prosecuted in class actions under Rule 23 of the Federal Rules of Civil Procedure. The Supreme Court has heightened the standard that must be met to prove commonality in a Rule 23(b) class action, however, making them difficult to establish [82].

Damages

Damages available under Title VII include lost wages, front pay, compensatory damages, punitive damages, and reasonable attorneys' fees [83]. Title VII caps compensatory and punitive damages between $50,000 and $300,000, depending on the size of the employer [84].

A Comparison of the Equal Pay Act and Title VII and Their Interplay

As noted in the introduction, the EPA was enacted to remedy (just) gender-based pay disparities. The Civil Rights Act of 1964 was enacted in the context of the civil rights movement, to address more wide-ranging discrimination: failure to hire, failure to promote, and wrongful termination, for instance, as well as disparate pay. As a result, although both laws provide remedies for gender-based disparate pay, there are a number of significant differences between EPA and Title VII claims for sex-based wage discrimination. Among other things, the Equal Pay Act does not require proof of intent to discriminate, has no coverage threshold in terms of number of employees, carries a longer limitations period for back pay than does Title VII, and does not require a plaintiff to file an administrative complaint or await the EEOC's conciliation efforts before proceeding in court [85]. And as noted above, an EPA collective action proceeds using a more lenient "opt-in" rules of the Fair Labor Standards Act, rather than the "opt-out" approach used in Title VII class actions. Because of these differences, gender-based pay disparity complaints often allege both EPA and Title VII claims and proceed under both, given the slightly different burdens of each.

Recovery for the same period of time may be had under both the EPA and Title VII so long as relief is not duplicative [86]. In addition, the availability of a remedy under Title VII that would entitle the lower-paid employee to be hired into, or to

transfer to, a higher-paid job does not defeat the right of the lower-paid employee to be paid the same wages as are paid to a member of the opposite sex who receives higher pay for equal work pursuant to the EPA [87].

State Laws

As noted above, many states have for years had analogs to the EPA and Title VII that often provided greater protections and remedies than their federal counterparts [88]. General Law Chapter 151B, Massachusetts' analog to Title VII, for example, applies to employers with six or more employees (not fifteen), imposes strict liability on an employer for the actions of its supervisors, and imposes no caps on punitive damages, among other things [89]. California's anti-discrimination laws apply to companies with five or more employees [90]. Michigan's anti-discrimination law applies to companies with one or more employees [91].

In the face of intractable gender-based pay inequities, however, many states have recently enacted new laws to expand protections and take more forceful steps. According to one law firm that represents primarily organizations (rather than individuals) in employment law matters, since 2016, more than 200 bills addressing pay equity were introduced in nearly every state [52]. The laws have primarily come in three forms: more aggressive pay equity laws, bans on salary history inquiries, and wage transparency laws.

Numerous states have enacted pay equity laws or significantly strengthened already existing laws; among them, Alabama, Maryland, Massachusetts, New Jersey, New York, Oregon, and Washington have enacted or broadened pay equity laws [52]. California's new Fair Pay Act is likely the most robust. It applies to *all* employers with California-based employees [92], allows employees to be compared even if they do not work at the same establishment [93], and requires only a showing that the employees are engaged in substantially similar work, "when viewed as a composite of skill, effort, and responsibility, and performed under similar working conditions" [94]. It limits the factors that employers can use to justify pay differentials and mandates that the factors explain the entire pay differential and also creates a private right of action for retaliation under which employees may seek reinstatement, reimbursement for lost wages and benefits, interest, and equitable relief [95].

Laws have been enacted prohibiting employers from inquiring about an applicant's prior compensation history, which are intended to prevent successive employers from using past discriminatorily low compensation to justify pay disparities (i.e., "market forces"). Alabama, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Massachusetts, New Jersey, New York, Oregon, Puerto Rico, Vermont, and Washington have enacted such bans [96, 97]. Several cities/local jurisdictions have also enacted salary history bans: San Francisco; Kansas City, MO; New York City; Albany County, NY; Suffolk County, NY; Westchester County, NY; Cincinnati; Toledo; and Philadelphia (see text box) [98].

Salary History Laws

Laws prohibiting employers from inquiring about an applicant's prior compensation have been enacted and intend to prevent successive employers from using past discriminatorily low compensation to justify pay disparities (i.e., "market forces"). The following states and cities/local jurisdictions have enacted such bans:

Alabama	California	Colorado	Connecticut	Delaware
Hawaii	Illinois	Maine	Massachusetts	New Jersey
New York	Oregon	Puerto Rico	Vermont	Washington

San Francisco, CA	Kansas City, MO	Albany County, NY	New York City, NY	Suffolk County, NY
Westchester County, NY	Cincinnati, OH	Toledo, OH	Philadelphia, PA	

Wage Transparency Protections

Protections prohibiting employers from banning pay disclosure in the workplace and from retaliating against employees who do so have been enacted in the following states:

California	Colorado	Connecticut	Delaware	District of Columbia
Hawaii	Illinois	Maine	Maryland	Massachusetts
Michigan	Minnesota	Nevada	New Hampshire	New Jersey
New York	Oregon	Vermont	Washington	

Wage transparency protections, which prohibit employers from banning pay disclosure in the workplace and from retaliating against employees who do so, have been enacted in California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Hampshire, New Jersey, New York, Oregon, Vermont, and Washington (see text box) [96].

Special Considerations for Healthcare Institutions

Three main laws impact employment arrangements between hospitals and physicians: the Stark Law [99], the Anti-Kickback Statute [100], and the Internal Revenue Code and related guidelines.

The Stark Law generally "prohibits a physician or immediate family member who has a financial relationship with a healthcare organization from making referrals to that entity for 'designated health services' covered by Medicare, unless a specific exception applies" [101]. The Stark Law has an exception for *bona fide* employment arrangements, however, which provides that physicians are permitted to be compensated as employees of hospitals as long as the amount paid to the physician is (i) for identifiable services, (ii) consistent with the fair market value for services performed, and (iii) not determined in a manner that takes into account the volume or value of referrals by the referring physician to the hospital. Further, the remuneration provided under the employment agreement between the hospital and physician must be commercially reasonable even if no referrals were made by the physician to the hospital. The Stark Law is a strict liability statute, and civil penalties may be imposed for violations.

The Anti-Kickback Statute provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce business reimbursed under the Medicare or state healthcare programs, unless a safe harbor applies [102]. The safe harbor for employment relationships provides that remuneration does not include any compensation paid by an employer to an employee who has a bona fide employment relationship with the employer [103].

Section 501(c)(3) of the Internal Revenue Code exempts from federal income taxation certain nonprofit entities including hospitals. Specifically, a tax-exempt hospital cannot pay more than "reasonable compensation" for services rendered by physicians [104]. Violations of the IRS guidelines may cause a hospital to lose its tax-exempt status [105]. In addition, IRC 4958, the section of the Internal Revenue Code that provides for excise taxes on excess benefit transactions (also known as "intermediate sanctions"), is important when considering physician compensation arrangements [106].

To be compliant with all three laws, compensation paid to physicians by hospitals and health systems must be generally consistent with fair market value and cannot reflect the value or volume of referrals an employed physician may direct to the hospital or its affiliates [107].

A claim for items or services resulting from a violation of the Stark Law or Anti-Kickback Statute constitutes a false claim under the False Claims Act (FCA), which imposes liability on persons and companies who defraud governmental programs [108]. The FCA includes a "qui tam" provision that allows people who are not affiliated with the government to sue on behalf of the government (permitting them to recover a percentage of damages and thereby incentivizing those with knowledge of fraud to report the same); the damages that flow from such claims can be significant. In *United States ex rel. Drakeford v. Tuomey*, for instance, a $237 million judgment was issued where compensation paid to physicians under certain part-time employment agreements violated both the FCA and the Stark Law [109], although the matter eventually settled for (just) $72.4 million.

Given the potentially catastrophic consequences of failing to comply with these laws, institutions should carefully monitor physician compensation and employment arrangements [110].

What Can/Should Employers Do to Address Gender-Based Pay Inequities?

First, conduct an audit. Liability (like potential energy) exists regardless of the audit, and an audit will actually help the organization mitigate its potential future exposure. An internal audit should thoroughly review pay practices, job descriptions, salaries, bonuses, benefits, and the performance evaluation process to identify gender-based (and other) pay inequities and their potential causes, like location, education, seniority, responsibility, and performance. To the extent the organization is not fully committed (or able to commit) to organization-wide redress, the audit should be conducted by counsel, so that it is protected by the attorney-client privilege: otherwise, the disclosure of audit results (particularly if not coupled with the implementation of remedial action, if such remedial action is necessary) risks publicizing the evidence that will support a disparate pay discrimination claim. To the extent the organization is fully committed to organization-wide redress, there may be significant value in conducting a transparent internal audit involving institutional stakeholders, as described in Chap. 5 of this book: transparency can build trust around the organizational commitment to equity and facilitate a new culture that identifies bias and eliminates disparities.

Second, *correct the inequities*. *Documenting awareness of pay inequities based on gender (or any other protected category like race or national origin or age) and failing to correct it increase the risk that an organization will be subjected to punitive damages for knowing disregard of the law*. Reducing disparities will also likely reduce the risk of litigation and will certainly reduce potential damages – perhaps significantly [111]. (Note that in correcting a pay differential, an employer may not reduce any employee's pay. Instead, the pay of the lower-paid employee(s) must be increased [112].) Correcting the inequities has additional benefits beyond reducing risk and liability: research has shown that pay transparency leads to more equitable salary practices [113] and that workers who have access to organizational financial information earn more than those who do not [114]. Research suggests pay transparency may also increase collaboration and productivity [115]. Pay secrecy, in contrast, leads to more disengagement and decreased performance and may "ultimately do more harm to individual task performance … than good" [116].

Finally, although it will undoubtedly require considerable effort, create fair compensation plans (and do so with a careful eye to the Stark Law, the Anti-Kickback Statute, and the Internal Revenue Code). As the American College of Cardiology suggests [117]:

> A fair and equitable compensation plan does not need to create compensation parity, but it should create compensation equity. Every member of the organization – whether a practice, medical group, academic division, or other unit – should have an equal opportunity through the compensation plan to achieve a market-equitable income, applicable performance bonuses, and the resources required to do their specific job well. Plans should avoid undervaluing essential but nonrevenue-producing work, such as educational activities, travel to remote but strategic satellite locations ("windshield time"), committee work, research, and mentoring. Plans must also include consideration of how to balance individual productivity with team-based success, and account for differences in wRVU valuation between proce-

dural and nonprocedural work, while specifying how to appropriately reward different career stages, health risks (e.g., radiation exposure), or those with different work-life balances. For multispecialty groups …, whether employed, practice, or academic, compensation models should be differentiated by specialty in light of unique considerations including but not limited to supply, demand, training, risk and acuity, and job demands. Although many plans are constructed to reward and enhance productivity, an equally important test of the plan is the impact it has on the organizational culture – whether it aligns the members around common goals and milestones. Successful plans will provide multidimensional gains. Once implemented, most, if not all, of the impacted individuals must feel the plan is fairly and equitably applied. The plan must be flexible enough to evolve with changing circumstances in the market or organization without needing a complete overhaul annually. Every plan must be designed to meet local needs, achieve system goals, and fulfill mission-driven values. The plan should retain enough income to cover leadership costs, support underfunded key mission areas, and allow for program growth and development, including reserving funds for unexpected events. Additionally, a good compensation plan helps attract and retain candidates for positions and aligns incentives to achieve the goals of the practice, group, or academic unit. Organizations need to ensure that their compensation models are fluid and reflect industry trends (thus maintaining market competitiveness) while fulfilling legal and compliance requirements. Finally, no formula or approach is perfect, but routine review of individual total compensation under the plan, particularly with an eye to disparities, will help to close any gaps and achieve equal compensation for equal work.

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6. 1 Legislative History of the Equal Pay Act of 1963, Pub. L. No. 88-38, 88th Congress, H.R. 6060 and S. 1409 i (1963), at page 92.
7. Equal Pay Act of 1963, Pub. L. No. 88-38, 77 Stat. 56, 29 U.S.C. § 206 (June 10, 1963).
8. "Congress' purpose in enacting the Equal Pay Act was to remedy what was perceived to be a serious and endemic problem of employment discrimination in private industry -- the fact that the wage structure of 'many segments of American industry has been based on an ancient but outmoded belief that a man, because of his role in society, should be paid more than a woman

even though his duties are the same.'" *Corning Glass Works v. Brennan*, 417 U.S. 188, 195 (1974) (*citing* S. Rep. No. 176, 88th Cong., 1st Sess., 1 (1963)).

9. Education Amendments of 1972, Public L. No. 92-318, § 906(b)(1), 86 Stat. 235, 375 (June 23, 1972) (removing operation of FLSA exemption of professional employees from EPA).
10. Fair Labor Standards Act (FLSA) of 1938, 29 U.S.C. § 201 et seq. (2006); 109 Cong. Rec. 9193 (1963) (remarks of Rep. St. George) ("All of the [FLSA] exemptions apply; and this is very noteworthy, agriculture, hotels, motels, restaurants, and laundry are excluded. Also all professional, managerial, and administrative personnel[.]")
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13. According to the *West Encyclopedia of American Law*, Representative Howard W. Smith (D-VA) added the word. "His critics argued that Smith, a conservative Southern opponent of Federal civil rights, did so to kill the entire bill (a so-called 'poison pill' amendment)." The Civil Rights Act of 1964 and the Equal Employment Opportunity Commission [Internet]. National Archives. April 25, 2018 [cited December 14, 2019]. Available from: https://www.archives.gov/education/lessons/civil-rights-act.
14. Lilly Ledbetter Fair Pay Act of 2009. Pub. L. No. 111–2, 123 Stat. 5, (2009).
15. 550 U.S. 618 (2007).
16. 29 U. S. C. § 206 (d)(1).
17. "An 'establishment' is generally defined as 'a distinct physical place of business' instead of a business enterprise. Only in 'unusual circumstances' may 'two or more distinct physical portions of a business enterprise [be treated] as a single establishment.' Such treatment may be appropriate where a central administrative unit hires all employees, sets wages, and assigns the location of employment.'" *Price v. N. States Power Co.*, 664 F.3d 1186, 1194 (8th Cir., 2011).
18. In deciding whether jobs require substantially equal "skill," courts consider factors such as the level of education, experience, training and ability necessary to meet the performance requirements of the jobs. Effort refers to the mental, physical and emotional requirements for performing the job. Responsibility refers to the degree of accountability expected by the employer for a person filling the jobs, as well as the amount of preparation required to perform the job duties. United States Court of Appeals for the Third Circuit. Model Jury Instructions: Chapter 11: Instructions for Sex Discrimination Claims Under the Equal Pay Act. October 2018 [cited December 17, 2019]. Available from: https://www.ca3.uscourts.gov/sites/ca3/files/11_Chap_11_2018_Oct.pdf.
19. Although enacted to prohibit sex-based wage discrimination against women, the language of EPA is gender neutral and thus also protects men. *See, e.g., Board of Regents v. Dawes*, 522 F.2d 380 (8th Cir. 1975) (paying women more than men for substantially equal work violates the Equal Pay Act). Nevertheless, for purposes of this chapter, I refer to plaintiffs in equal pay cases as women.
20. "Under the EPA, the term "wages" generally includes all payments made to [or on behalf of] an employee as remuneration for employment. The term includes all forms of compensation irrespective of the time of payment, whether paid periodically or deferred until a later date, and whether called wages, salary, profit sharing, expense account, monthly minimum, bonus, uniform cleaning allowance, hotel accommodations, use of company car, gasoline allowance, or some other name. Fringe benefits are deemed to be remuneration for employment. . . . [V]acation and holiday pay, and premium payments for work on Saturdays, Sundays, holidays, regular days of rest or other days or hours in excess or outside of the employee's regular days or hours of work are deemed remuneration for employment and therefore wage payments that must be considered." 29 C.F.R. § 1620.10.
21. 29 U. S. C. § 206 (d)(1).
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23. *EEOC v. Delaware Dept. of Health and Social Services*, 865 F.2d 1408 (3d Cir. 1989).
24. Riser v. QEP Energy, 776 F.3d 1191, 1196-97 (10th Cir. 2015) (*citing* Testing Equality of Jobs, 29 C.F.R. § 1620.14(a)).
25. *See, e.g., Merillat v. Metal Spinners, Inc.*, 470 F.3d 685, 697, 697 n.6 (7th Cir. 2006) (noting that the Seventh Circuit had "held that an employer may take into account market forces when determining the salary of an employee," although cautioning in a footnote against employers taking advantage of market forces to justify discrimination).
26. U.S. Equal Employment Opportunity Commission, Compliance Manual, Section 10: Compensation Discrimination (2000), at 10-IV(F)(2)(g), available at http://www.eeoc.gov/policy/docs/compensation.html#10-IV%20COMPENSATION%20DISCRIMINATION.
27. *See, e.g.*, *Belfi v. Prendergast*, 191 F.3d 129, 136 (2d Cir. 1999) (noting that an employer seeking to rely on the "factor other than sex defense [ ] . . . must . . . demonstrate that it had a legitimate business reason for implementing the gender-neutral factor that brought about the wage differential"); *Beck-Wilson v. Principi*, 441 F.3d 353, 365 (6th Cir. 2006) ("[T]he Equal Pay Act's exception that a factor other than sex can be an affirmative defense 'does not include literally any other factor, but a factor that, at a minimum, was adopted for a legitimate business reason.'" (*quoting EEOC v. J.C. Penney Co.*, 843 F.2d 249, 253 (6th Cir. 1988))).
28. "Reliance on past wages simply perpetuates the past pervasive discrimination that the Equal Pay Act seeks to eradicate. Therefore, we readily reach the conclusion that past salary may not be used as a factor in initial wage setting, alone or in conjunction with less invidious factors." *See Rizo v. Yovino*, 887 F.3d 453, 468 (9th Cir. 2018). *See also Irby v. Bittick*, 44 F.3d 949 (11th Cir., 1995); *Angove v. Williams-Sonoma, Inc.*, 70 Fed. Appx. 500 (10th Cir. 2003). *But see Lauderdale v. Ill. Dep't of Human Servs.*, 876 F.3d 904 (7th Cir. 2017); *Taylor v. White*, 321 F.3d 710 (8th Cir. 2003), both holding the opposite.
29. Paycheck Fairness Act, H.R. 7, 116th Cong., 1st Sess. (2019-2020).
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31. 29 U.S.C. § 215(a)(3); *Schwartz v. Florida Bd. of Regents*, 954 F.2d 620, 623 (11th Cir. 1991) (citing *Brock v. Georgia Southwestern College,* 765 F.2d 1026, 1036 (11th Cir. 1985).
32. Under the Equal Pay Act, the defendant at all times retains the burden of proving a legitimate reason for the discrepancy in pay. *See, e.g.*, *Stanziale v. Jargowsky*, 200 F.3d 101, 107-08 (6th Cir. 2000); *Mickelson v. New York Life Ins. Co.*, 460 F.3d 1304, 1311 (10th Cir. 2006).
33. 29 U.S.C. § 215(a)(3).
34. *Kasten v. Saint-Gobain Performance Plastics Corp.*, 563 U.S. 1, 4-5 (2011).
35. *Kasten* at 17 (applying the Court's usual practice of declining to "consider a separate legal question not raised in the certiorari briefs").
36. *See, e.g., Valentín-Almeyda v. Municipality of Aguadilla*, 447 F.3d 85, 94 (1st Cir. 2006) ("[P]rotected conduct includes not only the filing of administrative complaints . . . but also complaining to one's supervisors."); *EEOC v. Romeo Cmty. Sch.*, 976 F.2d 985, 989-90 (6th Cir. 1992) (retaliation claim actionable under the Equal Pay Act, for complaint to supervisor about male counterparts being paid $1/hour more); *EEOC v. White & Son Enters.*, 881 F.2d 1006, 1011 (11th Cir. 1989) (affirming finding that female employees were unlawfully terminated after complaining of unequal wages to their supervisors).
37. *Burlington Northern & Sante Fe Ry. Co. v. White,* 548 U.S. 53 (2006).
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Compensation Discrimination. [Cited December 17, 2019.] Available from: https://www.eeoc.gov/laws/types/equalcompensation.cfm.
40. 29 U.S.C. § 255.
41. 29 U.S.C. § 216(b).
42. *Wellens v. Daiichi Sankyo, Inc.*, 2014 U.S. Dist. LEXIS 70628 (N.D. Cal., May 22, 2015); *Dandan Pan v. Qualcomm Inc.*, 2017 U.S. Dist. LEXIS 120150 (S.D. Cal., July 31, 2017).
43. Morgan et al. v. U.S. Soccer Federation Inc., 2:19-cv-01717, U.S. District Court, Central District of California (Los Angeles).
44. The Equal Pay Act provides that recovery for an Equal Pay Act violation consists of the amount of underpayment and "an additional equal amount as liquidated damages." There is no statutory authority for an award of damages such as for emotional distress, pain and suffering, or lost opportunity. 29 U.S.C. § 216(b).
45. The Equal Pay Act provides for the following recovery for a violation of the anti-retaliation provision of the Equal Pay Act: "such legal or equitable relief as may be appropriate to effectuate the purposes of [the anti-retaliation provision] including without limitation employment, reinstatement, promotion, and the payment of wages lost and an additional equal amount as liquidated damages." 29 U.S.C. § 216(b).
46. *Travis v. Gary Community Mental Health Center*, 921 F.2d 108, 112 (7th Cir. 1990) ("Compensation for emotional distress, and punitive damages, are appropriate for intentional torts such as retaliatory discharge."). However, the Eleventh Circuit does not agree that this section of the FLSA warrants such an interpretation. *Snapp v. Unlimited Concepts, Inc.*, 208 F.3d 928 (11th Cir. 2000); *but see Jones v. Amerihealth Caritas*, 95 F. Supp. 3d 807, 818 (E.D. Pa., 2015) ("This Court finds Judge Pollak's well-reasoned opinion in *Marrow* persuasive and agrees that punitive damages are available for retaliation claims under the EPA and FLSA.").
47. *See, e.g., Riordan v. Kempiners*, 831 F.2d 690, 694 (7th Cir. 1987) ("The word 'employer' is defined broadly enough in the Fair Labor Standards Act … to permit naming another employee rather than the employer as defendant, provided the defendant had supervisory authority over the complaining employee and was responsible in whole or part for the alleged violation.").
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53. 42 U.S.C. § 2000e-2(a)(1).

54. *Coghlan v. Am. Seafoods Co. LLC*, 413 F.3d 1090, 1095 (9th Cir. 2005).
55. Direct evidence of discriminatory intent is evidence that, "if believed, proves the fact [of discriminatory intent] without inference or presumption." *Coghlan v. Am. Seafoods Co.*, 413 F.3d 1090, 1095 (9th Cir. 2005) (citation omitted).
56. 411 U.S. 792 (1973).
57. "Upon sustaining his initial burden, the burden shifts to the [defendant] to articulate a legitimate, non-discriminatory reason for the pay disparity." *Lakshman v. Univ. of Me. Sys.*, 328 F. Supp. 2d 92, 104 (D. Me., 2004); *see also Stanziale*, 200 F.3d at 107-08.
58. *Anupama Bekkem v. Wilkie*, 915 F.3d 1258, 1267 (10th Cir. 2019); *Spencer v. Va. State Univ.*, 919 F.3d 199, 203 (4th Cir. 2019).
59. In certain cases, where it appears that both legitimate and unlawful (discriminatory) motives played a role in an employment decision like a termination or failure to promote, courts may elect not to use the *McDonnell-Douglas* framework but instead evaluate a disparate treatment claim under the *Price Waterhouse* "mixed motive" framework, which permits an employer to defeat a discrimination claim if it can establish that in the absence of discriminatory animus it would have taken the same action. *Price-Waterhouse v. Hopkins*, 490 U.S. 228 (1989).
60. *Sprague v. Thorn Ams., Inc.*, 129 F.3d 1355, 1363 (10th Cir. 1997); *see also Spencer*, 919 F.3d at 203; *Mengistu v. Miss. Valley State Univ.*, 716 F. App'x 331, 333-34 (5th Cir. 2018) (explaining that "[i]n order to make out a prima facie case of pay discrimination under § 1981 or Title VII, a plaintiff must show (1) that he was a member of a protected class; (2) that he was paid less than a non-member; and (3) that his circumstances are nearly identical to those of the better-paid non-member") (internal citations and quotations omitted).
61. *County of Washington v. Gunther*, 452 U.S. 161, 168-71 (1981).
62. "The plaintiff need not demonstrate an exact correlation with the employee receiving more favorable treatment in order for the two to be considered 'similarly-situated;' rather, as this court has held in Pierce, the plaintiff and the employee with whom the plaintiff seeks to compare himself or herself must be similar in 'all of the relevant aspects.'" *Ercegovich v. Goodyear Tire & Rubber Co.*, 154 F.3d 344, 352 (6th Cir. 1998) (citing *Pierce v. Commonwealth Life Ins. Co.*, 40 F.3d 796 (6th Cir. 1994)); *see also Lewis v. City of Union City*, 918 F.3d 1213 (11th Cir. 2019).
63. *Sprague*, 129 F. 3d at 1363. *But see Figueroa v. Pompeo*, 923 F.3d 1078, 1092 (D.C. Cir. 2019) (finding that rather than merely stating or articulating a legitimate, non-discriminatory reason for its action "an employer at the second prong must *proffer admissible evidence* showing a legitimate, nondiscriminatory, clear, and *reasonably specific explanation* for its actions.") (emphasis supplied).
64. 42 U.S.C § 2000e-2(h) ("It shall not be an unlawful employment practice under this title [42 USCS §§ 2000e et seq.] for any employer to differentiate upon the basis of sex in determining the amount of the wages or compensation paid or to be paid to employees of such employer if such differentiation is authorized by the provisions of section 6(d) of the Fair Labor Standards Act of 1938, as amended (29 U.S.C. 206(d))").
65. See the discussion of the Bennet Amendment to Title VII in *County of Wash. v. Gunther*, 452 U.S. 161, 163 (1981). *See also* United States Court of Appeals for the Third Circuit. Model Jury Instructions: Chapter 11: Instructions for Sex Discrimination Claims Under the Equal Pay Act. October 2018 [cited December 17, 2019]. Available from: https://www.ca3.uscourts.gov/sites/ca3/files/11_Chap_11_2018_Oct.pdf.
66. *Niwayama v. Tex. Tech Univ.*, 590 Fed. Appx. 351, 357 (5th Cir. 2014); *Bowen v. Manheim Remarketing, Inc.*, 882 F.3d 1358, 1362 (11th Cir. 2018).
67. *Lauderdale*, 876 F.3d at 910 (internal quotation and citation omitted).
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70. *Burlington N. & S.F. Ry.*, 548 U.S. at 68 (2006).

71. *See Robinson v. Shell Oil Co.*, 519 U.S. 337 (1997).
72. *See Thompson v. North Am. Stainless*, 131 S. Ct. 863 (2011) (examining whether the third party falls within the "zone of interests" sought to be protected by the retaliation provision). *See also* U.S. Equal Employment Opportunity Commission. EEOC Enforcement Guidance on Retaliation and Related Issues at §4(b). August 25, 2019 [cited December 17, 2019]. Available from: https://www.eeoc.gov/laws/guidance/retaliation-guidance.cfm#b._Standing.
73. *See Univ. of Tex. Sw. Med. Ctr. v. Nassar*, 133 S. Ct. 2517, 2533 (2013).
74. *See generally Foster v. Univ. of Maryland-Eastern Shore*, 787 F.3d 243, 252 (4th Cir. 2015); Brown, L. Retaliation Claims Under Federal Civil Rights Statutes and the Constitution. National School Boards Association: Council of School Attorneys. March 23-25, 2017 [cited December 17, 2019]. Available from: https://cdn-files.nsba.org/s3fs-public/13.%20Brown%20Retaliation%20Claims.pdf.
75. "It is well settled that the participation clause shields an employee from retaliation regardless of the merit of his EEOC charge." *Sias v. City Demonstration Agency*, 588 F.2d 692, 695 (9th Cir. 1978) (citing *Pettway v. Am. Cast Iron Pipe Co.*, 411 F.2d 998, 1004-1007 (5th Cir. 1969)); *see also Johnson v. Univ. of Cincinnati*, 215 F.3d 561, 582 (6th Cir. 2000).
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81. 42 U.S.C. § 2000e-5(e)(3)(A).
82. *See Walmart Stores v. Dukes*, 564 U.S. 338, 354-60 (2011); *Comcast Corp. v. Behrend*, 133 S.Ct. 1426 (2013).
83. 42 U.S.C. § 2000e-5(g), (k).
84. For employers with 15-100 employees, the limit is $50,000; For employers with 101-200 employees, the limit is $100,000; For employers with 201-500 employees, the limit is $200,000; For employers with more than 500 employees, the limit is $300,000. 42 U.S.C. § 1981a(b)(3).
85. *EEOC v. Delaware Dept. of Health and Social Services*, 865 F.2d 1408 (3d Cir. 1989). For a comprehensive list of specific differences between Title VII and the EPA, see Perez-Arrieta AM. Defenses to Sex-Based Wage Discrimination Claims at Educational Institutions: Exploring "Equal Work" and "Any Other Factor Other Than Sex" in the Faculty Context. 31 J.C. & U.L. 2004-2005; 393, 397 n. 36.
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93. Cal. Lab. Code § 1197.5 The California Fair Pay Act expressly removed from the preexisting California pay law statutory exemptions that applied where work was performed "at different geographic locations" and "on different shifts or at different times of day." *See also* Gagnon M, Papasevastos M. Trends and Developments in Pay Equity Litigation. Seyfarth Shaw LLP. April 2018 [cited December 17, 2019]. Available from: https://www.seyfarth.com/images/content/7/8/v1/7828/Trends_PayEquityLitigation_April2018.pdf.

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97. *See* Code of Ala. § 25-1-30; Cal. Lab. Code § 432.3; C.R.S. 8-5-102; Conn. Gen. Stat. § 31-40z; Del. Code Ann. tit. 19, § 709B; HRS § 378-2.4; 820 ILCS 112/10(b)(10); Mass. General Laws c. 149 § 105A; 5 M.R.S. § 4577; 2018 Bill Text NJ A.B. 1094; NYC Administrative Code 8-107; Puerto Rico Act No. 16 of March 8, 2017; Or. Rev. Stat. § 652.220; Rev. Code Wash. (ARCW) § 49.58.005; 21 V.S.A. Section 495m. *See also* Gagnon M, Papasevastos M. Trends and Developments in Pay Equity Litigation. Seyfarth Shaw LLP. April 2018 [cited December 17, 2019]. Available from: https://www.seyfarth.com/images/content/7/8/v1/7828/Trends_PayEquityLitigation_April2018.pdf; and Visconti D. Keeping Compliant with Expanding State and Local Equal Pay Laws. Littler. August 19, 2019 [cited December 17, 2019]. Available from: https://www.littler.com/publication-press/publication/keeping-compliant-expanding-state-and-local-equal-pay-laws?utm_source=Mondaq&utm_medium=syndication&utm_campaign=View-Original.
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102. 42 U.S.C. 1320a-7b(b); Medicare and State Health Care Programs: Fraud and Abuse; OIG Anti-Kickback Provisions, 56 Fed. Reg. 35952 (July 29, 1991).
103. Medicare and State Health Care Programs: Fraud and Abuse; OIG Anti-Kickback Provisions, 56 Fed. Reg. 35952 (July 29, 1991).
104. Reasonable compensation is defined by IRS Treasury Regulations, 26 C.F.R. 1.162-7(b)(3): "It is, in general, just to assume that reasonable and true compensation is only such amount as would ordinarily be paid for like services by like enterprises under like circumstances. The circumstances to be taken into consideration are those existing at the date when the contract for services was made, not those existing at the date when the contract is questioned." *Id.* Moreover: [t]he IRS has stated that when determining whether a physician's compensation is appropriate, the tax-exempt hospital should ensure the total compensation package provided to a physician is reasonable for the physician's specialty and area. The IRS created a rebuttable presumption whereby physician compensation is reasonable if: (i) the compensation arrangement is approved in advance by an authorized body of the applicable tax-exempt hospital, which is composed of individuals who do not have a conflict of interest concerning the employment arrangement, (ii) prior to making its determination, the authorized body obtained and relied upon appropriate data as to comparability, and (iii) the authorized body

adequately and timely documented the basis for its conclusion concurrently with making that determination. If, however, an employment arrangement does not satisfy the rebuttable presumption requirements, a facts and circumstances approach will be followed, and intermediate sanctions may be imposed if it is found that the compensation is excessive. Intermediate sanctions may include the imposition of an excise tax against the physician and the hospital manager who approved the employment arrangement. The intermediate sanctions rules only apply to compensation arrangements with "disqualified persons." Disqualified persons are persons who are in a position to exercise substantial influence over the organization; this can include employed physicians, especially where the employed physician is highly compensated or holds an administrative position. However, even if a compensation arrangement does not involve a disqualified person, a tax-exempt institution cannot pay more than fair market value due to the restrictions on private inurement. Becker's Hospital Review. Physician Compensation: 10 Core Legal and Regulatory Concepts. August 19, 2013 [cited December 17, 2019]. Available from: https://www.beckershospitalreview.com/legal-regulatory-issues/physician-compensation-10-core-legal-and-regulatory-concepts.html (referencing Rebuttable presumption that a transaction is not an excess benefit transaction, 26 C.F.R. 53.4958-6).

105. IRC 501(c)(3) prohibits inurement of the net earnings of an organization to any private shareholder or individual. 26 C.F.R § 1.501(c)(3)-1states that an organization is not operated exclusively for one or more exempt purposes if its net earnings inure in whole or in part to the benefit of private individuals. *See also* Brauer LM, Kaiser CF. C. Physician Incentive Compensation. U.S. Internal Revenue Service. [Cited December 18, 2019.] Available from: https://www.irs.gov/pub/irs-tege/eotopicc00.pdf.
106. Brauer LM, Kaiser CF. C. Physician Incentive Compensation. U.S. Internal Revenue Service. [Cited December 18, 2019.] Available from: https://www.irs.gov/pub/irs-tege/eotopicc00.pdf.
107. "Fair market value is defined by the Stark Law as the 'value in arm's length transactions, consistent with the general market value…' The federal regulations have interpreted 'general market value' to refer to the compensation that would be included in a service agreement as the result of a bona fide bargaining arrangement between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, at the time of the service agreement." Becker's Hospital Review. Physician Compensation: 10 Core Legal and Regulatory Concepts. August 19, 2013 [cited December 17, 2019]. Available from: https://www.beckershospitalreview.com/legal-regulatory-issues/physician-compensation-10-core-legal-and-regulatory-concepts.html.
108. False Claims Act, 31 U.S.C. § 3729.
109. 976 F. Supp. 2d 776 (D.S.C. 2013). *See also* U.S. Department of Justice, Office of Public Affairs. St. Joseph Medical Center in Maryland to Pay U.S. $22 Million to Resolve False Claims Act Allegations; Press Release. November 9, 2010 [cited December 17, 2019]. Available from: https://www.justice.gov/opa/pr/st-joseph-medical-center-maryland-pay-us-22-million-resolve-false-claims-act-allegations (settling for $22 million allegations of payment of kickbacks; The settlement specifically resolved issues relating to professional services agreements which were being investigated for being above fair market value, not commercially reasonable or for services not rendered.); U.S. Department of Justice, Office of Public Affairs. Covenant Medical Center to Pay U.S. $4.5 Million to Resolve False Claims Act Allegations; Pres Release. August 25, 2019 [cited December 17, 2019]. Available from: https://www.justice.gov/opa/pr/covenant-medical-center-pay-us-45-million-resolve-false-claims-act-allegations (settling for $4.5 million an alleged violation the Stark Law by paying commercially unreasonable compensation (more than $2 million per year) to five physicians in return for referrals.).
110. Becker's Hospital Review recommends that: (a). A hospital should ensure that all compensation contracts with physicians are in writing, signed by all parties, do not take into consideration the volume or value of referrals and internal documentation should be retained to support the fair market value nature of the compensation. The documentation should include the manner in which the compensation was determined, the surveys utilized and whether

an opinion from a third-party valuation firm was sought. (b) All physician compensation arrangements should include a clear job description outlining the specific duties and services to be performed. Hospitals should also maintain an analysis and record of why a physician position is reasonably needed by the hospital. This may be particularly important where the need for the position may not be inherently clear or where a newly created position is being filled. (c) Hospitals should strongly consider obtaining third-party support for physician compensation arrangements where the physician is unusually productive or the compensation structure is outside normal practice. (d) As part of periodic compliance reviews, the hospital and physician should ensure that all agreements meet a core exception under the Stark Law and with comply or substantially comply with a safe harbor to the Anti-Kickback Statute. (e) It is also important that each compensation relationship is periodically reviewed on an on-going basis to ensure the compensation is still consistent with FMV and complies with applicable law. (f) A hospital should also consider adopting a reasonable compensation cap, especially if the arrangement is pursuant to a productivity-driven compensation structure. This concept is based on IRS guidance and may be more important where the arrangement has the potential for unusually high compensation. Becker's Hospital Review. Physician Compensation: 10 Core Legal and Regulatory Concepts. August 19, 2013 [cited December 17, 2019]. Available from: https://www.beckershospitalreview.com/legal-regulatory-issues/physician-compensation-10-core-legal-and-regulatory-concepts.html.

111. Massachusetts provides an affirmative defense to a Massachusetts Pay Act claim if the employer can show that within the prior three years, it completed a reasonable self-evaluation of its pay practices in good faith; and can demonstrate that reasonable progress has been made towards eliminating wage differentials based on gender for comparable work. Mass. Gen. Laws c. 149 § 105A. Oregon also provides a limited safe harbor to employers who conduct audits. Or. Rev. Stat. Ann. §§ 652.210 et seq.
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Chapter 5
Utilizing Change Management Principles to Establish Organizational Infrastructure and Operations That Drive Salary Equity

Kimara Ellefson and Kevin Eide

While many organizations may value salary equity, implementing institution-wide practices necessary to achieve it can be daunting. The process requires intentionality, short- and long-term planning, and fortitude. Institutional change takes time and leaders must stay the course. A willingness to begin the journey, agility and curiosity, and an openness to feedback can usher in greater pay equity. Stagnation is possible in the face of the hurdles that may arise; thus, it is important to keep forward movement, no matter how imperfect.

When embarking on salary equity initiatives, the overarching challenge is one of culture. As Morahan et al. state:

> Culture change is the linchpin. It is also the most difficult and intransigent of the challenges facing a transition to increased gender equity… Small and incremental changes are the best way to move forward… small incremental changes are made through assessment, critique, revision, and experimentation to promote gender equity and improve organizational effectiveness [1].

While Morahan et al.'s work focuses on gender equity in leadership, many of their insights apply to addressing the gender pay gap. Culture transformation, irrespective of the content, requires an intentional approach [2]. Iterative change and strong, consistent communication that includes sharing of information are critical to the success of salary equity initiatives [1]. Since implementing programs to close the gender pay gap and shifting individual perceptions around salary equity require a thoughtful change management approach, all explanations and recommendations in this chapter will be framed in this context.

K. Ellefson (✉)
Vice President, Human Resources and Faculty Affairs (Interim),
Medical College of Wisconsin, Milwaukee, WI, USA
e-mail: kellefso@mcw.edu

K. Eide
Associate Vice President, Financial Planning and Analytics,
Medical College of Wisconsin, Milwaukee, WI, USA

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Employing Change Management to Close the Gender Pay Gap

Buchanan and McCalman's perpetual transition model (Fig. 5.1) [3] is a roadmap for organizations embarking on the journey toward salary equity. The model illustrates Morahan et al.'s observation that transformative change is achieved through ongoing, iterative approaches. Continuous quality improvement practitioners also legitimize ongoing improvement through the Plan-Do-Study-Act (PDSA) approach (Fig. 5.2) [4].

The perpetual transition model is not linear but rather a series of intersecting steps that both repeat and overlap. The first component is aptly named the trigger layer. Faculty, staff, and leadership will be "triggered" when pay is explored. Challenges in this layer are characterized by reactive and emotional responses where clarification and communication are key. A sense of threat to established norms may result in heightened emotions in some.

Trigger Layer *This layer is concerned with need identification. Avenues for change are created deliberately and introduced as opportunities instead of threats or any crisis* [3].

If not prepared, trigger responses can come as a surprise to senior leadership. When first addressing salary equity, leaders may imagine that efforts will be received with ringing endorsement. What organizations often fail to consider is that truly exploring salary equity will threaten long-established norms, expose areas of vulnerability within existing compensation programs and structures, and trigger those in majority groups. Additionally, based on the level of department chair autonomy with an organization, salary equity initiatives can elicit a sense of control depletion or a fear of overarching bureaucracy.

While few would argue against equity, deep concerns will likely be expressed concerning how it will be achieved. Organizations should be aware that simply being "the right thing do" is not enough to garner support and adoption. A grand announcement declaring equal pay for equal work does not result in pay equity or

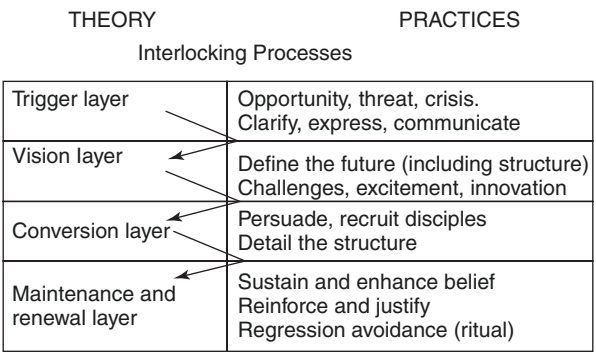

Fig. 5.1 The perpetual transition model. (Republished with permission of Taylor & Francis Informa UK Ltd. Adapted from Buchanan OA, McCalman J. High-performance work system: the digital experience. London: Routledge; 1989 and republished with permission conveyed through Copyright Clearance Center, Inc.)

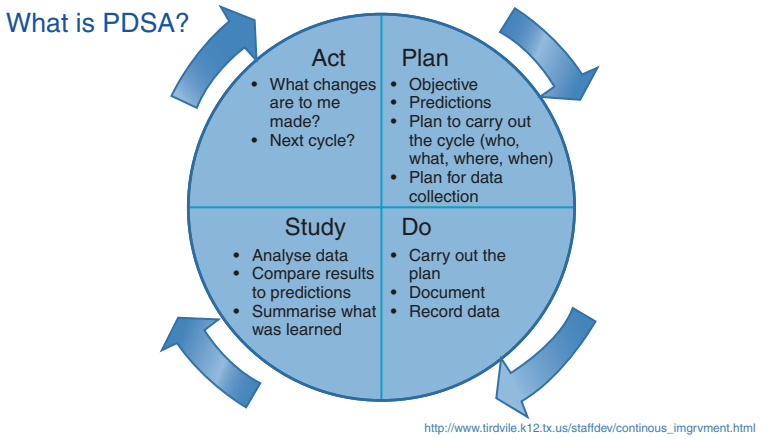

Fig. 5.2 The Plan-Do-Study-Act (PDSA) process is represented in the diagram above. The four quadrants of the circle represent steps in PDSA analysis and associated actions. (Adapted from Langley GJ, Moen RD, Nolan KM, Nolan TW, Norman CL, Provost LP. The improvement guide: a practical approach to enhancing organizational performance. 2nd ed. Hoboken: Wiley; 2009. p. 512 and reprinted with permission of John Wiley & Sons)

even greater support. What is equal pay? How is equal work defined? Will *my* work be devalued? Will *their* work be overvalued?

Organizations embark on salary equity reviews for numerous reasons, including a compelling sense that it is ethical, pressure from women physicians, or a result of work conducted at other institutions. As Lewiss et al. state, "Salary and promotion disparities are considered macroinequities; however, they are likely supported by many years of cumulative microinequities" [5]. The trigger layer is an opportunity for leaders to define the specific drivers of salary inequity and frame an approach that is oriented toward opportunities versus deficit. Understanding the goal and what success will look like is foundational to overcoming many of the hurdles that come at this stage of change management. What is the ultimate goal? Who should be part of the solution? A successful effort starts with, as Simon Sinek so aptly instructs, understanding the why [6].

The road to gender salary equity is not a one-size-fits-all solution. The micro-inequities that lead to the macrodisparities are influenced by unique cultures that exist within institutions. While studying successful approaches is instructive, each organization should develop a clear, individualized problem statement along with what success looks like. Not doing so could affect focus and result in bifurcated efforts. A core group of stakeholders, e.g., senior leadership of compensation, finance, the physician practice plan, and faculty affairs, should be identified and engaged in creating the problem statement. These individuals should have access to data needed to analyze the problem and the appropriate influence and power to effect change. The group should remain small and agile. A larger governance body can be established later to enable a broader representation of voices. We will refer to this entity as the "core group."

Gathering data that fully capture compensation inequities unique to one's organization is a foundational activity of the core group. Conducting analyses of this data, with an eye toward its limitations in examining gender pay gaps, will greatly assist in responding to trigger responses. For instance, if an institution struggles to obtain longitudinal data that fully encompass the variables present in total compensation, simply publishing information revealing men earn more base compensation than women does not clearly define the issue. Equity does not mean base pay rates are the same, and leading with too much simplicity may cause motives and planned actions to be met with skepticism. Crafting a statement identifying the problem, laying out a roadmap for success, and clearly cascading that information throughout the organization is critical. Preparation of a socialized communication plan supported by tested data analytics can assist with greater and faster adoption.

After addressing initial triggers, the core group will need to work with senior leadership, e.g., the CEO and dean, to set the vision. Challenges within the vision layer consist of governance and longitudinal planning. The vision stage acknowledges that cultural change rests on a long-game perspective. Achieving salary equity requires investment. Correcting microinequities built up over many years can be expensive and push against established practices or larger organizational pay policies. Persistence and clarity are necessary to stay the course.

Vision Layer *This layer involves articulating the future state of the organization and effectively communicating strategies and intended courses of action* [3].

Salary equity is not a problem that can be solved overnight. Disparities in early career build and by mid-career women in medicine are often systemically disadvantaged [5]. Organizations do not happen into equity. True and lasting change involves structure and the creation of common language and understanding [2]. It is in the vision stage of change management that senior leadership, in partnership with the core group, should consider establishing a larger governance body charged with crafting and adopting a compensation philosophy with equity parameters.

The governance body should have a defined charter and be composed of practice, mission, and administrative influencers (staff and physicians) across the organization with insight into institutional policies and procedures. The group will be responsible for the long-term evaluation and maintenance of policies related to salary equity and, to that end, should be empowered to solicit data, input, and recommendations from organizational constituencies and to adjudicate salary offers that fall outside of standard pay policies, guidelines, and ranges. The governance group, thus, serves as a check and balance to individual compensation decisions deemed "special" or "unique." The governance body may also help inform the core group's problem statement and guide senior leadership through obstacles as they arise.

Devoting time and resources to this step is critical for success. If oversight and standards around salary determination, from initial offer to annual and promotional increases, have not been present historically, count on a level of resistance to occur. Some department chairs may sense a loss of autonomy and fail to see how a uniform compensation policy could allow for unique expressions of need and reward at the department level. Others may welcome the guidance and shared accountability. In either case, robust dialogue most likely will ensue. Allowing debate and demonstrating a willingness to engage in conversation enhances adoption in the long run [2].

In the visioning layer of the perpetual transition model, it is important to create institutional focus and commit resourcing. Structure, definition, and inclusion characterize this stage of change management, which ushers in a move toward greater adoption. Achieving the organization's vision is dependent on prioritizing and addressing larger systemic and enterprise barriers at play. Charging the governance body with an action plan for addressing these challenges will position pay equity initiatives for success. After defining the problem, setting the vision, establishing a compensation philosophy, and prioritizing an approach to systemic barriers, the core group and governance body should begin the work of the conversion layer by engaging partners and allies. Clearly communicating an awareness and understanding of the complexity of the issues and gaining commitment from appropriate constituencies will assist in clearing the path toward action and change.

The conversion layer of Buchanan et al.'s model is focused on adoption by the masses. In this stage of change management, broader acceptance of the compensation philosophy, policies, and practices developed in the vision layer should be sought. Most of the challenges encountered at this stage involve the intersection of representation, market structures, and global implicit bias effects on pay structures.

Conversion Layer *Mobilizing support for the realization of vision can be the most efficient approach for handling the triggers of change* [3].

Wrestling with value of work and the microinequities that have led to a lack of representation in medicine are likely challenges during this stage. Michelle Obama is quoted as saying, "no country can ever truly flourish if it stifles the potential of its women and deprives itself of the contributions of half of its citizens" [7]. However, what happens when the contributions of half of those citizens are recognized but not at the same rate as that of the other half? Although more and more women have entered medicine over the past 50 years, we have witnessed no real progress in pay equity [8, 9]. This disparity remains even after controlling for the many variables that complicate determining equity like specialty, hours worked, publications, and grants.

Increased representation of women in traditionally male-dominated specialties has been described as "pink collar medicine," and physicians in these fields tend to be compensated at lower rates [10]. Organizational leadership must wrestle with this phenomenon. For example, in pediatrics, women comprise 72% of residents, 63% of physicians in practice, and 57% of academicians [11]. Is it possible that pediatrics is one of the lowest-paid specialities because it is female-dominated? Procedural specialties tend to be both male-dominated and highly compensated. Is it possible that the market value of specialties within medicine is inherently gender biased? As pay policies and practices become more public, expect these questions to be raised. It will not be enough to indicate that pay levels are what the market indicates. The market itself may be questioned. There are legitimate factors that contribute to market rate fluctuations such as supply and demand and complexity of duties. However, leaders should consider that bias may be inherent in the compensation models and market benchmarks themselves.

Additionally, women are underrepresented at the highest rungs of medical leadership [12–14], and while this phenomenon and pay equity may seem to be separate concerns, they are arguably interrelated. With fewer women than men at highly compensated organizational and academic ranks, questions of opportunity are likely

to surface with the roll out of new compensation philosophies and policies. Jena et al. looked at a cross-sectional comprehensive database of US physicians with medical school faculty appointments and found men achieve the rank of professor faster than women and overall are more likely to be full professors [15]. Moreover, it is in the early and mid-career years of being a faculty member that building the portfolio for advancement occurs and when leadership development opportunities, professional collaborations, and research funding must be secured. Much of this "opportunity" occurs during the childbearing years for female faculty, and women physicians still shoulder the majority of domestic responsibilities. Additionally, in professional life, women more than men are expected to assume essential organizational tasks, such as being on committees, which may not help with career advancement [10]. All these factors contribute to women's inability to advance and thus their diminished earning potential [15].

As organizational leaders try to understand and address microinequities inherent in the status quo, socialization of the future state should continue. However, leaders need to stay clear on the problem they are uniquely attempting to solve and avoid the temptation to fix everything at once. Start somewhere. Do something. Stay diligent in not allowing the enormity of the situation to distract from what can be done.

Factors contributing to a lack of salary equity are numerous and complex. Ongoing review and evaluation are critical to lasting change. This occurs during the maintenance and renewal layer of change management. Most of the challenges healthcare institutions encounter in this layer will involve long-established practices, both locally and nationally, as well as pressure to reevaluate compensation philosophies adopted earlier in the change management process. The perpetual transformation model defines maintenance and renewal as follows:

Maintenance and Renewal *Bringing reforms in the values, attitudes, and behaviors to realize the sustained advantages of change.*

During the maintenance and renewal layer of change, it is critical to set expectations of what ongoing governance will look like, evaluate policies and procedures, and engage leadership in continued conversation. There are often numerous institutional practices that need to be systemically assessed and altered. For instance, many organizations have embarked on representation initiatives without review of the unintended impact on salary (e.g., when women are excessively tapped for institutional service opportunities like workgroups and search committees). This "representative" service may unintentionally redirect women from work that is valued within the promotion process and compensated at higher levels. For those who are primarily clinical, it could adversely impact work relative value unit (wRVU) levels and, on the research side, impede opportunities in the lab or diminish time for grant proposal creation. Additionally, excessive citizenship responsibilities may disproportionately place women at risk for burnout and departure from medicine altogether [16].

Other organizational practices that may contribute to salary equity challenges include rigidity around cycles of rank and tenure, grant deadlines, and development opportunities such as leadership or educator training. These institutional

factors are often dictated by faculty governance policies, long-held traditions, and requirements of external funding agencies (e.g., NIH grant cycle deadline). Engaging human resources administration and faculty governance leadership to review these practices and identify possible options to increase flexibility and support women's career development should be considered. As salary equity is emphasized and becomes part of the organizational cultural milieu, practices that appear neutral at face value may be questioned. It is critical that the core group and governance body are willing to listen to all voices and work with broad constituencies to evaluate current policies and procedures and prioritize what can and will be addressed and when. Enterprise-wide partnerships and collaborations with university-based offices of compensation and human resources are also critical to long-term impact and change. Educating these compensation administrators on the nuances of physician salary (e.g., market forces, cultural context) is critical and leads to a common understanding and consensus around ways to approach existing pay gaps (see Fig. 5.2).

Experimentation at this stage is fundamental. Organizations should try models and interventions that align with identified philosophies. Leaders can employ the PDSA method (see Fig. 5.2) to explore, study, and revise multiple interventions. While many of the challenges and obstacles encountered to this point may be more conceptual in nature, the maintenance and renewal stage of change is where the operationalization of salary equity is realized. It is in the practical roll out of initiatives that an additional set of challenges may become apparent. Important considerations and their consequences in the experimentation stage are described below.

Practical Considerations and Operational Challenges

Conducting Salary Studies

A baseline salary analysis is necessary to understand which inequities need to be addressed. Taken at face value, such an endeavor may seem simple. However, conducting a salary study with data that are reliable and results that are actionable can be complicated (although highly rewarding). What are the key factors to be considered? What level of analysis and rigor is necessary? Who conducts the analysis and where and how are results shared? Consultation with legal and compliance offices is critical prior to conducting analysis and creating the first study report. Organizational stakeholders such as the head of human resources, provost, chief financial officer, faculty affairs dean, and department chairs should have an opportunity to provide input on variables where appropriate. Considering different salary benchmarks and compensation methodologies and establishing standards around survey reporting are all part of the experimentation stage. Reaching out to healthcare and academic medicine colleagues across the country and utilizing resources such as the Association of American Medical Colleges' (AAMC's) *Promising Practices for Understanding and Addressing Salary Equity at US Medical Schools*

are valuable exercises. Additionally, acknowledging and seeking to understand potential challenges inherent in assessing salary equity is useful. Challenges are as follows:

- Benchmarking when the "*n*" is low. Many benchmark or reasonableness algorithms are based on exception reporting. They are designed to identify only those salaries that are two standard deviations or more beyond the norm. Analysis therefore is implicitly looking at whether a particular individual's salary is outside of the "majority." Traditionally, this type of exception analysis assumes a minimum number in the minority and majority groups: an "*n*" of no less than three, for example. Understanding that some groups may not have a large enough "*n*" of women and men for comparison, how does one audit those salaries in a systematic, fair fashion?
- Validity of the comparison once potential discrepancies are identified. Are the men and women being compared really doing the same work? What variables are being considered? What duties would be considered "similar enough" for comparison, and which factors are delineators of difference?
- Salary standards and referenced benchmarks may vary within and between departments. When organization-wide salary standards do not exist, it is common for department-level leadership to create their own models and norms that may not align with new expectations set by the governance body. Additionally, lack of uniformity and clarity around how to quantify clinical full-time equivalents, educational and/or research effort, and pay premiums for leadership roles contributes to this challenge. Even when clarity does exist, how individual department chairs or other leaders apply them and how work is tracked and documented impede robust data analysis and impact the credibility of any salary study.

Performance and Evaluation

In light of well-described implicit biases that negatively impact the way women in the workplace are assessed [17–19] and promoted, understanding local evaluation practices is a first step toward addressing salary disparities. The highly matrixed nature of healthcare also makes it difficult for supervisors of record to be fully aware of all reports are accomplishing or the quality of those contributions. Therefore, reviewing how merit increases are determined and distributed is critical. Minimizing subjective judgment is the goal.

Many for-profit organizations have begun to remove numerical or other subjective rating systems from performance reviews [20]. Eliminating forced curves and moving to a pass/fail evaluation system have been shown to increase collaboration [21], and monetary awards may not enhance creativity, innovation, quality, or engagement [22]. In a resource-limited environment emphasizing patient-centered healthcare, team science, and clinical-translational research, any effort that encourages greater teamwork is worth considering. Goals should be created along

institutional lines of priority and areas of best contribution with merit compensation based on achievement.

Lastly, performance reviews ideally facilitate a conversation about expectations and goals. Strengths are emphasized and future success is outlined. Progress toward career advancement and promotion is forefront. With a highly educated and mission-driven physician workforce, ratings may serve little purpose beyond giving structure to merit increases which, as discussed, may be inherently biased against women. Moreover, millennials' desire to receive frequent, meaningful feedback supports a move from annual ratings to ongoing career conversations.

Cost of Equitization

Perhaps one of the most daunting challenges that organizations face when seeking to narrow the gender pay gap is how to correct salary disparities once identified. Preexisting institutional commitments, limited financial resources, and inflexible timing of business cycles and budget planning make it difficult to tackle all issues simultaneously. While we do not propose letting identified inequities continue, developing a plan that has overt leadership support may prove the best first step forward. We recommend a measured approach that ensures both the financial viability of the institution and concrete action toward correcting identified pay gaps. The salary equity governance body in partnership with department chairs and senior administrators should contribute to creating the action plan. Frank conversations about total monetary investment required must be part of discussions from the beginning and considered in relevant annual budgeting processes. Leadership must consider and determine parameters such as how far into the past should the institution go to correct pay disparities and what does that correction look like in terms of dollars and process. In addition to the initial investment to correct inequities of the past, leadership should also determine a way to address ongoing expenses. Recognizing that implicit bias exists in the culture at large (despite intentional efforts to address) and that market-based compensation benchmarks tend to increase over time, one salary correction will not solve the pay gap problem permanently.

Procedures and methodology will also need to be put in place to ensure maintenance and renewal. How often to conduct salary studies and how to fund ongoing equitization are all considerations for the governance body and senior leadership. Extending salary adjustments over multiple years may seem most prudent and realistic; however, such an approach may be too slow for those experiencing salary inequity. If affordable, annual and midyear increases should be considered for all those deemed "too low" based on institutional standards derived from core group and governing body recommendations. Special attention should be paid at least annually to make these individuals whole as soon as possible. How this equitization interfaces with usual and customary merit increases and how incentive payouts intersect must also be considered. Transparency with departments and affected individuals about plans to address salary inequities is critical.

Starting Salary, Promotion, and Tenure

Research reveals that women physicians start at lower salaries compared with their male counterparts, and this gap inflates over time [23–25]. Promotion and tenure processes are inflection points for salary progression. As detailed in Chap. 2 of this book, gender-biased differences in performance assessments and evaluations, disproportionate burden of domestic responsibilities, penalties for childbearing and negotiation, fewer allocation of professional resources, and less sponsorship impact women's ability to produce and advance. Additionally, inequities in speaking opportunities, lectureships, and award recognition impact women's ability to achieve academic promotion [5]. What are the cumulative effects of these microinequities on compensation? Taking an inventory of the metrics for promotion and tenure metrics and assessing these elements for potential gender disparities are worthwhile exercises that could lead to policy change in support of equality of opportunity and ultimately salary equity.

Depending on which entities determine and oversee recruitment, compensation practices, and academic advancement policies, partnering with human resources specialists and office of faculty affairs leaders is very useful. Routinely conducting starting-salary audits is also necessary. In addition to institutional efforts, studying the issues outlined above at the department and division level can help highlight and adjust for inequities locally. Working with unit leaders to understand why certain compensation practices exist is an important part of this process.

Academic Medicine Pay Structures

Challenges to achieving salary equity amidst the various academic missions (clinical, education, research) may need to be addressed on a case-by-case basis. Examples include the following:

- Alternative payment models that prioritize value over volume.
- Labor distribution systems that may make it difficult to understand which mission area is financially responsible for a pay gap correction.
- Diverting educational or research stipends from individuals underperforming in these domains to equitize salaries for others. This consideration may lead to a broader conversation about the value of mission-based contributions and how opportunities are determined, distributed, and compensated. Tenure considerations related to compensation may complicate adjustments.

Perceptions Despite Efforts

Closing the gender pay gap does not happen overnight. The perception that no work is being done or that change is not occurring fast enough will likely be an ongoing hurdle. In many ways, these responses reflect how organizational

leaders communicate their intentions and plans. Partnering with communications and marketing specialists around salary equity initiatives is highly recommended. Women physicians may not believe that there is gender equity in compensation or other academic resources [8]. Addressing this perception is critical. Organizations should populate equity-initiative leadership with technical and operational experts (e.g., compensation and finance staff), as well as rank and file physicians and individuals dedicated to the advancement of women in medicine and science. Diversity and inclusion staff may also be included. Creation of a center or an office that focuses specifically on gender equity within the institution should be considered.

After making it through the change cycle for the first time, employing a PDSA approach assists with ongoing review and improvement. A review of who has been represented in change leadership efforts to date and who is needed at the table moving forward is important. A common challenge when first embarking on salary equity initiatives is that influential stakeholders who populate the core group and governance body, as outlined above, tend to be men. As time goes by, the committee should review the composition of these leadership teams to ensure that female representation is robust.

We recommend that organizations examine compensation data by gender on an annual basis. Results should be shared with senior organizational administrators (e.g., medical school dean, CEO, department chairs) and all stakeholders including leaders within offices of faculty affairs, compensation, faculty council, and women's advancement. As institutional culture evolves in the context of salary equity initiatives and women physicians begin to expect transparency, an executive summary of findings and efforts should be shared broadly and consistently. Dialogue should accompany distribution of salary data, particularly with individuals who can serve as advocates and early adopters of strategies to narrow the gender pay gap. All potential inequities identified should be investigated at the organizational, department, divisional, and/or physician level as appropriate. The governance body should solicit feedback from these local constituencies and determine if strategic or organizational interventions are necessary beyond equity adjustments to correct identified pay gaps. This same governance body is responsible for continually tracking and reviewing outcomes and making adjustments to improve processes when necessary. Again, being open about what worked and what did not and what steps will be taken to narrow the gender pay gap is critical for credibility and culture change. There is a delicate balance between individual confidentiality and institutional accountability. Engaging the institution's legal and compliance teams early on in the process is advisable.

Summary

Closing the gender pay gap for physicians is not an easy undertaking. However, the complexities described above should not deter adoption of a strategic vision to compensate physicians equitably for equal work regardless of gender. Overturning processes that have been in place for decades will take time.

Intentionally evaluating salary data and thoughtfully reviewing practices that impact women's compensation are key. Being transparent about existing barriers to equity and demonstrating a willingness to address them in a timely fashion will create forward momentum.

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Chapter 6
Organizational Strategies to Support the Culture Change Necessary to Sustain Salary Equity

Valerie M. Dandar and Diana M. Lautenberger

While individual women physicians may have some agency in ensuring their compensation is fair and equitable, organizations play a greater role in closing the gender pay gap because they have the power to assess, monitor, and ultimately achieve salary equity. Institutions also have the power to create policies that sustain equitable compensation practices and to rectify biases in workplace expectations and structures that may unintentionally perpetuate pay inequities. In addition to conducting compensation audits rigorously and routinely, we recommended that organizations adopt a holistic approach that addresses the forces that potentially drive the gender pay gap [1]. To that end, this chapter will revisit the gender disparities described in Chap. 2 and referenced in Chap. 5 and provide examples of what organizational leaders can do to mitigate, if not eliminate, them to ensure equitable compensation.

To begin, institutional leaders should reflect on the following: In which roles are women physicians represented most and least throughout the organization? Where are racial, ethnic, and other minoritized groups represented? Asking these questions is the first step to taking responsibility for the diversity, equity, and inclusion in a medical enterprise because it establishes a baseline of institutional presence, agency, and power these individuals have. Leaders should also familiarize themselves with the legal risks associated with ignoring equity issues (outlined in Chap. 4) that may ultimately be greater than the costs of intentionally addressing them.

V. M. Dandar (✉)
Director, Medical School Operations, Association of American Medical Colleges, Washington, DC, USA
e-mail: vdandar@aamc.org

D. M. Lautenberger
Director, Faculty and Staff Research, Association of American Medical Colleges, Washington, DC, USA

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Medical Education and Early Career Effects on Salary

Women are overrepresented in non-procedural, less remunerative specialties. While this phenomenon does not fully explain the gender pay gap, it is a significant contributor [2–4]. However, career choices are not made in a vacuum, and academic medicine as a whole must endeavor to understand students' experiences in the early stages of medical training to identify how mentoring and environmental factors influence perceptions of specialty "fit." In a qualitative study published in 2013, women students expressed the belief that their male mentors had made gender-based assumptions when advising them about specialty choice and the feeling that gender had impacted the counsel they had received about their professional trajectories, notably advice that certain specialties were a "good career choice for women" [5]. In another study published almost a decade earlier, 45% of women medical students reported that exposure to gender discrimination and sexual harassment had influenced their specialty choices [6]. Discriminatory experiences overwhelmingly impacted women medical students; however, men students also reported similar effects when expressing interest in specialties that were not seen as gender concordant (e.g., obstetrics and gynecology). In addition to experiencing harassment and gender bias personally, witnessing discriminatory behaviors and comments directed toward others may influence women's specialty choices by signaling a culture that engenders and tolerates such actions. These studies highlight that the concept of specialty "choice" is complex and such decisions may reflect awareness of cultural contexts that are not supportive of women.

Institutions must be mindful that asking residency applicants questions about marital status and plans to have a family is not only illegal but may dissuade women from considering their organizations for graduate medical training. In a study of nearly 11,000 medical students, half of the women respondents reported being asked about these personal matters, and queries were more likely to occur in surgical program interviews [7]. Organizations have a responsibility to eliminate these gender biases that impact medical students and make faculty aware of potentially sexist career advice and queries, however well intentioned. Workshops and trainings for faculty that address how to pay attention to situations and conversations in which unconscious gender bias could emerge are vital to support equitable guidance for all students. Schools can also confidentially survey their students about their mentoring experiences, formal or informal, to assess the level of satisfaction with their mentors, especially their perceptions of gender stereotypes impacting the advice they receive. Additionally, residency program directors should take steps to standardize interview processes and conduct program-wide trainings to ensure that interviewers do not ask candidates questions about marital status and childbearing/child-rearing plans, as well as other personal questions. Lastly, medical student mentors can help equip their students with ways to respond to gender-biased questions if they arise and inform them about recourse and reporting options.

Strategies to Support Salary Equity During Recruitment and Hiring

The gaps in salary between men and women physicians emerge at the beginning of their careers, as they leave training, even when controlling for specialty, practice location, and productivity [8, 9]. Implementing standardized processes for recruitment and hiring, such that qualifications are transparently and equitably accounted for, may help eliminate initial differences in title, compensation, and resources. In particular, organizations should review policies and practices across the following areas in which implicit bias could emerge:

- Creation of job descriptions and establishment of required qualifications
- Advertisement of open positions
- Searches and active recruitment of candidates
- Review of applications and requested background materials
- Composition of interview panels
- Interview questions and evaluation of interviews
- Salary setting, negotiations, and start-up offers

Assessing gender, race, and ethnicity trends across applicants and new hires can help identify areas of opportunity to enhance diversity, particularly in specialties where women are underrepresented (e.g., surgical subspecialties). Continuous monitoring of these trends over time is a best practice to understand the impact of interventions to support equitable practices.

At the start of the recruitment process, organizations can promote salary equity by ensuring that position descriptions clearly explain duties, qualifications, and expected competencies. Institutional leaders and their human resource partners should use consistent position descriptions and general qualifications (e.g., years of experience, education completed) as much as possible for employees at the same level (e.g., rank) across units and departments. Additionally, job descriptions and recruitment materials should employ non-gendered language and neutral adjectives. For example, descriptions that use language such as “aggressive” and “risk-taking” may unintentionally dissuade women and other minoritized groups from applying [10]. Organizations may want to consider illustrating their commitment to equity from the start of the recruiting process by publishing salary ranges for open positions, eliminating questions about salary history in applications (which is illegal in certain states), and including statements in recruiting materials about the institution’s commitment to salary equity, as well as diversity, equity, and inclusion broadly. Furthermore, organizations could publicly share the number of diverse applicants and new hires to illustrate their commitment to inclusion and create accountability for progress [11].

To ensure a diverse candidate pool, organizations should broadly advertise open positions and identify, before announcing the job opportunity, the skills and competencies required for the roles. They should also post position announcements in

forums that reach diverse applicant pools, such as websites of professional societies and those specifically supporting women physicians and physicians of color. Being transparent about available positions, especially leadership positions, is critically important to facilitating gender equity because women and other marginalized groups may not have the requisite social networks to learn about these types of opportunities [12, 13]. When the process for selection is narrowly focused, or is closed altogether, outstanding candidates who may enhance the organization potentially go unnoticed and inequitable systems of hierarchy are reinforced. For senior leadership positions that may require targeted recruitment efforts, organizations should assess both equity of internal succession planning processes and opportunities for a national search.

Establishing diverse hiring committees and interview panels is critical to achieving gender equity in general and salary equity in particular. These groups, particularly those responsible for filling leadership positions, should be composed of employees who identify across genders, races and ethnicities, and position levels (e.g., ranks), among other groups, and be held responsible for identifying a diverse candidate pool for consideration [11]. To facilitate this process, organizations should require internal recruiters, hiring committees, and interviewers to undergo unconscious bias training prior to engaging in the recruitment and hiring process.

Developing standard criteria for candidate selection and de-identifying names and genders from applications are useful strategies to support gender equity. Some institutions have taken steps to implement "Rooney Rule"-like practices as part of their search processes, i.e., continuing a search until the candidate pool satisfies previously agreed upon diversity metrics. (Adopted in 2003, the Rooney Rule is a National Football League policy requiring every team with a head coaching vacancy to interview at least one or more diverse candidates.) The rationale for this approach is supported by Johnson and colleagues' study that found that the chance of a woman being hired was 67% when 75% of a candidate short list was women, 50% when half were women, and 0% when only 25% of the short list were women. As the authors stated, "If there is only one woman in your candidate pool, there is statistically no chance she will be hired" [14].

Establishing expected competencies, applicant review criteria, and interview questions ahead of time helps prevent biased assessments and hiring recommendations such as "getting a good feeling" about a candidate or deeming that a certain individual would be a good "fit." Additionally, descriptions of "feelings" or "fit" should be red flags to committee chairs and hiring authorities that implicit gender bias may be contributing to the selection process. Similarly, when determining appropriate compensation for a recruit, ranges for total cash compensation and amount of start-up support should be discussed among appropriate individuals in the organization, versus determined by one individual, and identified prior to applicant selection for interviews.

Historically in medicine, individual compensation and professional resource allotment (e.g., administrative assistance, office space, lab equipment) have been subject to negotiation. While institutions can offer negotiation skills training to all employees to enhance their comfort and competence, closing the gender pay gap

requires systems-level attention and change to diminish the effects of negotiation on salary and other support. To eliminate the pay gap, organizations must tackle implicit biases and cultural expectations that disadvantage women and benefit men [15–17].

Research has shown that women report less comfort with negotiating because they fear being labeled as aggressive or unlikeable [16, 17]. This finding is particularly relevant because women's success in the workplace has been linked to their perceived "likeability," as opposed to their performance or competence [18]. By minimizing the impact of negotiation on offers of compensation and other support, there is an opportunity to ensure that comparable skill sets and roles, and not what an individual may say they want, dictate the terms of employment. Such an approach facilitates equity [19].

Organizations may also choose to disclose salary ranges for new positions publicly. Alternatively, institutions could eliminate negotiation processes for new hires all together, similar to employment among government workers [15]. Regardless of an organization's decisions to disclose salaries or eliminate negotiations, institutions can implement a system of checks and balances by designating a small group of leaders to review offer letters prior to final presentation to candidates. With this type of oversight, offers can be examined for consistency in salary and non-salary resources such as start-up funds, lab space, and administrative staff.

Determining Compensation and Assigning Physician Workload

Achieving salary equity relies on increased access to information about compensation, open dialogue, and consistent, systematic review. Such efforts help dismantle beliefs that employees are discouraged from discussing compensation [20]. Organizations stand to gain employee trust, engagement, and retention through transparency around compensation practices.

Pay equity should be a primary goal when setting salary at the start of a physician's career, in addition to throughout one's career progression, because initial salary disparities widen and add up financially over time. In order to prioritize equity, organizations should examine their compensation and reward structures to ensure alignment with their mission and values. Additionally, institutions should consider developing an overarching compensation philosophy that clearly articulates the components of pay, the process by which physicians earn specific compensation, and the principles, such as employee equity, patient satisfaction, and healthcare quality, that underpin approaches to determining compensation.

In 2018, the American College of Physicians (ACP) issued a statement on equity in physician compensation that may serve as guidepost for organizations seeking to actualize their commitment to salary equity. The announcement stated that the "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; not based on characteristics of personal identity, including gender. Physicians should not be penalized for working less than full-time" [21]. The following section of this chapter will detail why organizations should consider these factors when designing compensation plans, setting individual salaries, and conducting equity studies.

Consistent Use of Equitable Compensation Plans

As part of their compensation philosophy, organizations should establish clear criteria and processes for determining compensation. These standardized salary-setting practices should be implemented across the organization to ensure consistency and accountability. Whether compensation is determined by human resources or front-line managers, organizational leadership and those with hiring responsibilities should be held accountable for implementing salary standards [22]. To ensure consistent application of compensation policies, hiring authorities in the organization should receive training on the current compensation plan and data on the current state of salary equity at the institution, as well as educational programming about the ways that inequities can emerge in salary setting. Additionally, "in large organizations, as managers come and go, it is important to ensure that both unconscious bias training and the continuous evaluation of pay inequities is [an] ongoing" and annual organizational consideration [19]. These types of trainings are opportunities to empower individuals involved in hiring and salary setting to take ownership for equitable pay practices and help them to communicate with employees about the compensation plan and the organization's efforts to support equity (e.g., regular salary studies). Further, by hosting annual informational sessions for employees about compensation plans, organizations can promote a foundational understanding of institutional practices.

When developing or revising compensation plans, organizations should consider the complex array of forces that drive physician pay and establish clear criteria for determining base salary, incentives and bonuses, and administrative supplements for leadership roles. If job descriptions are comparable, physicians of similar educational experience, certifications, and time in position should be paid similar salaries. Organizations should also use salary benchmarks from national physician organizations and specialty societies to inform compensation setting and assess equity with the external market. For research positions, expectations of productivity and salary coverage should also be clearly established. As described earlier in this book, incentive payments are often where gender inequities arise. Easily understood metrics for determining this type of compensation, such as excellence in productivity, quality, service, or other performance indicators, should be part of an

organization's compensation plan. Institutions may also consider if specific types of incentive payments, such as those for productivity or quality, are distributed based on individual performance or divided equally among individuals within a department. Furthermore, those who supervise physicians must also assess fairness among workload assignments, if productivity plays a role in compensation.

Equitable Assignment of Physician Responsibilities

Organizations can address potential salary inequities by ensuring equitable distribution of duties and schedules both at initial hiring and as part of annual performance reviews. If pay reflects the number of patients seen and procedures completed, it is important to ensure that there are opportunities for all physicians to generate similar compensation within a given specialty, division, or department as appropriate. Organizations should designate individuals to review the aspects of workload and compensation that may impact a physician's ability to generate revenue like procedural volume, on-call duty and coverage scheduling, billing practices, and payer mix [23]. In doing so, they should also consider that time studies and studies of readmission rates demonstrate that women physicians may be seeing fewer patients but have better patient satisfaction and health outcomes [21, 24].

Compared with their male colleagues, women physicians have increased responsibilities for dependent care and domestic duties [25–28]. Leaders should ensure that women do not face "penalties" in the workplace for attempting to balance their time and consider flexible scheduling options to ensure equitable earning opportunities for all employees. Adopting an identity-conscious approach that accounts fully for individual physician scheduling needs could promote equity of compensated workload among employees [29].

Likely as a result of implicit gender bias, women in the workplace are assigned or expected to volunteer for nonrevenue-generating activities, such as teaching and organizational service, more than their male counterparts [30, 31]. If organizations are committed to closing the pay gap as well as valuing teaching, research, and organizational engagement, they must consider accounting for and/or allocating additional compensation for this type of work.

Lastly, organizations should have clear and accessible policies for employees who wish to pursue part-time positions and processes for returning to full-time work. Those who seek to switch from full-time to part-time should not be penalized. Compensation may be proportionally reduced, but evaluation of productivity and achievement should be also proportionally assessed. If a physician works part-time for a certain period and then returns to full-time work, her compensation should equal that of a peer who worked full-time throughout [32].

In order to assess the adherence to compensation policies and equitable workload assignments within and across departments, organizations should regularly review salary equity trends within the context of workload distribution to ensure

opportunities for pay are available to all physicians. In addition to examining the quantitative data, departmental leaders and physicians should engage in ongoing conversations about compensated and uncompensated work and seek to understand how gender-driven factors, such as the need to take care of dependents, might be contributing to eligibility for remunerative assignments.

The Impact of Family and Dependent Care on Salary

In most healthcare enterprises, the less time physicians spend seeing patients or bringing in grant funding, the less income they will earn. As noted above and in previous chapters, implicit cultural expectations around family and dependent care exist in our society and our workplaces. Studies have shown that women physicians assume family and domestic duties more than their male counterparts, which may reasonably translate into the need to work fewer hours [25–28]. Yet, the rationale that women choose to work less and therefore earn less oversimplifies a complex set of challenges to salary equity driven by societal and organizational gender stereotypes that inform and dictate such "choices." Institutions have an opportunity to introduce policies, benefits, and language that recognize and mitigate these cultural biases.

As a first step, organizational leaders should hold critical meetings during the workday since early morning and evening gatherings tend to conflict with family responsibilities. If meetings must be held at these times, institutions should make it easy to participate remotely. With so many technological options available for virtual meetings, as well as availability of IT staff at most healthcare organizations, hosting meetings that allow remote participation should be the norm not the exception. It should also be emphasized that adjusting organizational policies and practices to reflect the current imbalance of family and dependent care is not enough. Institutions should strive to create workplaces that dismantle gendered expectations of domestic responsibilities and adopt standards that promote cultures supportive of both men and women physicians balancing careers and family responsibilities.

While shifting organizational culture may seem daunting, simple actions can support an equitable environment around family and dependent care. For example, using gender-neutral terminology like "parental leave" instead of "maternity leave" in institutional policies and communications negates stereotypes about what mothers' and fathers' roles are in the home. However, even when generous parental leave packages exist, there may be social stigma attached to men who take leave. Organizations should track usage and create educational programming for employees that actively encourages both men and women who parent to take advantage of this benefit. In fact, organizations could jump-start culture change in this realm by bringing greater awareness, visibility, and clarity around parental leave policies when initially onboarding learners, physicians, and staff. Lastly, elder care has been shown to fall disproportionately on women, and so organizations should consider these responsibilities as part of family-friendly policies to avoid penalizing women

physicians' productivity in early career due to parenting and then later when elder care responsibilities typically emerge [33]. Again, this loss in productivity is not necessarily due to individual choices but to societal expectations about who cares for the family and can have significant impact in total compensation over time.

Advancement, Promotion, and Leadership

We learned in earlier chapters about how organizational transparency regarding open leadership opportunities and sponsorship from those with power can support successful advancement for women and also how the gender biases in promotion processes can contribute to salary inequities. Eliminating potential drivers of disparities and closely monitoring advancement outcomes will be key to building greater diversity at the top leadership levels of healthcare organizations. This endeavor builds momentum as individuals who achieve these positions of power can strongly influence systems-based change in support of gender equity and narrow the pay gap.

Bringing clarity and transparency to promotion processes itself is a good first step. Promotion criteria, particularly in academic medicine, are often complex and vulnerable to subjective interpretation, and research indicates that women may be encouraged to wait longer before seeking academic promotion when compared with men [34]. Creating greater transparency about the metrics and process for promotion can mitigate the impact of this gender bias. Designing easily accessed websites and policies explaining the promotion process, offering promotion and career-planning workshops, and requiring discussion of professional goals and advancement strategies as part of a physician's annual review support equity of opportunity in this sphere. Additionally, ensuring equitable representation of men and women on academic promotion committees and performance review panels and requiring unconscious bias training for members of these entities are essential in raising awareness and promoting fair processes. These trainings should include a discussion of gendered language that evaluators may unconsciously use in their recommendations and support letters [35]. To help with this endeavor, institutions could choose to use commercially available software programs to detect when this language appears in promotion documents. Lastly, given that women physicians might be spending increased time in organizational service activities or teaching, as opposed to clinical duties, it is important to consider these contributions and potential inequities among work assignments in promotion decision-making.

Last but not least, organizations must cultivate a culture of sponsorship for all physicians at all ranks, recognizing that sponsors are integral to organizational and academic advancement and provide the networks and opportunities that facilitate consideration for open leadership positions [36]. Sponsorship that happens informally or without a mandate for inclusion most often benefits men and disadvantages women because of the existing imbalance of men in senior positions. Institutions should also require that leadership opportunities are advertised widely instead of

simply appointing individuals deemed qualified without consideration of others who might be interested and eligible. Particular attention should be paid to "batter-up" positions like medical director, division chief, department vice chair, and roles that require budgetary, operations, and people management since these are often the precursor positions for senior-most leadership. In additon, organizations would do well to track which leadership responsibilities carry additional compensation, who tends to fulfill those duties, and why.

Measuring Organizational Progress Toward Salary Equity

Institutions that openly and proactively look to address and reduce systemic inequities demonstrate there is an organizational commitment to creating an environment of equal opportunity and diversity in the workplace. Critical to this conversation is the notion that equity is not just a women's issue or an issue only for marginalized people. It is a sound business practice in which the organization and all its employees benefit from increased transparency, objectivity, and inclusivity in culture, policies, and practice [37]. By acknowledging that equity is an issue for all employees and reporting their current progress toward equity, leaders can build trust and ensure organizational accountability for outcomes [38].

While some organizations in the United States publicly communicate their progress towards equity, and some states and cities have developed regulations in this sphere, the U.S. has not enacted federal laws mandating salary equity disclosure [19]. However, in the United Kingdom, "employers must publish their gender pay gap data and a written statement on their public facing website and report their data to the government through an online portal." In Australia, "all private sector employers with 100 or more employees must annually report pay data [and other gender equity measures] to [their national] Workplace Gender Equality Agency [20]. Common to both approaches is the regular evaluation of salary equity, public reporting on progress, and accountability to address the issue. While U.S. federal laws do not mandate reporting, other organizations external to direct healthcare providers, such as funding agencies, accrediting bodies, licensing boards, and medical societies should, "closely examine their operations and leverage for change to ensure parity of funding, research, and leadership opportunities as well as transparency of assessment and accreditation" [38].

To build accountability, boards of organizations and CEOs should hold leaders responsible for setting gender equity goals and making progress toward equity akin to other organizational performance metrics in finance and operations. To do so might entail the development of "gender equity plans […] defined as a consistent set of measures and actions aimed at achieving equity by gender" or incorporating gender equity measures into organizational scorecards [11]. Leaders might consider including the following types of metrics examined by gender for scorecards that they continuously monitor: trends in applicants and new hires, ratios of new hires compared to internal promotions, ratios of women and men physicians by specialty

Table 6.1 Suggested metrics for a gender equity scorecard

These metrics should be tracked over time by gender, specialty, rank/position level, race/ethnicity, and age:
1. Full-time and part-time positions
2. Organizational leadership (e.g., medical director, division chief, department chair, vice president, C-suite/decanal positions)
3. Applicants and new hires for recently open positions
4. Internal promotions and time to promotion
5. Retention trends (e.g., retirees, turnover, and open positions)
6. Participation in mentorship and leadership development programs
7. Selected grand rounds speakers and organizational awardees
8. Initial salaries and start-up packages for new hires
9. Pay gap analyses
10. Allocation of incentive and bonus payments
11. Organizational climate assessment data (e.g., engagement, harassment, perceptions of equity)
12. Usage of ombudsman office and harassment reporting systems, including rates of resolved incidents
13. Usage of family and dependent care policies and programs (e.g., parental leave, child/elder care services)

and rank, salaries and start-up packages, time to promotion, and women in leadership, among others (Table 6.1). All metrics established should also account for intersectional approaches to analysis and examine differences among women by race and other identities. Doing so might illuminate deeper inequities and challenges that women who identify with multiple marginalized groups may face. Organizations can build trust among employees by publishing these goals and progress toward them, in addition to results of salary equity studies and changes to policies that may impact compensation.

Moreover, organizations benefit when employees across all levels are involved in equity efforts. In order to monitor progress on salary equity and gender equity issues at large, institutions should create standing committees responsible for designing, reviewing, and managing ongoing salary studies, in addition to those reporting on gender equity metrics. Equity committees should have a diverse membership of men and women from across different disciplines and specialties across the healthcare enterprise to allow for maximum feedback and support. Leaders from human resources, finance, and diversity offices, as well as department leaders and junior- to mid-level physicians, should be engaged. Bringing together a diverse group is critical to ensure all employee voices can be represented. Especially as salary equity studies are conducted or changes to compensation plans are made, it will be important for organizations to designate a small group that can be seen as trusted experts to address physicians' questions about salary setting and equity.

Given their systemic nature, issues of equity are rarely solved easily or quickly and will require ongoing, dedicated organizational approaches that are holistic in scope [1] (Table 6.2). In addition to conducting salary studies and launching equity

Table 6.2 Top-ten organizational actions for holistically addressing salary equity [1]

1. Establish gender equity 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 as well as identifying and addressing drivers of compensation disparities
3. Track the representation of women across units, in leadership roles, among new hires, and among academic and organizational promotions, and assess the impact of gender equity initiatives on these metrics
4. Examine recruitment practices, and audit salary offers and start-up packages to identify opportunities to improve gender and pay equity through process change
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 in which gender bias can emerge such as job negotiations, performance evaluations, and sponsorship
7. Develop formal sponsorship programs and networking opportunities to promote professional advancement for women physicians
8. Explore underlying challenges to compensation and productivity that may result from increased domestic responsibilities (e.g., bonus pay for extra call, inflexible work hours), and implement solutions that increase opportunity for all (e.g., remote meeting attendance)
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 the gender pay gap. Track and share progress to enhance accountability and garner trust

initiatives, institutions must anticipate and gain clear consensus around funding sources to address compensation inequities. Organizations should determine whether funds used to correct these inequities will come from a central organizational budget or individual departmental budgets. In either case, they should consider allocating funds for equity adjustments as part of the overall annual budgeting process. While addressing salary equity is a challenging task, institutions that commit to transparency and dedicate resources to advancing gender equity can make true progress. The most important step in eliminating the gender pay gap, however, is self-assessment and reflection. By closely examining salary data, compensation practices, and human resource management policies, organizations can start the journey toward achieving and sustaining equity.

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Chapter 7
Exemplar: Closing the Gender Pay Gap at the Medical College of Wisconsin

Kimara Ellefson and Kevin Eide

The Medical College of Wisconsin (MCW) is a private health sciences university located in southeast Wisconsin. MCW is home to approximately 1,300 students across its Medical, Pharmacy, and Graduate Schools, 700 physicians in residency, 200 physicians in fellowship training, and 2,000 faculty (Fig. 7.1). Additionally, MCW has more than 1,650 physicians and employs the largest physician practice group in the state. The institution has over a decade of experience successfully addressing the gender pay gap among its physicians, faculty, and staff and during that time has carefully developed processes, methods of communication, and cross-disciplinary collaborations necessary to achieve salary equity; positioned leaders to support the mission, and adopted measures and practices to ensure accountability.

MCW's effort to incorporate principles of gender pay equity into compensation decisions began in 2007 when the Women's Faculty Council (now Council for Women's Advocacy) requested information about the institution's pay practices and how it ensured equitable compensation for women. With consistent leadership support and an overt organizational commitment, MCW created infrastructure and processes over the subsequent 2 years that have since allowed the institution to prioritize equitable pay outcomes for MCW faculty and staff. In this chapter, we will review the stages involved in building that essential foundation and share the faculty pay practices, business rules, and governance structures that sustain the work to this day. As has been stated in preceding chapters, closing the gender pay gap in medicine is an ongoing process and takes constant vigilance. However, it is our hope that MCW's journey will help other institutions lay the groundwork necessary to achieve equitable compensation among its valued faculty and physicians.

K. Ellefson (✉)
Vice President, Human Resources and Faculty Affairs (Interim),
Medical College of Wisconsin, Milwaukee, WI, USA
e-mail: kellefso@mcw.edu

K. Eide
Associate Vice President, Financial Planning and Analytics,
Medical College of Wisconsin, Milwaukee, WI, USA

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Faculty	
Teaching/Research/Clinical	1,715
Lecturer/Instructor	103
Visiting, Emeritus, Voluntary Adjunct	105
Total Faculty	**1,923**
Students	1,300
Postgraduates, Associates and Fellows	1,000
Staff	4,364
Total Community	**8,587**

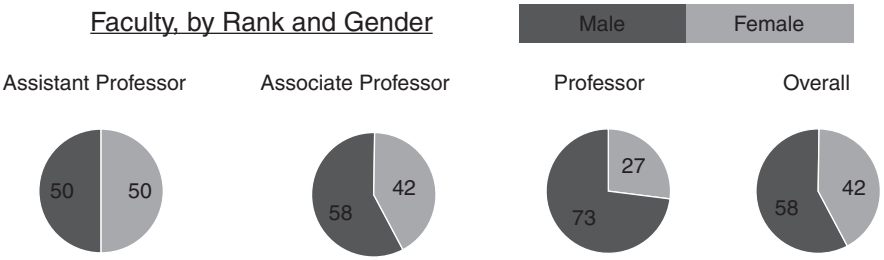

Fig. 7.1 Medical College of Wisconsin, 2019, workforce and learner overview

We will describe MCW's journey based on the following segments:

I. Laying the foundation: philosophy and governance
II. Communication: clarity and transparency
III. Business process: benchmarking and definitions
IV. Accountability: annual review and reporting
V. Next steps: sharpening the saw

Laying the Foundation

It has been said that culture, a system of shared beliefs, eats strategy for breakfast. Appreciating this reality, MCW began its journey by articulating salary equity as a core principle of the organization's compensation philosophy such that examining salaries with an eye toward fairness and paying individuals based on experience, performance, responsibility, and market-competitive benchmarks became identified as the "right thing to do." Furthermore, it was explicitly acknowledged that these principles, and not gender, were to drive how compensation decisions were made, negotiated, evaluated, and reviewed going forward. From this baseline, key elements of an equitable compensation system could then be developed, maintained, and assessed. While there was immediate support from the top leadership to adopt the new compensation philosophy, MCW proactively sought buy-in from Chairs and other department leaders who would be making the lion's share of pay decisions.

MCW established an Institutional Compensation Committee (ICC), which reported directly to the president and chief executive officer (CEO). The institution's primary business officer, the executive vice president and chief operating officer, was appointed chair of the committee and other key leaders were appointed as members, including individuals from each mission area – education, research, patient care, and community engagement. The institution's compensation team staffed the committee to ensure that members had ongoing and direct access to internal pay data, market benchmarks, and professionals who could provide analysis, address questions, and field ad hoc requests.

The preamble to the ICC's charter defined its responsibilities as follows:

- Assisting the president in matters related to the compensation of MCW faculty and staff and ensuring compliance with all applicable rules and regulations
- Developing or revising MCW compensation policies or guidelines and reviewing and approving department compensation plans.
- Reviewing and approving benchmark methodology and reviewing and approving individual compensation levels beyond thresholds established in policy.

With a governance body comprised of key leaders representing different missions and functions across the organization and reporting to the president convened, institutional support for the initiative gained momentum. The ICC gathered and reviewed compensation data and developed policies to reflect the new compensation philosophy. Pay decisions heretofore were based on the four elements of experience, performance, responsibility, and alignment with market-competitive benchmarks.

Communication

Communicating and engaging department leaders, while laying the foundation described above, was a time-consuming and, at times, difficult undertaking. Historically, MCW had relied on a decentralized faculty compensation process distributed across a federated array of departments. While there was no debate about the importance of pay equity, there was tremendous concern expressed about potential consequences of centralizing a process critical to the success of each academic unit. The perceived consequences were many, such as an inability to account for nuances of faculty effort and skills, generalizing data without appreciating the local perspective, lack of flexibility when needed, loss of control over decision-making, increased workload, and accuracy and availability of national benchmarks. Over an 18-month period, the compensation team facilitated over 90 meetings with department chairs and other leaders to shape a formal Faculty Compensation Policy that defined and offered guidance on the four elements involved in setting levels of compensation. Subcommittees of the ICC worked on messaging and building a communications strategy, refining the methodology for making compensation decisions,

and evolving compensation practices that, by the end of the year-and-a-half long process, achieved a high level of adoption.

In retrospect, developing a thoughtful, inclusive, and strategic communication plan was a critical activity. This is where the rubber hit the road and determined how comfortable leaders would be with an intentional shifting of culture. Sitting at the table with leaders who would be making individual compensation decisions and taking the time to listen to their concerns took patience and perspective. We built trust by adapting policies to address credible concerns while maintaining the core principles of equity. How other institutions will successfully operationalize this work will likely vary. Our experience suggests the value of finding trusted individuals within the organization who agree to champion the initiative and participate not just in conversations but also in crafting frameworks for discussion and next steps. These champions are essential. Seeking them out and imparting the compensation vision to then will reap great dividends.

Finally, MCW's new compensation philosophy held that paying people equitably was the right thing to do and was also a good business decision. As such, part of the communication process was to ensure that financial elements, like resources and funding to support salary equity, were thoughtfully and transparently addressed.

Business Process

MCW intended to incorporate equity considerations into routine compensation discussions and to influence each decision point, including initial hire, promotion, annual compensation planning cycle, market adjustment actions, ad hoc retention, and exceptional situations. Achieving this level of coordination took an ongoing collaborative effort among the compensation, faculty affairs, and compliance teams, as each domain had responsibility and influence over different aspects of these processes.

Using the most robust benchmark data available is critical for successful salary equity work. Therefore, MCW invested a significant amount of time developing a fair market value (FMV) methodology based on well-regarded benchmarks and best practices in the marketplace.

To achieve consensus about which benchmark data would be most trustworthy and appropriate, the compensation team circulated a white paper setting forth principles and selection criteria to define benchmark data that would be both compliant with applicable legislation and reflective of accepted practices. To create this guide, the compensation team relied on discussion points raised during the prior 18 months. The white paper outlined how MCW would utilize various sources of data from professional associations as well as ad hoc, unpublished, and "park bench" data. Because validating this information would require time and resources, it was important to communicate the criteria MCW would employ to evaluate appropriateness

What to Look For	What to Avoid
Surveys that follow survey safe harbor guidelines	Surveys that report any data in violation of Survey safe harbor guidelines
Surveys conducted by firms that take care to clean and analyze data	Surveys conducted by firms that do not clean or analyze participant data
Surveys that have a consistent level of participation year over year	Surveys with wild fluctuations in participation year over year

Fig. 7.2 Medical College of Wisconsin, characteristics of reliable benchmarking data

and rigor and the threshold that data had to meet to be considered as compensation benchmarks. These criteria are described below.

MCW relies on the following elements to define reliable data and characterize the salary survey data it will accept:

- In compliance with the Sherman Anti-Trust Act.[1]
- Survey must have an adequate sample size.
- No secrets about the data or methodology.
- Survey sources and sample sources always identified.
- Data are timely and up-to-date, and the effective date of the data are well-defined.
- Job matching standards are clear.
- Competitive marketplace from which they are drawn is understood.

Additionally, the best practices for survey selection require the characteristics outlined in Fig. 7.2 to ensure consistent business rules and data continuity from year to year.

Lastly, in selecting benchmark data for FMV calculations, MCW considers survey methodology, who reported the data, and how it was collected. Data reported by institutional personnel and collected through a method that is reliable and as error-proof as possible is the most desirable. When appropriate, we also consider who is reviewing and aggregating the data and determine whether data anomalies are confirmed with participants.

Our FMV methodology has established a standard platform to review compensation from a regulatory, market-based, and consistent perspective. It blends total compensation benchmark data from clinical, academic, and administrative leadership survey sources into a single composite value and weights data based on faculty's allocation of effort. Figure 7.3 is an example.

[1] The Survey Safe Harbor Guidelines, which dictate how compensation data are reported, originate in legislation dating back to the Sherman Anti-Trust Act of 1890 and require that survey data must be conducted by an independent third party; reported data must be at least 3 months old; each disseminated statistic must have at least five companies reporting data, and no individual company's information can represent more than 25% of each disseminated statistic.

Rank	Total FTE	Clin FTE	Acad FTE	Admin FTE	Ext FTE	Base Pay	Incentive Pay	Total Comp	FMV Total Comp Median Benchmark	FMV Percentile
Assistant Professor	1	0.60	0.20	0.20	0.00	$200,000	$20,000	$220,000	$229,835	44%

Clinical Benchmarks	Median
American Medical Group Association (AMGA)	$233,396
Medical Group Management Association-Physician Practice (MGMA)	$237,052
Sullivan Cotter and Associates, Inc.	$200,129
Average	**$223,526**

Academic Benchmarks	Median
Association of American Medical Colleges (AAMC)	$228,825
Medical Group Management Association-Academic (MGMA)	$202,730
Average	**$215,778**

Administrative leadership Benchmark	Median
Sullivan Cotter and Associates, Inc. (Medical Director Role)	**$262,818**

Clinical FTE Weighted Benchmark (0.60 x $223,526):	$134,115
Academic FTE Weighted Benchmark (0.20 x $215,778):	$43,156
Administrative FTE Weighted Benchmark (0.20 x $262,818):	$52,564
	$229,835

Fig. 7.3 Medical College of Wisconsin, example of fair market value methodology (blends total compensation benchmark data from clinical, academic, and administrative leadership survey sources into a single composite value and weights data based on faculty's allocation of effort)

Figure 7.3 shows only the FMV median values. However, benchmark data typically report quartile ranges (25th, 50th (median), 75th, etc.) as well. The MCW Faculty Compensation Policy defines compensation quartiles based on faculty experience, performance, and responsibilities. Individual compensation is reviewed for alignment to FMV. (Clinical productivity metrics are sourced from academic medical centers as published by Vizient; research productivity is often measured by publications in tier-one journals and percent of grant funding; educational productivity is typically measured through teaching evaluations, awards, etc.)

1. *Total Compensation <25th percentile*: Total compensation <25th percentile of FMV typically reflects faculty new in their rank or career, low in academic and/or clinical productivity, or other reasonable business factors. Departments are responsible for annually reviewing and assessing compensation under the 25th percentile for appropriateness and developing action plans.
2. *Total Compensation ≥25th percentile but <50th percentile*: Total compensation approaching the 50th percentile of FMV characterizes faculty consistently performing near expected levels and demonstrating academic and/or clinical productivity approximating market averages.
3. *Total Compensation ≥50th percentile but ≤75th percentile*: Total compensation ≥50th percentile but ≤75th percentile of FMV, when appropriately matched with productivity, characterizes faculty consistently performing at/or above expected

levels and demonstrating academic and/or clinical productivity at/or exceeding market averages.

4. *Total Compensation >75th percentile but <90th percentile:* Total compensation >75th percentile must be justified by benchmark academic and/or clinical productivity metrics or other reasonable business factors such as those listed below:

   - Institutionally recognized strategic importance of a clinical specialty or program
   - Documented recruitment/retention difficulties in a clinical specialty
   - Individual training, clinical skills, and national reputation
   - Exceptional sponsored research and/or scholarly activity

The approach above is anchored in rigorous benchmark data that adhere to safe harbor guidelines and creates a common framework for all those who make compensation decisions. Its methodology is communicated widely and allows the organization a consistent set of standards against which to test compensation decisions and assess for outliers. Each compensation decision, from hiring, promoting, and awarding annual increases, follows the same set of guidelines.

Accountability

At MCW, our goal is that every faculty salary is benchmarked to the best possible data and complies with parameters set forth in the Faculty Compensation Policy. By infusing each decision point with principles grounded in pay equity and providing benchmark-based guidelines, we expect to identify a limited number of pay inequities during the annual internal audit process. For example, out of 1389 qualifying faculty in the 2017 internal review, salaries of three women and three men were flagged for further investigation and follow-up. This represents less than 1% of each gender population.

MCW's Office of Corporate Compliance conducts individual and cohort-based reviews of all faculty compensation annually with a focus on levels that are less than the 25th percentile or greater than the 75th percentile of stated benchmarks. Biennially, the Office of Corporate Compliance performs a faculty compensation analysis for potential gender and ethnicity equity issues that follows the methodology suggested by the US Equal Employment Opportunity Commission (EEOC) and incorporates elements of the Median Compensation Analysis suggested by the Department of Labor's Office of Federal Contract Compliance Program (OFCCP). (These audits involve statistical approaches that use regression analysis or standard deviation from the mean to flag compensation rates for review.)

Corporate Compliance in partnership with Compensation Services first discusses outliers or areas of concern with academic department leadership and requires written explanation to justify potential differences. Corporate Compliance reviews these justifications and in partnership with Compensation Services presents them to the

Institutional Compensation Committee along with recommendations for remediation. The Compensation Services team follows through with academic department leadership to implement any compensation adjustments. A summary of all results and actions taken is then presented to the president/CEO, provost/dean of the school of medicine, and executive vice president/chief operating officer.

Compensation Services, a team of consultants and analysts within human resources at MCW, works collaboratively with academic department leaders on these decisions throughout the year and provides insights based on available benchmarks, internal data, and institutional equity considerations. Department leaders also receive, as part of the annual compensation planning cycle, a Compensation Consulting Report with salary data for their individual departments and specific recommendations for the upcoming fiscal year. These suggestions incorporate the gender equity pay principles discussed above as well as general, merit-based guidelines.

Below is an inventory of elements included in the Corporate Compliance analyses as well as the Compensation Consulting Reports shared with the departmental leaders:

Equity Review Methodology

Inclusions

- Basic science and clinical department faculty
- Chair, chief, professor, associate professor, and assistant professor ranks
- DC, DDS, DO, DVM, MD, MS, PhD, PsyD Degrees
- Full-time and Full Professional Effort faculty (total FTE $\geq$ 0.5)
- MCW and external (e.g., VAMC) compensation, including bonus and incentive
- MCW productivity data (work RVUs, % of extramural funding to research salary)
- External compensation and productivity benchmarks (AAMC, AMGA, MGMA, Sullivan Cotter, UHC)

Criteria

- Must have been employed by MCW at least 6 months of the year
- MCW base salary > $0 (e.g., excludes affiliate employees with MCW appointments)

1. *Market Percentile Distribution Analysis (Organization Level)*
   All faculty compensation rates are stratified by market percentile category (<25, 25–50, 50–75, >75) and gender or URM group. Using a chi-squared test, flags a market percentile category if there are disproportionate counts by gender or URM group. If a category is flagged for review, further analysis is performed to identify the factor(s) causing the difference in distribution.
2. *Internal Gender and URM Equity Analyses (Peer Group and Individual Level)*
   Assigns faculty into peer groups based on specialty, rank, and people group (e.g., faculty clinical, faculty research). Peer groups qualifying for review must

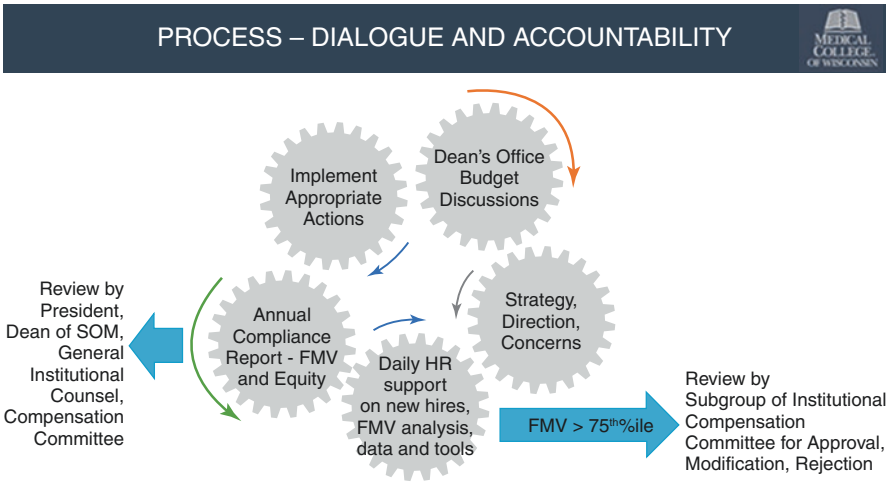

Fig. 7.4 Medical College of Wisconsin, salary equity process

have at least three faculty members and one faculty of each gender or from each URM group. Identifies peer groups where one gender or URM group has lower median compensation ($2000 or greater difference) and higher median years in rank. Within the peer groups flagged for a potential compensation gap, individual faculty compensation is flagged for departmental review if lower than the other group's median ($2000 or greater difference) and the individual has equal or higher years in rank and productivity.

3. *External Benchmarking Analysis (Individual Level)*
   Flags set for further review of individual faculty compensation less than the 25th percentile with disproportionately high productivity when compared to their compensation percentiles.
4. *Departmental Justifications and Action Plans*
   Obtains justifications or compensation action plans from the departments for the faculty flagged by the equity analyses in steps 2 or 3 above.

To summarize the complex matrix of decisions, influence points, accountability, and annual internal audits, Fig. 7.4 illustrates the ongoing salary equity process as gears all moving together. When one of the gears does not turn smoothly, the pressure of the other gears is brought to bear to bring about an appropriate resolution.

Next Steps

MCW's work to close the gender pay gap is not done. While the institution has achieved much, challenges remain, such as how to address salary disparities between departments that have different funding levels or payer mix and how these factors

impact gender pay equity. As a private institution, the culture around data transparency is a moving target. Unlike our public institution colleagues, one cannot look up an individual's compensation on a public website. Through online communities such as Glassdoor, LinkedIn, and others, pay transparency is gaining more momentum in the marketplace. MCW is currently working to create an individualized benchmark statement for each faculty member, which will show where his or her compensation falls within an MCW cohort. To implement this level of transparency, we will circle back through steps, such as the communication strategy and leader buy-in process, outlined earlier in this chapter.

Striving to achieve salary equity throughout the institution communicates value to each person who gives professional effort to the worthy missions of MCW and our greater academic medical community. We desire to be leaders in this space and present regularly at Association of American Medical Colleges (AAMC) conferences, share our work in publications like this one, and actively champion pay equity within our professional organizations and societies.

Chapter 8
A Road Map for Closing the Gender Pay Gap in Medicine: How Organizations Can Begin the Journey

Amy S. Gottlieb

As I write this concluding chapter, I sit amidst a world forever altered by SARS-CoV-2 and am in awe of the physicians who are on the front lines fighting the devastating effects of the COVID-19 pandemic. We all owe these women and men tremendous gratitude for risking their health and well-being to ensure that of others. It is therefore deeply troubling to think that, among those care providers, half are paid 25% less than the other half for the exact same work. Now, more than ever, we as a profession should be compelled to eliminate this senseless disparity.

We have learned from the preceding chapters that the gender pay gap in medicine represents the convergence of multiple forces that reward the way men physicians have typically worked and lived for decades (if not centuries). This traditional paradigm is not inherently better than a more equitable one that takes into account the unique contributions of women physicians as well as the demands and biases facing them – it is simply more familiar and codified within our existing institutional structures and practices. In fact, as several of our authors have noted, a new, more inclusive way of doing business has the potential to generate superior outcomes within our industry. Our road map therefore is not only a resource to help healthcare enterprises assess, identify, and correct the dollar amount of their gender pay gap but also to address and rectify seemingly unrelated practices that perpetuate it. Unaltered, these activities will prevent institutions from reaching a new normal where fairness flows naturally from accepted standards and may undermine initial efforts and expenditures to correct salary inequities. Alternatively, when aligned with an explicit institutional mission to compensate men and women physicians equitably, policies and procedures move organizational culture forward in support of this objective.

Closing the gender pay gap is achievable with organizational commitment and openness to culture and process change. Specifically, our authors have outlined how

A. S. Gottlieb (✉)
Associate Dean for Faculty Affairs and Professor of Medicine and Obstetrics and Gynecology, University of Massachusetts Medical School – Baystate, Springfield, MA, USA

Chief Faculty Development Officer, Baystate Health, Springfield, MA, USA

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institutions can go about taking a hard look at basic assumptions that underlie their compensation methodologies to understand the expectations they generate. These expectations may not be consistent with twenty-first-century work patterns or the types of clinical outcomes and business results healthcare enterprises are now seeking. Additionally, our authors have offered detailed guidance on building the governance structures and institution-wide coalitions necessary to incorporate principles of equity into usual human resources, finance, and departmental practices. For senior leaders who understand the value of recruiting, retaining, and rewarding their physician workforce fairly, the preceding chapters describe how organizational transformation to sustain equity is achieved through open dialogue, consistent messaging, and thoughtful communication cascaded throughout the institution. Transparency about the status quo and efforts to improve it, as well as challenges and successes, is what will ultimately drive culture change toward salary equity and build trust among women physicians that leadership genuinely seeks to eliminate gender pay disparities.

Organizational compliance with statutory mandates is indeed a critical element in the movement toward salary equity but, as savvy leaders know, it cannot be the driving force. Harnessing talent by equitably rewarding contributions of the entire physician workforce is the most compelling rationale. The cost of doing business the old way runs the risk of incentivizing the wrong types of care and disengaging a considerable proportion of the workforce that supports enterprise viability and vitality. Since compensation is the single largest expense in our labor-intensive industry, paying more attention to human capital investment and compensating our physician workforce appropriately seem fiscally prudent as well as ethically sound [1]. As several of our authors note, closing the gender pay gap will require funding, especially up front. However, organizations routinely prioritize capital expenditures, and so, the hurdle here is as much about shifting perceptions of need as the actual dollars required for the effort.

The road map to closing the pay gap begins with understanding the current institutional landscape and, as such, starts with a robust salary study that is approached with the following questions in mind:

- Who should conduct the study? How, with whom, and when will results be shared?
- Which level of analysis would be most useful to examine existing salary disparities (department, division, individual)? Is reliable salary data available at that unit of analysis? (If not, why and how can the data be improved upon going forward?)
- Which benchmarks (external and internal) should be utilized and what are the standards for assessing their rigor?
- Which professional duties are considered similar enough for comparison and which factors delineate differences?
- What currently defines clinical, educational, and research productivity? Is the data that has been collected in these domains reliable? (If not, why and how can the data be improved upon going forward?)

- Do productivity metrics reflect enterprise goals such as patient-centered care, quality, and value? Are there pockets of productivity (e.g., mentoring trainees, performing service-related tasks for the organization) that are being ignored when it comes to compensation?
- What other factors affect compensation (e.g., career advancement opportunities) and therefore need to be considered when assessing pay differences? At what level (e.g., department, division) should these inequities be assessed and then rectified going forward?

The last bullet point above merits further exploration, especially since disparities in leadership roles have been associated with the gender pay gap in medicine [2]. Leadership opportunities typically accrue to those who are deemed promotable, and our authors have done an outstanding job delineating the biases in performance evaluation, sponsorship, and expectations around "non-promotable," service-related tasks that impede women's professional advancement. Fortunately, there are relatively simple strategies organizations can adopt to mitigate their effects on compensation. For example, leaders and their deputies can allocate citizenship tasks more equitably (e.g., on a rotating basis), monitor these responsibilities, and recognize them in promotion metrics and compensation methodologies. They can also begin to talk openly about biased language in performance evaluations and encourage supervisors, through training and audits, to pay attention to these situations in which gender biases emerge. Equally important, organizations can support transparency around professional opportunities by developing standards for communicating open leadership positions and widely disseminating calls for applications.

In addition to designing and conducting robust salary studies, institutions should consider the following questions as they forecast the cost of closing the gender pay gap:

- How far back should corrections for pay disparities go (e.g., just the current year or the past five years for those eligible)?
- In academic medical institutions, how should the clinical, educational, and research enterprises share responsibility for the expense of correcting salary inequities?
- How do equity adjustments interface with customary merit and incentive pay practices and what is the process and timeline for fully correcting identified compensation disparities (e.g., lump sum payout, distribution over a certain period)?
- What is the plan for monitoring pay equity and making adjustments after initial corrections?

Once again, the last bullet point above merits further consideration. As has been emphasized throughout this book, closing the gender pay gap in medicine is a business proposition as much as an ethical one. Organizations should treat it as such, monitoring its status, progress, and cost with the same attention to detail and rigor as they do other operating expenses. Pay equity metrics should be reported to business unit leaders (e.g., health system, department, division, and practice leaders) in the same fashion and with the same regularity as data used for operating margin

surveillance. Similarly, leaders should have goals and accountability for pay equity results, and there should be an institutional appetite to discuss challenges and opportunities to achieving them. Addressing salary equity as part of routine business practice allows it to be monitored readily and also normalizes it as an ongoing effort that requires constant attention like other expenses.

After finishing this book, I expect that readers will have a deeper understanding of the compensation methodologies, organizational practices, and cultural expectations that perpetuate the gender pay gap among our physician workforce. My hope is that the road map offered herein will also allay concerns about how best to approach the problem and inspire institutional leaders to begin to effect meaningful change in the policies and practices over which they hold sway to close the gender pay gap in their organizations.

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