I Cannot Be What I Cannot See: Time To Unleash A JEDI Healthcare Environment

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Disclosures

- I am a full time employee at the American College of Physicians
- I am an Adjunct Professor of Medicine at the Lewis Katz School of Medicine at Temple University
- I have no financial or IP conflicts to disclose
- Many thanks to my physician colleagues and society/organizational staff for sharing content used in this presentation

Women in ACP Leadership

Susan Thompson Hingle, MD, MACP

2017-2018 Chair, Board of Regents

Women In ACP Leadership 2019-2021

Ana Maria Lopez, MD, MPH, MACP
Past President
2018-19

Jacqueline Fincher, MD, MACP
President

Heather Gantzer, MD, FACP
Chair Board of Regents

Educational Objectives

- Review data germane to women in medicine including compensation and advancement
- Define specific obstacles to achieving equity at the micro and macro level
- Describe potential actionable interventions to work towards achieving equity at the micro and macro levels, not just for women, but for all underrepresented groups in healthcare

Like An MMS, Remember The Following Phrases

- A Pink Elephant
- The Ladies Bathroom
- A Crowded Intersection
- An Energized Village
- Do The Right Thing
- The Iceberg

Not A Zero Sum Game…

Dear Women, It’s Not You, It’s Us…

Dear Rosalind,

Thanks so much for your hard work on unlocking the secret to the helical structure of DNA. Great stuff. Has been v. useful for us. So sorry to leave your name off the paper – we totally forgot!
We are such scatterbrains.
By the way, could you fill out the online catering order for our Nobel Prize celebration luncheon? Awesome sauce. (We may be Nobel winners, but we’re just so bad with technology!)
- Watson & Crick

https://www.newyorker.com/humor/daily-shouts/office-housework-a-history

Gender Equity

- Improves
  - Productivity
  - Creativity
  - Communication
  - Employment
  - Job satisfaction
  - Work engagement
  - Policy development

"We're doing everything we can to make him comfortable, short of dressing up as male doctors."

By Paul North
The New Yorker

After Controlling For All Possible Factors…

Differences In Starting Pay For Male And Female Physicians Persist; Explanations For The Gender Gap Remain Elusive

HEALTH AFFAIRS 39,
NO. 2 (2020): -

ABSTRACT A large literature has documented differences in salary between male and female physicians. While few observers doubt that women earn less, on average, than men do, the extent to which certain factors contribute to the salary difference remains a topic of considerable debate. Using ordinary least squares regression and Oaxaca-Blinder decomposition models for new physicians who accepted positions in patient care for the years 1999–2017, we examined how the gender gap in total starting pay evolved and the extent to which preferences in work-life balance factors affect the gap. We found that the physician earnings gap between men and women persisted over the study period. Interestingly, despite important gender differences in preferences for control over work-life balance, such factors had virtually no ability to explain the gender difference in salary. The implication is that there remain unmeasured factors that result in a large pay gap between men and women.

Anthony T. Lo Sasso (alosasso@depaul.edu) is professor and Driehaus Fellow in the Economics Department, DePaul University, in Chicago, Illinois.

David Armstrong is a project director at the Center for Health Workforce Studies, University at Albany, State University of New York (SUNY).

Gaetano Forte is assistant director of the Center for Health Workforce Studies, University at Albany, SUNY.

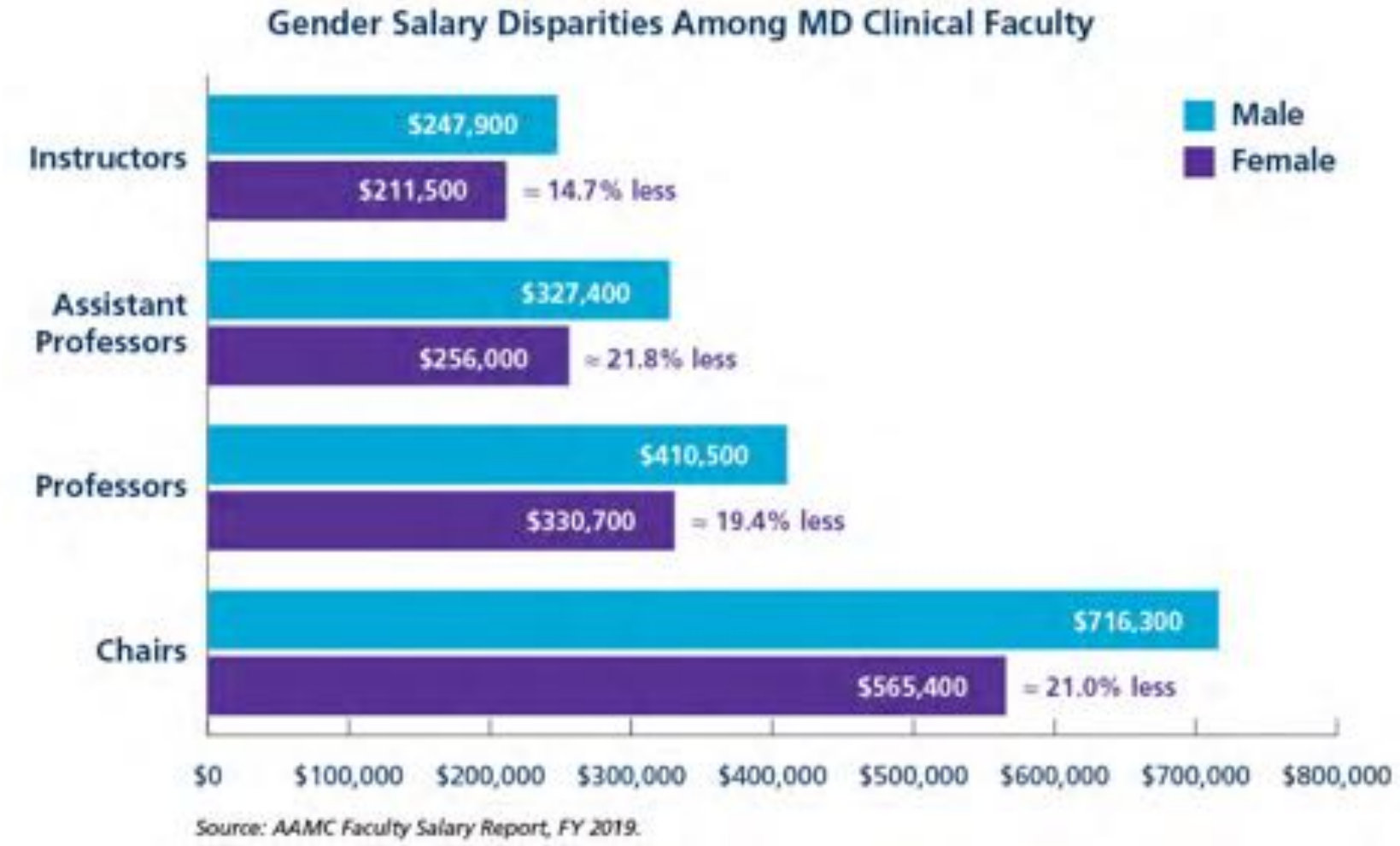
Susan E. Gerber is an associate professor in the Departments of Obstetrics and Gynecology and Medical

Compensation Disparities By Gender In Internal Medicine, Read et al, Annals of Internal Medicine, 11/18

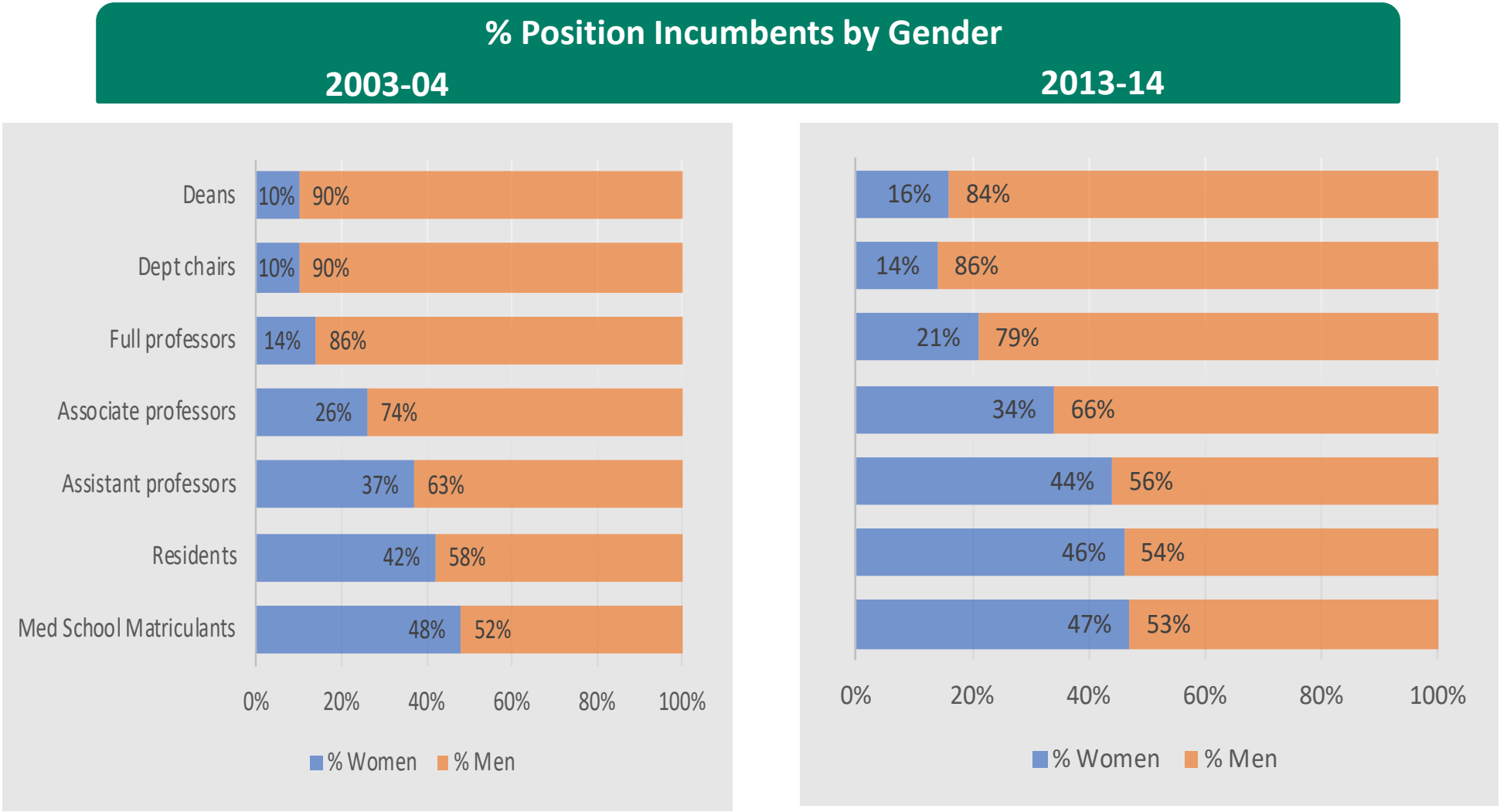
8. **Married/Partnered vs. Not Married/Partnered:** The salary for men was $50,000 higher than for women when physicians were married/partnered, and $52,500 higher when physicians were not married/partnered.

Currently Married or Partnered	Women (*n* = 120)	Men (*n* = 254)
Yes	82%	92%
Median salary (IQR), *$*	200,000 (169,500 – 250,000)	250,000 (200,000 – 300,000)
No	18%	8%
Median salary (IQR), *$*	197,500 (165,750 – 223,250)	250,000 (206,250 – 315,000)

2019 AAMC Faculty Salary Data



Medical schools are making modest progress in moving women physicians into positions of academic leadership

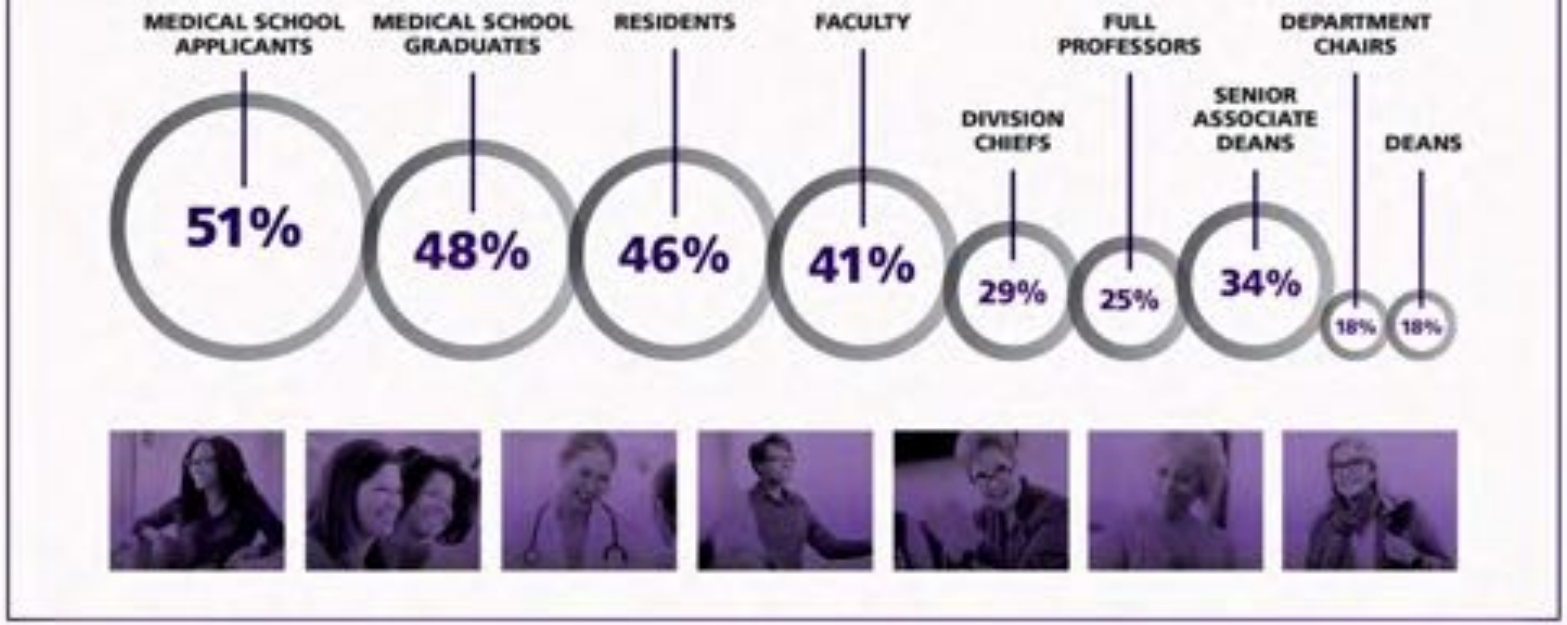


Source: AAMC, "The State of Women in Academic Medicine, 2013-14",
https://members.aamc.org/eweb/upload/The%20State%20of%20Women%20in%20Academic%20Medicine%202013-2014%20FINAL.pdf

Executive Summary

AAMC

REPRESENTATION OF WOMEN IN ACADEMIC MEDICINE 2018-2019

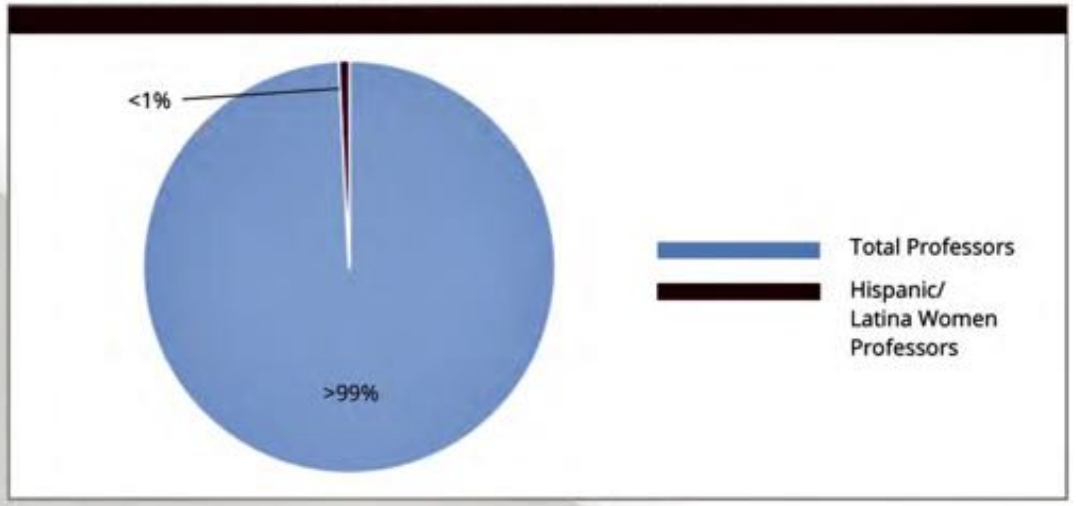


Association of American Medical Colleges

The Inexorable Zero of US Medical School Faculty- #HerTimeIsNow, Julie Silver, 9/20, www.hertimeisnow.org

Figure 7

US Medical School Faculty at Professor Level - Hispanic/Latina Women



Source: AAMC US Medical School Faculty by Sex, Race/Ethnicity, Rank, and Department 2019 (Table 19)

This table and figure use the categories designated by the AAMC. Multiple race is not included.

#HerTimeIsNow

Cite as: Her Time Is Now Report. Versi
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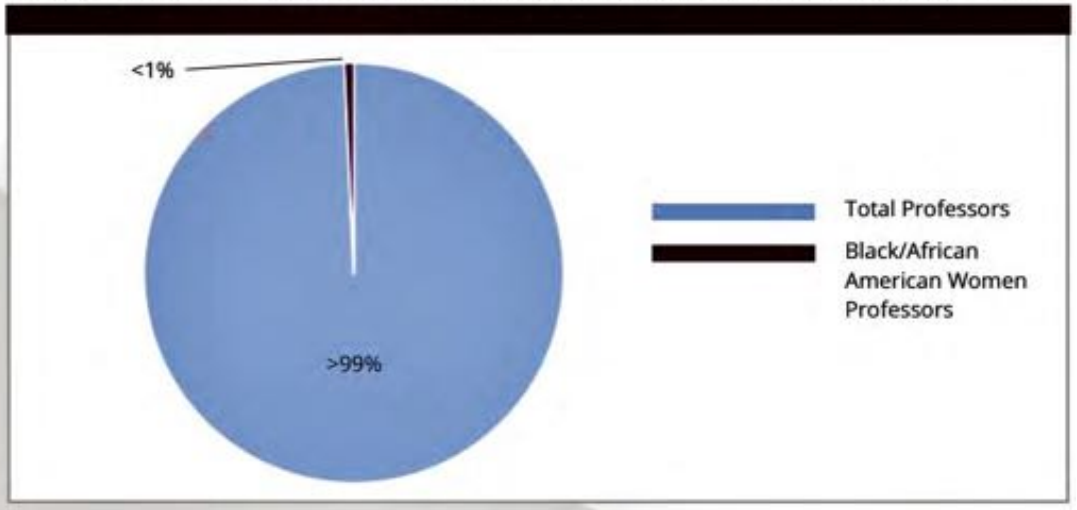
Figure 6:

US Medical School Faculty at Professor Level - Black/African American Women



Source: AAMC US Medical School Faculty by Sex, Race/Ethnicity, Rank, and Department 2019 (Table 19)

This table and figure use the categories designated by the AAMC. Multiple race is not included.

#HerTimeIsNow

Cite as: Her Time Is Now Report. Versi
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#HerTimeIsNow 2020: Dr. Quinn Capers states…

Academic medicine should be a meritocracy. It isn't. Even if we ignore the preliminary data that, in some circumstances, women physicians have been shown to outperform men in terms of following evidence-based guidelines, there is no rational explanation for why so many brilliant women are underpaid and underpromoted in academia. When institutional bias and racism are layered on top of gender disparities, it becomes a feat of heroic proportions for women of color to advance to the highest levels of medicine. Cities are burning, and the world is crying out for an end to racism and oppression on any basis. Academic medicine can heed this call by dismantling processes that frustrate her ability to thrive, grow, and lead. For the sake of our patients, #HerTimeIsNow."

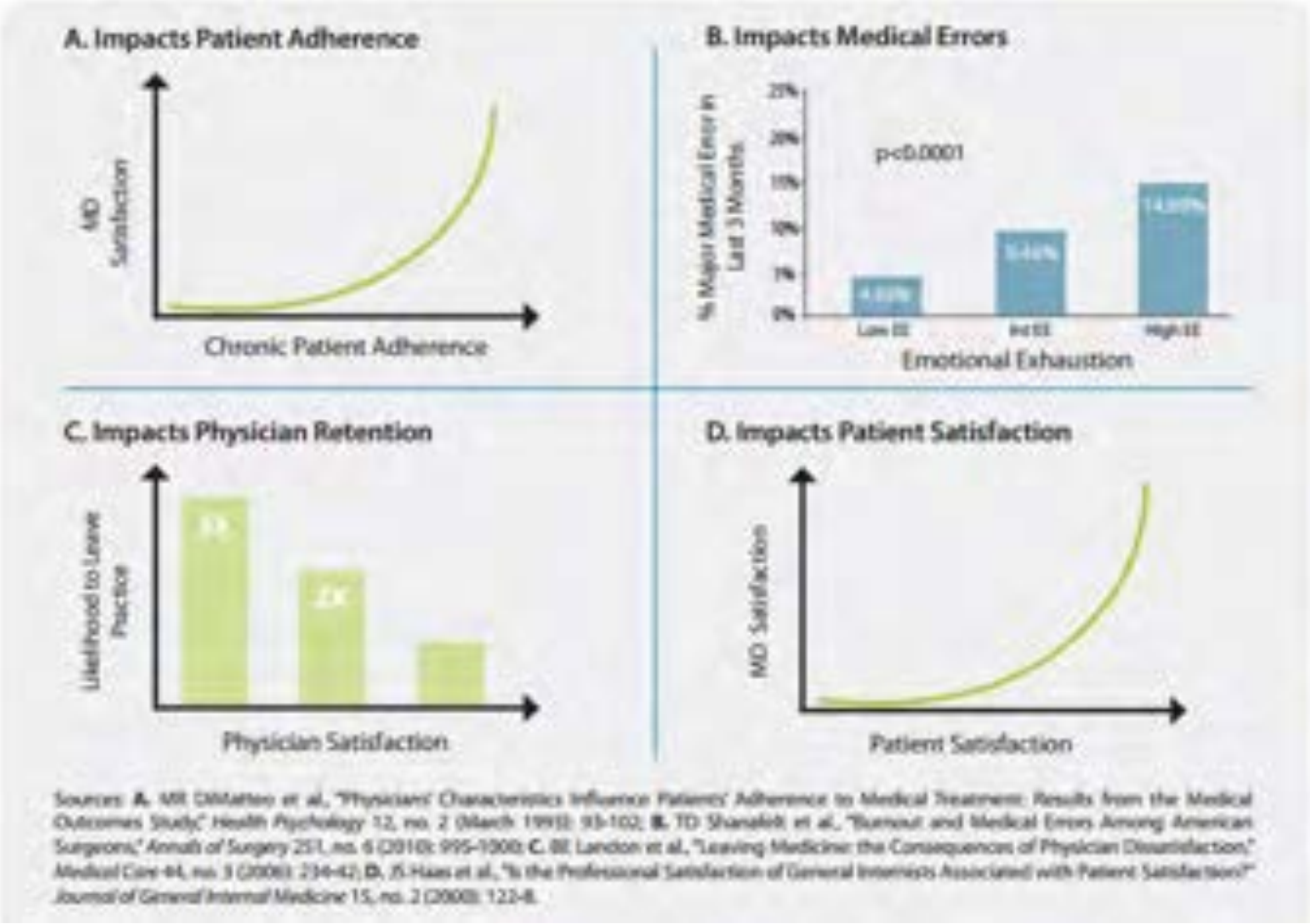
A Strong Signal On Quality of Care of Women and URiM Physicians

- Women and URiM physicians are more likely to follow EBM Clinical Guidelines and provide care for underserved patients
- Women physicians are more likely to provide patient-centered communication and health counseling, compared to male physicians
- Patients with female practitioners were more likely to receive guideline-recommended treatment for heart failure and diabetes, and may have better clinical outcomes
- Compared with majority group physicians, URiM physicians are more likely to care for the underserved, Medicaid, and poor patients
- URM patients are more likely to consent to both preventive and health services if the recommending physician is also a URM

Gendered Expectations: Do They Contribute To High Burnout Among Female Physicians?

- Female physicians have more female patients, and more patients with social complexity
- Up to a 60% excess in burnout in female vs. male physicians
- Differing expectations in empathy, listening time, decisiveness which have implications for patient evaluations
- Possible solutions- adjusting for patient gender in compensation plans, education, co-locating behavioral medicine specialists, adjusting visit times

- **Linzer et al, JGIM online, 2/18**



Sources: **A.** MR DiMatteo et al., "Physicians' Characteristics Influence Patients' Adherence to Medical Treatment: Results from the Medical Outcomes Study," *Health Psychology* 12, no. 2 (March 1993): 93-102; **B.** TD Shanafelt et al., "Burnout and Medical Errors Among American Surgeons," *Annals of Surgery* 251, no. 6 (2010): 995-1000; **C.** BE Landon et al., "Leaving Medicine: the Consequences of Physician Dissatisfaction," *Medical Care* 44, no. 3 (2006): 234-42; **D.** JS Haas et al., "Is the Professional Satisfaction of General Internists Associated with Patient Satisfaction?" *Journal of General Internal Medicine* 15, no. 2 (2000): 122-8.

I Cannot Be What I Cannot See…

JAHA
Journal of the American Heart Association

About Sections Tools

OPEN ACCESS | RESEARCH ARTICLE

Perceptions on Diversity in Cardiology: A Survey of Cardiology Fellowship Training Program Directors

Anna Lisa Crowley, MD, Julie Damp, MD, Melanie S. Sulistio, MD, Kathryn Berlacher, MD, MS, Donna M. Polk, MD, Robert A. Hong, MD, Gaby Weissman, MD, Dorothy Jackson, PhD, RN, Chittur A. Sivaram, MD, James A. Arrighi, MD, Andrew M. Kates, MD, Claire S. Duvernoy, MD, Sandra J. Lewis, and MD, and Quinn CapersIV MD

Originally published 25 Aug 2020 |
https://doi.org/10.1161/JAHA.120.017196 |
Journal of the American Heart Association. 2020;9

It’s About the Patients…How Patient-Physician Racial and/or Gender Congruity Leads To Better Outcomes

Table 3. Key References on the Benefits of URM Physicians

Minority Physicians More Likely to Serve the Underserved; Minority Patients Prefer Race-Concordant Physicians and More Likely to Comply With Recommendations by Minority Physicians
Jackson. Public Health Rep. 2014[10]
Marrast. JAMA Intern Med. 2014[11]
Brotherton. Arch Pediatr Adolesc Med. 2000[12]
Cooper. Ann Intern Med. 2003[13]
Gordon. Cancer. 2006[15]
Traylor. J Gen Intern Med. 2010[16]
Alsan. Am Econ Rev. 2019[17]
Saha. J Gen Intern Med. 2020[18]

URM indicates underrepresented minority.

It's About the Patients…How Patient-Physician Racial and/or Gender Congruity Leads To Better Outcomes

Table 2. Key References on the Benefits of Female Physicians

Female Physicians More Likely to Provide Patient-Centered Care, Guideline-based Care, and May Have Better Outcomes
Baumhakel. Eur J Heart Fail. 2009[6]
Roter. Annu Rev Public Health. 2004[7]
Schmittdiel. J Women's Health (Larchmt). 2009[8]
Tsugawa. JAMA Intern Med. 2017[9]
Cooper-Patrick. JAMA. 1999[14]

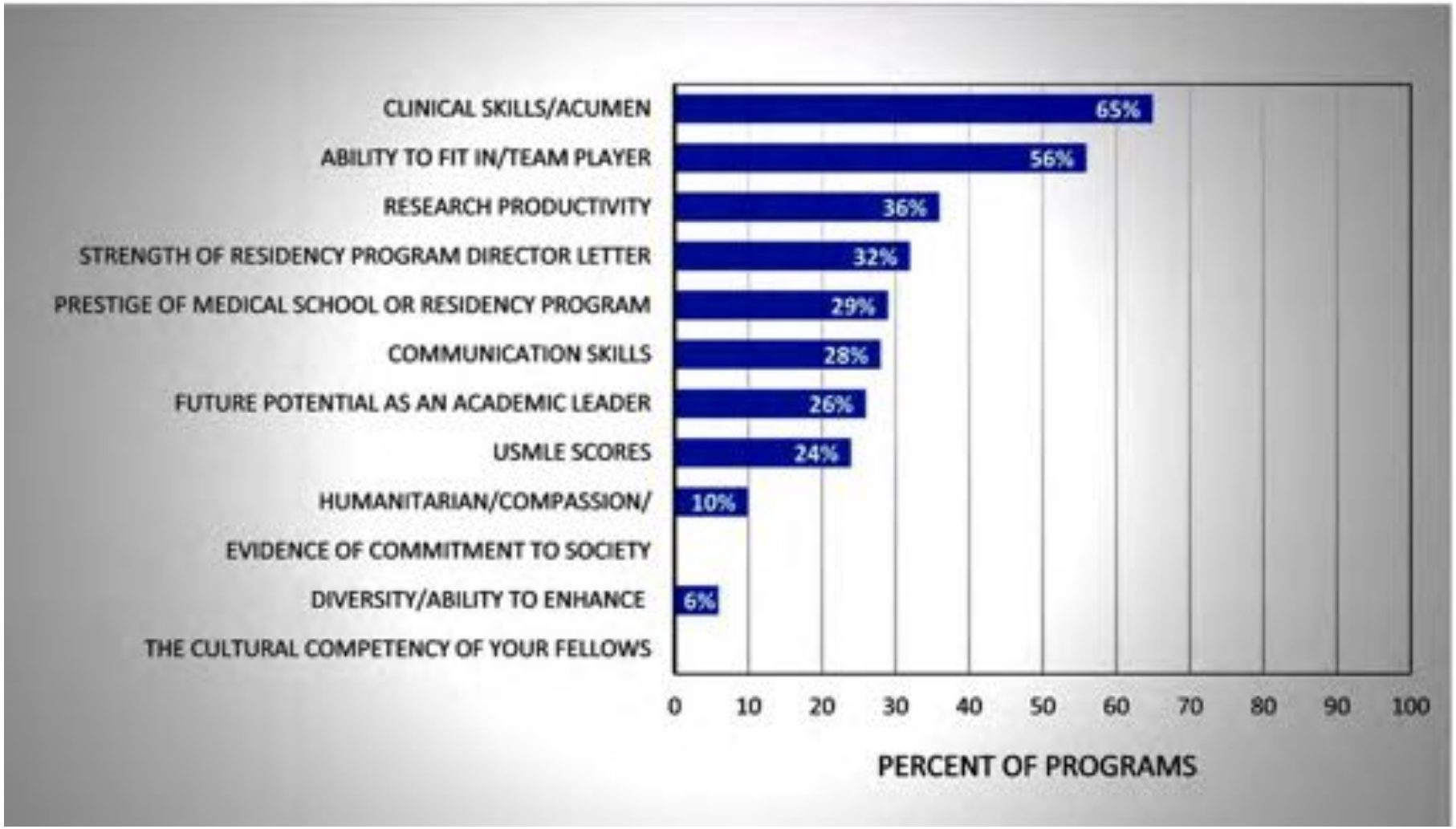
In Order To Know Where You Need To Go…Know Where You Are:

- In 2015, 6% of Cardiology Fellows self IDed as URiM, 11.6% in 2018
- In the 2015 U.S. population, 17.6% Hispanic, 13.3% black, 1.2% Native American
- 12 question survey by the ACC CV Training Committee, administered in 2016
- 110/193 programs represented: 84% said URiM were underrepresented at their institution

Capers et al, JAHA, 8/2020

- 69% believed that the following statement was true: “Diversity is the driver of excellence in the healthcare setting”, 31% are uncertain or do not believe the statement
- 63% chose “our program is diverse already so diversity does not need to be increased”
- 37% want to increase diversity, but only 6% listed “diversity” as a top 3 priority when creating fellowship rank lists, and < ½ had a plan to increase diversity
- Clinical skills/acumen, ability to fit in/team player, research productivity are the top 3 priorities of CV fellowship ranking

Survey of CV Training Programs-Fellowship Ranking Criteria

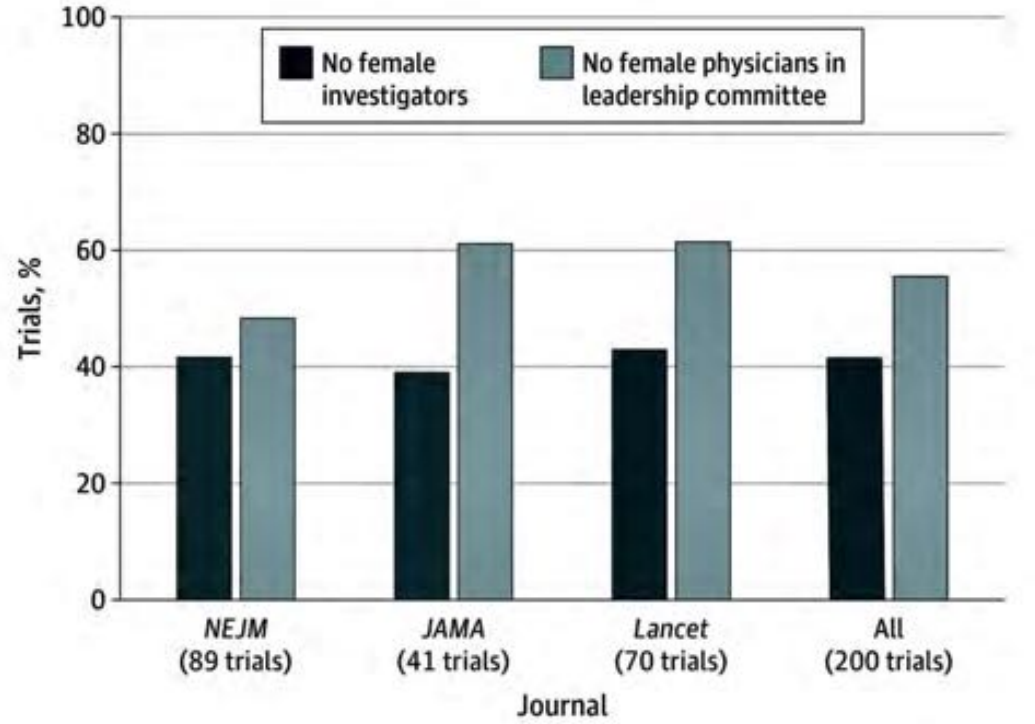


So How Do We Get To A Better Place? GME Example from Duke

- Evaluation of Women and UREG Representation in a General Cardiology Fellowship After a Systematic Recruitment Initiative, Rymer et al, JAMA Network Open, 1/21
- Multipronged initiative 2015-19 that started with a CV Fellowship Diversity and Inclusivity TF which drafted recommendations including fellowship recruiting committee reorg, changes to fellowship applicant screening process, interview day, applicant ranking process, and post match interventions
- 5 Domains- Diversity as a priority, seeking out candidates, implementing inclusive recruitment practices, investing in trainee success, building the pathway/pipeline
- Post intervention, 25% increase in applications, interviewed applicants went from 20% to 35% women, 14% to 20% UREG
- Matriculated fellows (5 yr mean) went from 27% to 54% women, 6% to 33% UREG, and overall women and/or UREG, 28% to 67% with no significant changes nationally during intervention period

I Cannot Be What I Cannot See…Silver, Walsh, Cho et al, JAMA IM 8/20

Figure. Proportion of Women as Cardiovascular Clinical Trial Investigators and in Leadership Committees



NEJM indicates *New England Journal of Medicine*.

Building Bridges Over Troubled Pathways For URiM Groups… Campbell et al JAMA Network Open 8/20

- Blacks comprise ~13% of the U.S. popn only 5% of physicians and < 7% of recent med school grads
- 4/13 HB Med Schools remained open after 1910 Flexner report
- Extrapolation of data from schools that remained open
- 5 of the closed med schools might have collectively provided training to an additional 35.5K graduates by 2019, ~29% increase in black physicians in 2019
- None of the 30 new medical schools opened since 2000 and associated with AAMC were located at HBCUs, and none specifically focused on health disparities
- Cherokee Nation and Oklahoma State University established the OSU School of Osteopathic Medicine at the Cherokee Nation
- Physicians from HB med schools disproportionately pursued clinical practice, research, and advocacy that target the needs of medically underserved communities
- Need to review all opportunities including education beginning in preschool, access to SES resources/reduction of debt burden, address coaching, mentorship, sponsorship opportunities

On The Important Role of Medical Societies and Academic Journals…

For too long, the leadership of women in medicine has been limited by structural barriers. The partnership of institutions, medical societies, and academic journals will be a pivotal step in ensuring systematic change that addresses gender equity within the full context of diversity, equity, and inclusion."

Eliza Lo Chin, MD, MPH, FACP, FAMWA, Executive Director, American Medical Women's Association

1982 ACP Board of Governors

Presidential Leadership of National Medical Professional Societies Over Decade 2007-2017-Silver et al, JAMA IM, 1/19

Society/Societies	% Women Presidents
AGS, APA	50-60%
ASNR, SCCM	40%
AACAP, ACEP, ASH, ASN, AAP, ATS, ACR, RSNA	30%
ACP, AAFP,ACS, IDSA, AAO, AAOHNS, AAPM&R, ACPM,	20%
AAAAI, ASA, AACE, ACG, ACOG, ASPS, ASTRO, SVS	10%
CAP,AAD,SCAI,AANS, AAN, AAOS, AAPM, AATS, AUA, SIR	0%

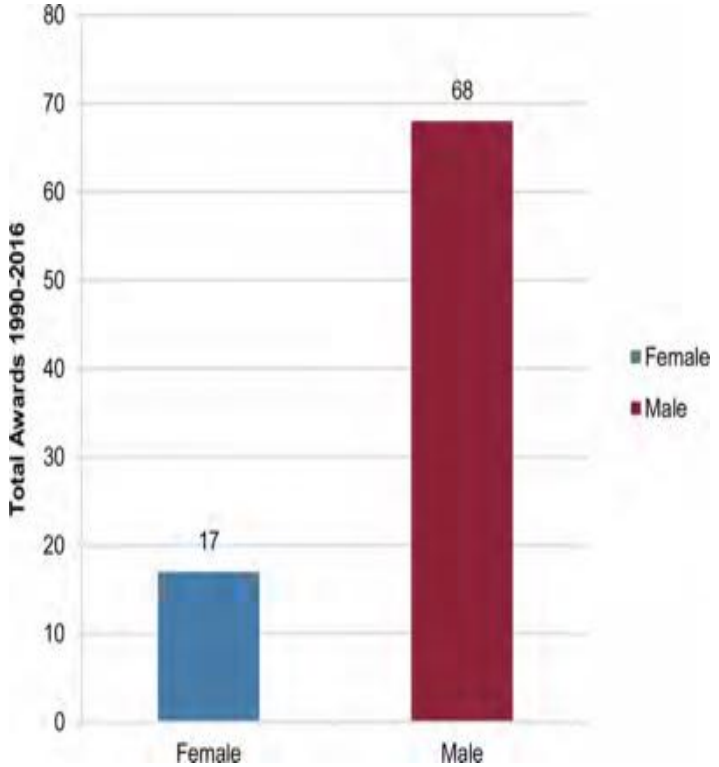
Professional Society Boards of Trustees/Regents/Directors

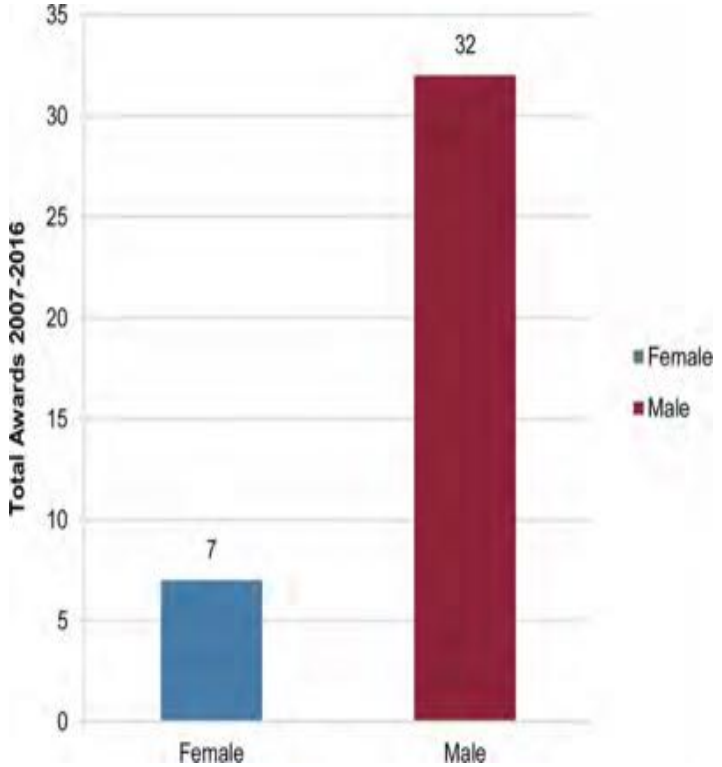
Organization	Number of Women	Number of Men	Percentage of Women
AMA	6	15	28.5%
ACP(20-21)	11	14	44%
ACS	6	26	18.7%
ACOG	13	17	43.3%
AAFP	4	12	25%
AAP	7	7	50%
APA	12	10	54.5%
AAHPM	10	8	55.5%

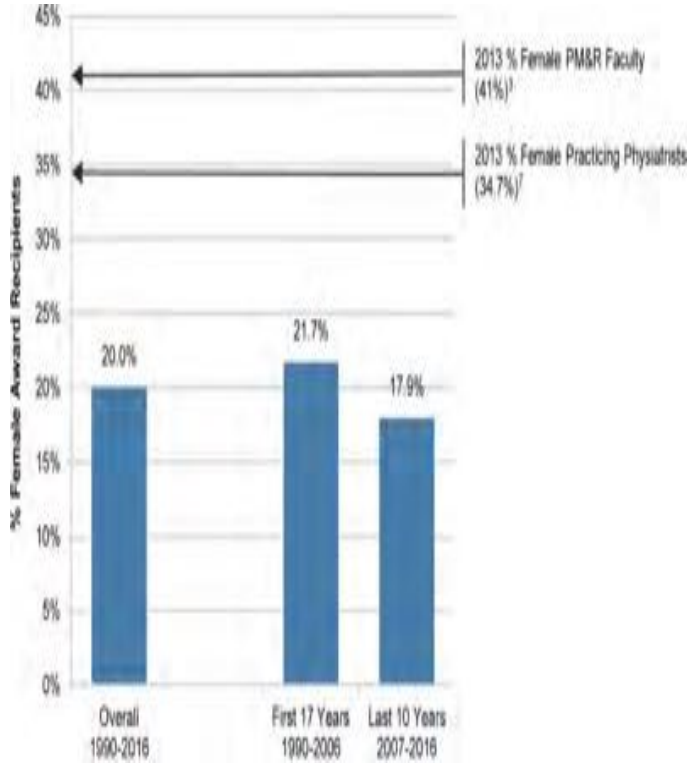
Women's Representation Among Members and Leaders of Medical Specialty Societies, Jagsi et al, Acad Med, 7/2020

- Avg proportion of female full members was 25.4% in 2005, and 29.3% in 2015
- Proportion of women serving as highest elected leader b/t 2000-2015 was 0% to 37.5% (mean 15.8%)
- Mean proportion of women on governing boards ranged from 0% to 37% (mean 19%) in 2000-2007 and from 0% to 47% (mean 25%)in 2008-2015
- 10 societies increased the mean percentage of women serving on governing boards by ~ 10% over the study period (AAD, ACP, ES, IDSA, ASN, ASCO, ATS, AANS, AAP, ASRO, ACR)

Women Physicians Are Underrepresented in Recognition Awards

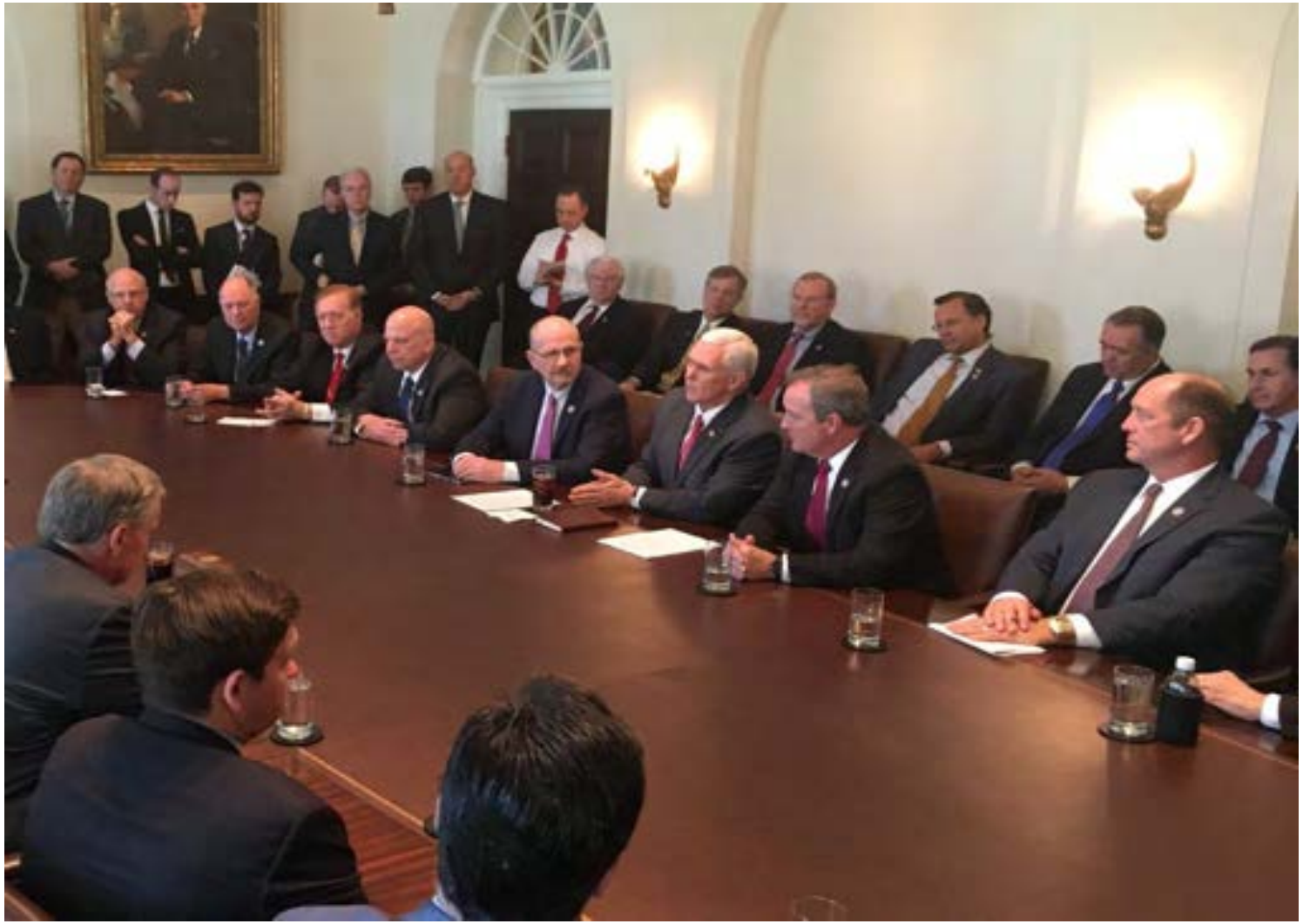






Julie Silver et al Am J Phys Med Rehabil. 2018 Jan; 97(1): 34–40.

Where Are The Women?




MEN
WOMEN
NOVAKANI


LADIES RESTROOM
(JULY 25 – 28)

Dr. Carlos del Rio on the Need For Men To Get Engaged…

"Over the past 40 years medical schools have achieved gender parity at the student level, but women physicians continue to remain underrepresented in the higher ranks of academic medicine and in healthcare leadership positions. Today women represent an unaccountably small proportion of full professors, department chairs, and deans. Shattering this glass ceiling is an urgent priority and we cannot expect women to do it by themselves. As men we need to work side-by-side with women colleagues pushing for gender equity. This is not only the right thing to do it is also the smart thing to do."

Carlos del Rio, MD, FIDSA, Distinguished Professor for Emory Clinical and Academic Affairs at Grady, Professor of Medicine, Executive Associate Dean for Emory at Grady, Emory University School of Medicine, Professor of Global Health and Epidemiology, Rollins School of Public Health

The Solution = Systematic Process + Metrics

1. Examine gender data through the lens of an organization's mission, values, and ethical code of conduct.
2. Report the results transparently to all stakeholders.
3. Investigate causes of disparities.
4. Implement strategies to address disparities.
5. Track outcomes and adjust strategies as needed.
6. Report/publish results

- Be Ethical, Julie Silver, 2018, sheleadshealthcare.com

Metrics For All Leaders

- Compensation at all levels and across all domains
- Hiring and/or promotion at all levels and across all domains
- Executive and departmental leadership
- Board representation- and inclusion on impactful committees/initiatives
- Newsletter, website, and press release content
- Promotional materials

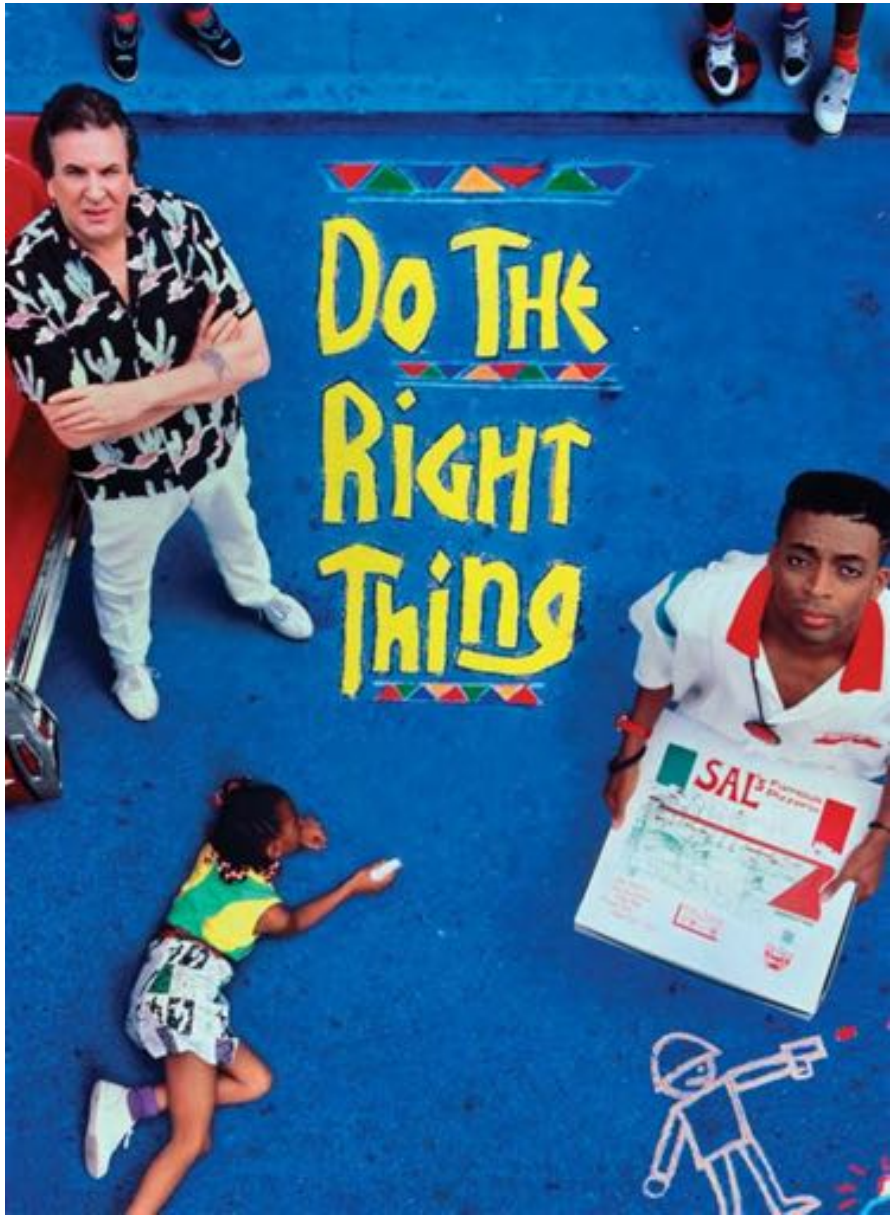
Metrics For All Leaders

- Introductions (e.g., biased language)
- Space allocations (e.g., office, laboratory, clinic, reception)
- Supplies (e.g., office, equipment, research)
- Financial allocation (i.e., size of budget)
- Financial control (i.e., independence in decision-making)
- Financial priority (e.g., President's reception versus women's task force)

Metrics For All Leaders

- Assistant allocation (administrative, clinical, research) and other personnel support
- Assistant type (e.g., full-time equivalent, shared with others)
- Consultant budget (e.g., attorneys, accountants, advisors)
- Training opportunities/programs (e.g., type, participants, directors, faculty, speakers)
- Mentors/Mentees (e.g., assignments, success in publishing, satisfaction with relationship)
- Amount of financial support going to organizations and businesses with a demonstrable track record of workforce equity and inequity (e.g., medical societies)
- Formal complaints of harassment or mistreatment
- Workplace culture surveys

The Crowded Intersection…


DO THE
RIGHT
THING
SAL

It Takes A Village…

Annals of Internal Medicine

POSITION PAPER

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

Renee Butkus, BA; Joshua Serchen, BA; Darilyn V. Moyer, MD; Sue S. Bornstein, MD; and Susan Thompson Hingle, MD; for the Health and Public Policy Committee of the American College of Physicians*

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

Ann Intern Med. doi:10.7326/M17-3438 **Annals.org**

For author affiliations, see end of text.

This article was published at Annals.org on 17 April 2018.

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

Several recent studies have documented the compensation inequity between male and female physicians. A 2017 survey found that male primary care physicians made $229 000 annually, compared with $197 000 for women, a gap of 16% (3). This gap is even wider (37%) for specialists: Men earned $345 000 annually and women $251 000. In academic medicine, female physicians made an average of $227 783 annually, compared with $247 661 for male physicians (a gap of $19 878), after adjustment for factors that included faculty rank, age, years since residency, specialty, funding from the National Institutes of Health, fessors, 15% of department chairs, and 16% of deans (6). This lack of female physicians in leadership positions has traditionally been believed to be a pipeline problem; however, because women have made up roughly half of medical student graduates for years, the systematic origins of this problem are becoming more apparent (7). In addition, women in medicine face other challenges, including a lack of mentors, discrimination, gender bias, cultural environment of the workplace, imposter syndrome, and the need for better work-life integration (8, 9).

Many factors have been cited as causes of compensation inequity and the relative lack of career advancement for female physicians compared with male physicians, including specialty choice, years of experience, number of hours worked, choices made to balance work and family, and a dearth of mentors and senior role models (10, 11). Yet, researchers find these disparities even when controlling for age, specialty, number of hours worked, and practice characteristics (4, 12, 13).

Achieving Gender Equity in Physician Compensation and Career Advancement

- Physician compensation
- Family and medical leave
- Leadership development
- Unconscious bias training
- Research on gender inequity
- Oppose harassment, discrimination, and retaliation

Butkus R, Serchen J, Moyer DV, Bornstein SS, Hingle ST, for the Health and Public Policy Committee of the American College of Physicians. Achieving Gender Equity in Physician Compensation and Career Advancement: A Position Paper of the American College of Physicians. Ann Intern Med. ;168:721–723. doi: 10.7326/M17-3438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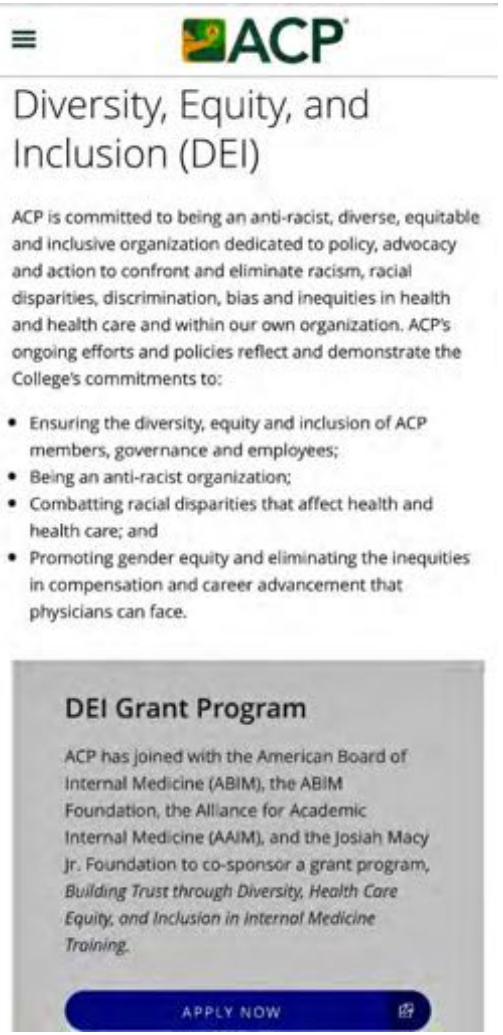
www.acponline.org
ACP
Women in Medicine
Pipeline Stats
Me Too movement for Physicians (F)
Leadership in Medicine
Parenthood
Click to expand and view full infographic.
Promoting gender equity and eliminating the inequities in compensation and career


ACP
Diversity, Equity, and Inclusion (DEI)
ACP is committed to being an anti-racist, diverse, equitable and inclusive organization dedicated to policy, advocacy and action to confront and eliminate racism, racial disparities, discrimination, bias and inequities in health and health care and within our own organization. ACP's ongoing efforts and policies reflect and demonstrate the College's commitments to:
Ensuring the diversity, equity and inclusion of ACP members, governance and employees;
Being an anti-racist organization;
Combatting racial disparities that affect health and health care; and
Promoting gender equity and eliminating the inequities in compensation and career advancement that physicians can face.
DEI Grant Program
ACP has joined with the American Board of Internal Medicine (ABIM), the ABIM Foundation, the Alliance for Academic Internal Medicine (AAIM), and the Josiah Macy Jr. Foundation to co-sponsor a grant program, Building Trust through Diversity, Health Care Equity, and Inclusion in Internal Medicine Training.
APPLY NOW

Times Up Is An Opportunity

Leading The Way-What ACP's Done So Far

- Established a Standing Committee for DEI that reports to the Board of Regents
- Reflected DEI more prominently in definitional components of the organization
  - Vision, College Goals, and Core Values
  - Priority for FY 2020-21
    - Organizational priorities, with the expectation that ACP will emphasize inclusion in health care, welcoming and hearing all voices, and actively engaging diverse members in local, national and global College activities across their career.
    - Goal – Be an Anti-Racist organization
- Updated "Diversity, Equity and Inclusion" policy
- Established Anti-Harassment policy and reporting process, including approach to professional behavior at ACP events
- Surveyed current/past leaders to help assess DEI needs
- Supported Chapters establishing local DEI/WIM committees and programming
- Created DEI-focused programming, including annual meeting and CLN content

Leading The Way-What ACP's Done So Far

- Policy and Advocacy
  - Predicated on seeing racial disparities, discrimination, harassment and violence as public health issues.
  - Advocate for evidence-based solutions to combat the social determinants of health (disproportionately harm racial and ethnic communities and exacerbate health disparities)
  - ACP's Vision for Health Care calls for systemic reform that addresses social determinants of health and reduces barriers to care.
- Forged external collaborations
- Developed pilot for establishing affinity groups
- Revised national award and Mastership descriptions to remove biased language and potential barriers to nominations
- Tracking/reviewing data, making adjustments, publishing on our website, and forthcoming publications
- Women In Medicine initiative
  - Promoted gender equity and elimination of inequities in compensation and career advancement
  - Developed policy, resources and programming

Framework for Moving Forward – The 3 Cs

- Communication
  - Develop and implement a comprehensive plan that articulates ACP's commitment to achieving College-wide diversity and inclusion, and equity in healthcare for our members and patients
- Coordination
  - Implement and provide oversight of DEI initiatives throughout the college so that our work is pervasive, organized and focused for maximal impact
- Collaboration
  - Harmonize, synergize, and amplify organizational efforts to increase the forward motion of DEI in healthcare through greater connections and partnerships that pursue common goals.

Seismic Shift in ACP Masterships and Awards for Women- A Case in Deliberate Practice

- From 2007-2014, < 10 women/year were nominated for MACP
- In 2007-8, 4/80 MACP nominees were women, all were selected (9% of all MACPs)
- In 2019-20, 27/87 MACP nominees were women, 18/27 were selected (2/3rd vs. 1/3rd), representing 33.3% of MACPs
- In 2007-15 < 15 women/year nominated for ACP ~ 22-25 Awards, 26 nominated in 2019-20
- In 2019-20, 8/26 or 31% of women nominated for ACP awards were selected, vs. 36% of overall group
- In 20-21, 32% of MACPs and 22% of Awardees are women

ACP's Journal *Annals of Internal Medicine* Leads The Way ….

- Editor In Chief- Dr. Christine Laine
- Deputy Editors- 3 women FTEs, 1.5 FTEs men
- Associate Editors- 5 Women, 6 men
- Associate Statistic Editors- 0.5 FTE woman, 5 < 0.1 male FTEs
- Freelance Statistical Editors- 2 women, 2 men
- Annals Editorial Board- 7 women, 8 men
- Publication Committee- 9 women, 8 men

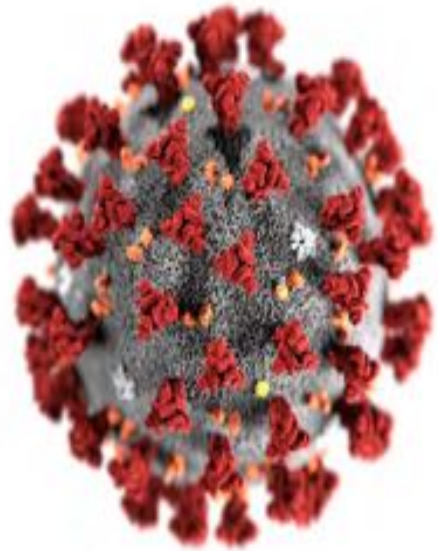
ACP Issues Organizational Commitment to be Anti-Racist, Diverse, Equitable, and Inclusive

- ACP made an organizational commitment to being an anti-racist organization dedicated to policy, advocacy and action to confront and eliminate racism, racial disparities, discrimination, bias and inequities in health and health care and within its own organization.
- ACP strives to embody a diverse, inclusive and equitable organization that facilitates effective and respectful interaction among individuals who hold a broad range of views, and respect, empathy and understanding of others.
- ACP is studying, listening, and developing evidence-based solutions to create an equitable and inclusive organizational culture, and to guide its interactions with members, staff, and others.

Visit ACP's Diversity, Equity and Inclusion page at:
https://www.acponline.org/dei

Equity In the Time Of COVID…

Darilyn V. Moyer MD, FACP
EVP/CEO American College of Physicians



American College of Physicians
Leading Internal Medicine, Improving Lives

Annals of Internal Medicine

Intersecting U.S. Epidemics: COVID-19 and Lack of Health Insurance

Steffie Woolhandler, MD, MPH, and David U. Himmelstein, MD

During the final week of March 2020, the U.S. Department of Labor reported that a record number of workers—6.648 million—filed new claims for unemployment benefits. That beat the previous record of 3.307 million filings, which was set the week before, bringing the 2-week total to 9.955 million. This is just the beginning of the surge in joblessness due to the coronavirus disease 2019 (COVID-19) pandemic. A Federal Reserve Bank economist estimated that the ranks of unemployed persons will swell by 47.05 million by the end of June (1).

For many, job loss will carry the added sting of losing health insurance. Congress has moved to cover severe acute respiratory syndrome coronavirus 2 testing for uninsured persons, but did not include provisions to cover treatment of COVID-19 (or other illnesses). The recent $2 trillion bailout bill offered no new health insurance subsidies or coverage.

Our projections are based on differences in cov
age rates for employed and unemployed persons
2019, but there is little reason to believe that the p
dicament of unemployed workers has improved sir
then. Although many who lose their jobs are likely to
eligible for Medicaid or subsidized Affordable Care A
coverage, and some will purchase continuing covera
under COBRA (Consolidated Omnibus Budget Reco
ciliation Act), the same was true in 2019. Indeed, t
situation may be worse today because some laid-
workers probably gained coverage through an e
ployed spouse in 2019, an option less likely to be ava
able in the face of the impending massive layoffs.

Urgent Policy Needs and Longer-Term Solutions

With jobs and health insurance coverage disa
pearing as the COVID-19 pandemic rages, states th

Annals of Internal Medicine

This Time Must Be Different: Disparities During the COVID-19 Pandemic

Kirsten Bibbins-Domingo, PhD, MD, MAS

After reports of racial and ethnic disparities in the U.S. pandemic, a large, nationally representative survey provided empirical evidence regarding the sources of these disparities (1). The authors found that increased likelihood of exposure to the virus, increased susceptibility to severe consequences of the infection, and lack of health care access were all important contributors, and they concluded with pointed, domain-specific recommendations to mitigate these disparities. The clarity of this path forward would be alluring and reassuring were the historical nature of these observations not so alarming. These data are not based on the coronavirus disease 2019 (COVID-19) pandemic; rather, they describe the nation's experience of the 2009 H1N1 influenza

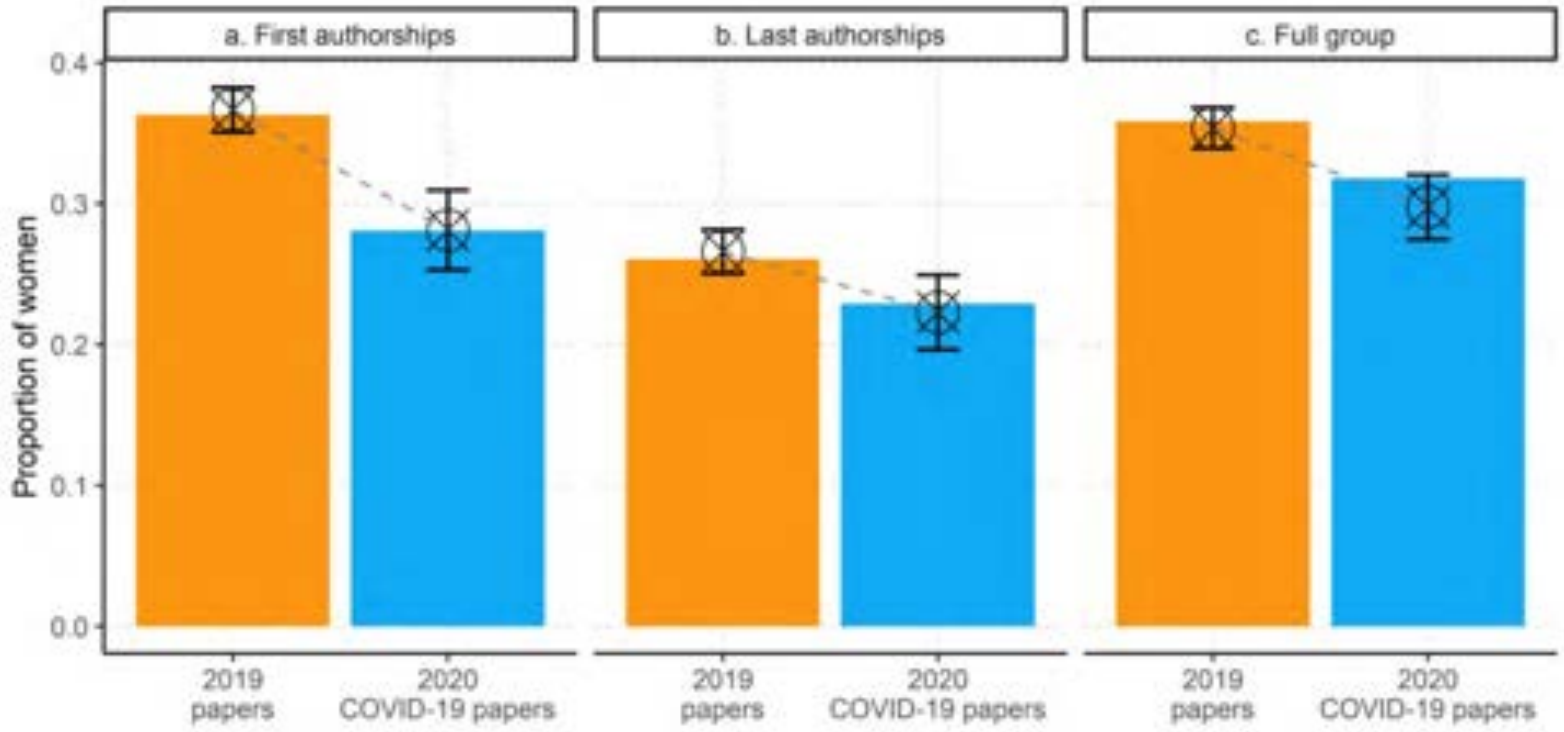
of a health care evaluation, resulting in barriers for those without insurance. Although data are not yet available, concerns about the equitable distribution of ventilators and treatments have also been raised.

We simply cannot afford to bear witness to yet another manifestation of health inequities. This time must be different because we are living in a global pandemic of massive proportion and uncertain duration, the management of which will require ongoing, effective, and equitable attention to the areas of greatest need if we are to avoid even more devastating consequences. This time must be different because the increasing diversity of the U.S. population and our essential workers remind us of our interdependence and means that fo-

Covid Conundrum: A Prescription For Inequities

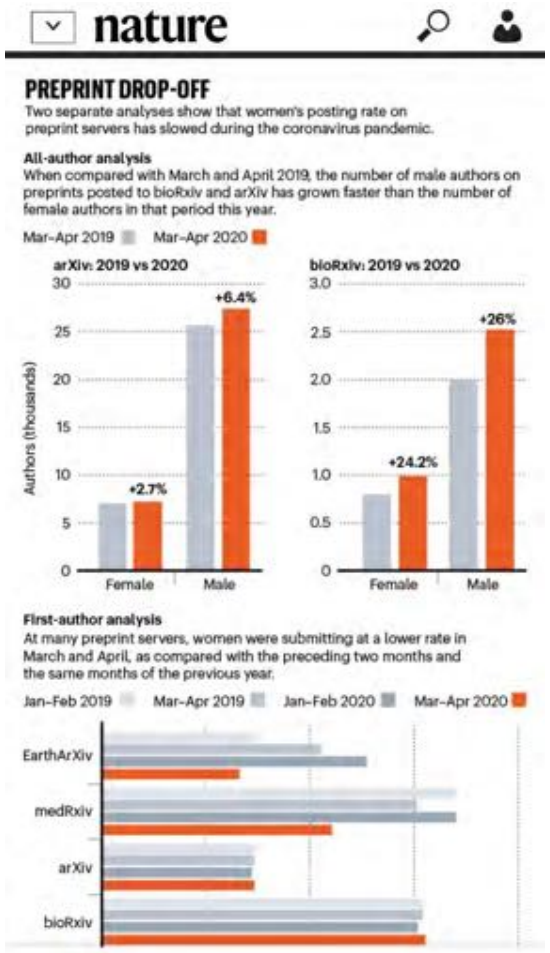
- Disproportionate impact on marginalized populations, essential workers, healthcare professionals (HCPs)
- 75% of HCPs infected with Covid are women
- Women physicians disproportionately working in communities hardest hit by Covid (both domain of practice and geography)
- Perpetual "Second, second shift" for female HCP caregivers- AKA the Third Shift
- Santhosh, Jain et al, "The Third Shift", JWomensHealth, 2020- promotions and career advancement tied to clinical revenue and grants
- Disproportionate role of women in med ed realm increased workload (conversion to virtual curriculum, etc)

Is Covid-19 Amplifying the Authorship Gender Gap in the Medical Literature?

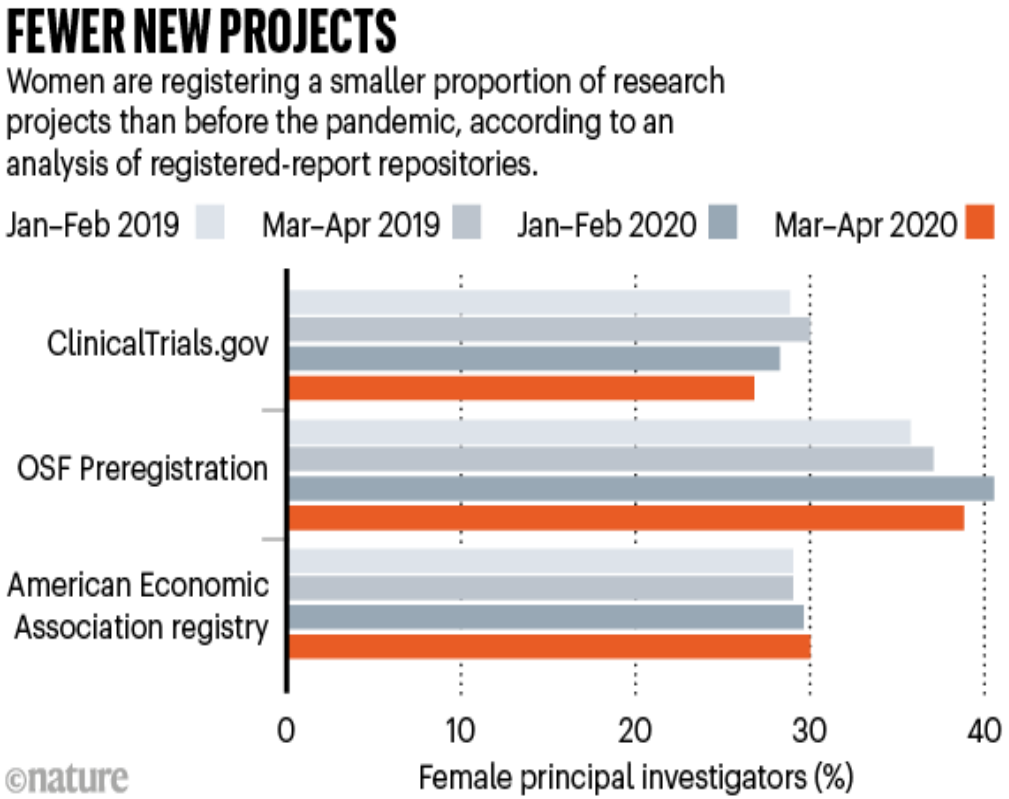


Andersen et al, arXiv, May 2020

Fewer Pubs Later… Viglione, Nature, May 2020



Fewer Projects Now… Viglione, Nature, May 2020



Claire Merchlinsky for Vox

The inescapable pressure of being a woman on Zoom

Why are women bemoaning their hair, clothing choices, and more, even during a pandemic?

By Leslie Goldman | Updated May 20, 2020, 9:40am EDT

SHARE

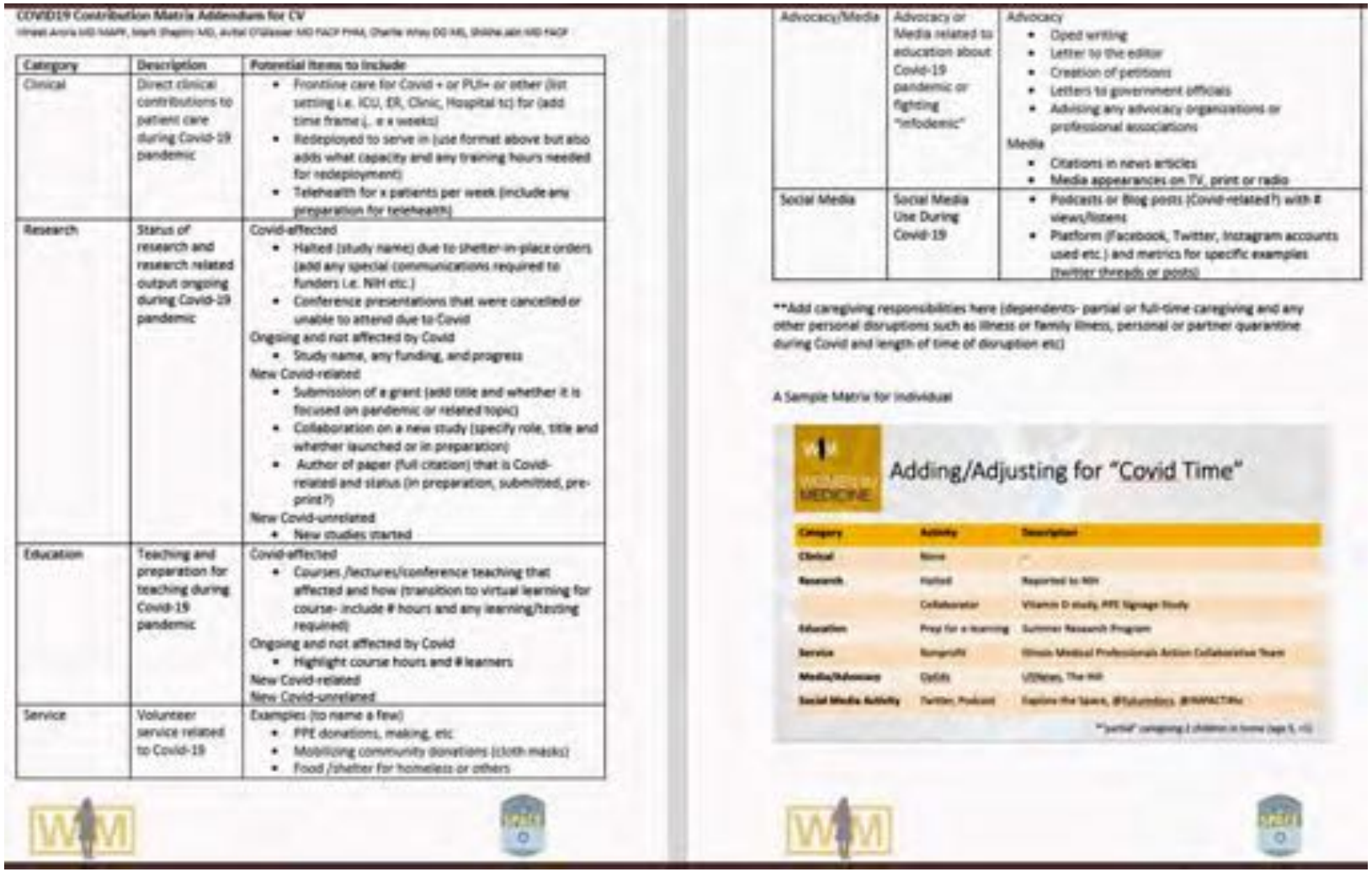
The Highlight BY Vox

Part of the **May Issue** of **The Highlight**, our home for ambitious stories that explain our world.

Can We Fill The Glass With Covid Activities? Arora, WIM Webinar- Covid and Gender Equity

- Promotion/ tenure clock stops and shifts
- Credit for clinical, educational, service, media/advocacy, social media, research
- Bridge funding
- Facilitate group work dynamics
- Capitalize on full on spotlight on inequities

Documenting Academic Progress In The Time of Covid-Arora et al, WIM Summit Webinar 2020



COVID19 Contribution Matrix Addendum for CV

Category	Description	Potential items to include
Clinical	Direct clinical contributions to patient care during Covid-19 pandemic	• Frontline care for Covid + or PUI+ or other (list setting i.e. ICU, ER, Clinic, Hospital tc) for (add time frame i.. e x weeks) • Redeployed to serve in (use format above but also adds what capacity and any training hours needed for redeployment) • Telehealth for x patients per week (include any preparation for telehealth)
Research	Status of research and research related output ongoing during Covid-19 pandemic	Covid-affected • Halted (study name) due to shelter-in-place orders (add any special communications required to funders i.e. NIH etc.) • Conference presentations that were cancelled or unable to attend due to Covid Ongoing and not affected by Covid • Study name, any funding, and progress New Covid-related • Submission of a grant (add title and whether it is focused on pandemic or related topic) • Collaboration on a new study (specify role, title and whether launched or in preparation) • Author of paper (full citation) that is Covid-related and status (in preparation, submitted, pre-print?) New Covid-unrelated • New studies started
Education	Teaching and preparation for teaching during Covid-19 pandemic	Covid-affected • Courses /lectures/conference teaching that affected and how (transition to virtual learning for course- include # hours and any learning/testing required) Ongoing and not affected by Covid • Highlight course hours and # learners New Covid-related New Covid-unrelated
Service	Volunteer service related to Covid-19	Examples (to name a few) • PPE donations, making, etc • Mobilizing community donations (cloth masks) • Food /shelter for homeless or others
Advocacy/Media	Advocacy or Media related to education about Covid-19 pandemic or fighting "infodemic"	Advocacy • Oped writing • Letter to the editor • Creation of petitions • Letters to government officials • Advising any advocacy organizations or professional associations Media • Citations in news articles • Media appearances on TV, print or radio
Social Media	Social Media Use During Covid-19	• Podcasts or Blog posts (Covid-related?) with # views/listens • Platform (Facebook, Twitter, Instagram accounts used etc.) and metrics for specific examples (twitter threads or posts)

**Add caregiving responsibilities here (dependents- partial or full-time caregiving and any other personal disruptions such as illness or family illness, personal or partner quarantine during Covid and length of time of disruption etc)

A Sample Matrix for Individual

Adding/Adjusting for "Covid Time"

Category	Activity	Description
Clinical	None	
Research	Halted	Reported to NIH
	Collaborator	Vitamin D study, PPE Signage Study
Education	Prep for e-learning	Summer Research Program
Service	Nonprofit	Illinois Medical Professionals Action Collaborative Team
Media/Advocacy	OpEds	USNews, The Hill
Social Media Activity	Twitter, Podcast	Explore the Space, @futurebecs, @WWACTWu

Minding The Gap: Organizational Strategies to Promote Gender Equity During the COVID-19 Pandemic, Gottlieb et al, JGIM 10/20

Academic productivity

- Capture Covid-19 contributions
- Encourage inclusion of women on research teams and ensure sponsorship for COVID-19 research funding opportunities
- Allow cancelled scholarly activities to be listed on CV
- Ensure women are included in decision-making
- Develop promotion structures that recognize Covid-19 teaching, clinical care leadership, administration and teaching
- Extend promotion deadlines

Minding The Gap: Organizational Strategies to Promote Gender Equity During the COVID-19 Pandemic, Gottlieb et al, JGIM 10/20

Compensation and Professional Effort

- Standardize how professional effort is calculated in 3 mission areas of education, research, and clinical care
- Conduct total compensation audits and capture professional effort related to non-clinical activities
- Evaluate and transparently share data, and provide forums for discussion and feedback BEFORE implementation
- Ensure that women physicians participate in organizational decision-making around changes to total compensation during and after the pandemic
- In the setting of pay freezes/salary reductions, consider pay equity in calculations
- Consider awarding stipends to those redeployed to COVID-19 work

Minding The Gap: Organizational Strategies to Promote Gender Equity During the COVID-19 Pandemic, Gottlieb et al, JGIM 10/20

Career development

- Capitalize on medical society and medical organization programming
- Maintain institutional funding streams for programming that support women's career advancement and leadership development
- Widely publicize organizational leadership opportunities
- Ensure that women have strong representation on promotion and search committees

Minding The Gap: Organizational Strategies to Promote Gender Equity During the COVID-19 Pandemic, Gottlieb et al, JGIM 10/20

Family support

- Alternate/flex work schedules
- Partner with local businesses to offer subsidize/bulk discounts for self and family care needs
- Develop and promote efforts at varied institutional levels to vet and pool dependent care providers for sharing
- Collaborate with local organizations such as childcare providers, to create or reopen care centers for children of essential workers

Does Career "Flexibility" Exist?

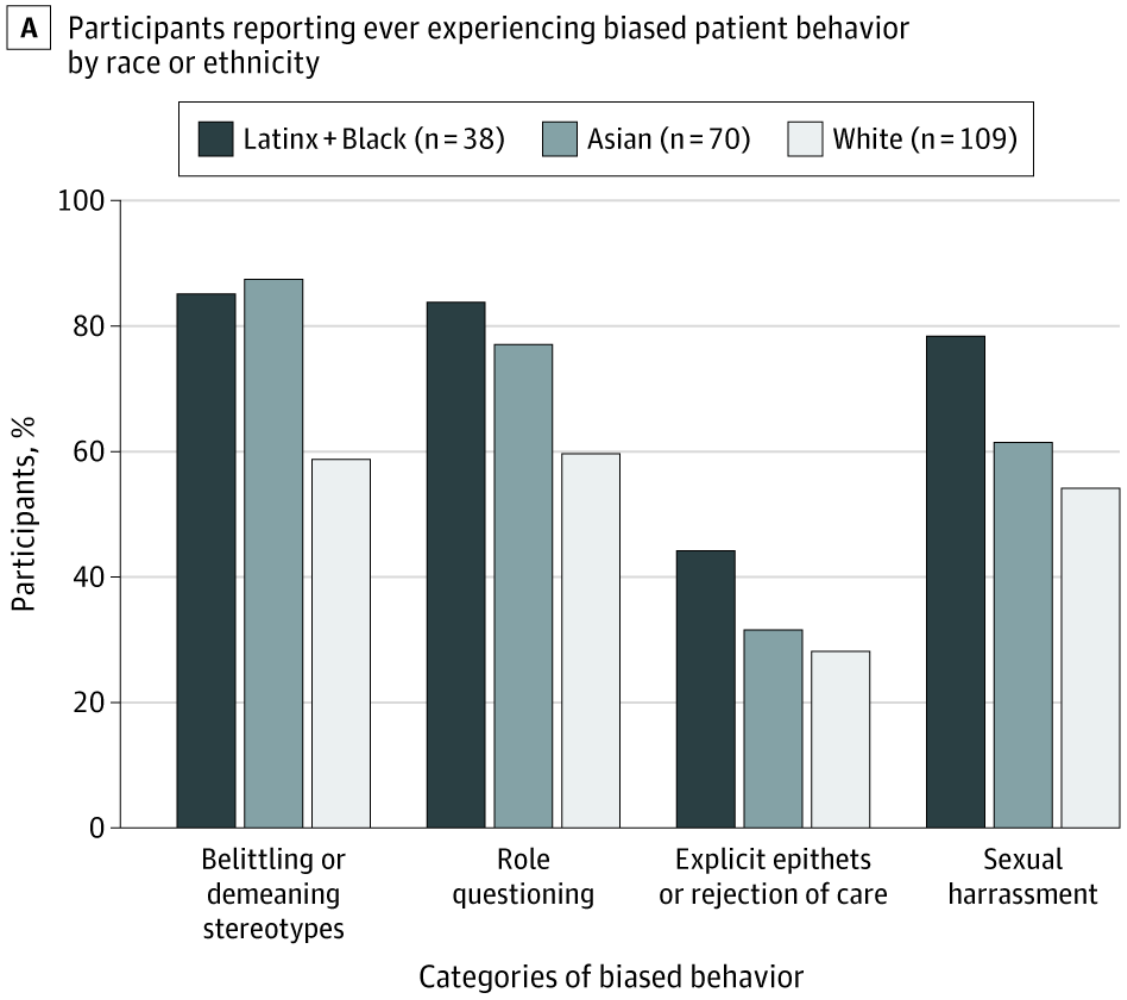
- UC system has had flexible policies (family/ childbearing leaves, stop the tenure clock active service modifications) since 1988 but only 6.7% of women and 0% of men have used these policies
- 1/3rd of those < 50 years old wanted to use but did not make the request
- Concerns about burdening colleagues, perceptions that they were not committed combined with an unsupportive culture, career damage, limiting future opportunities, and facetime bias
- Flexibility should be mutually beneficial and result in superior outcomes for all parties

- Howell, AcadMed, 8/17

What We Know…

- Women (and URiM/UREG) are recruited, evaluated, advanced, promoted, mentored, sponsored and compensated differently than those in majority power holding groups (UME, GME, practicing physicians, and patient satisfaction data)
- Data around women conference introductions, speaking time, interruptions, appropriation of comments/contributions of women is quite concerning
- Despite NASEM requirements that AAMC affiliated hospitals/healthcare orgs maintain a clearly written bill of rights and responsibilities communicating a zero-tolerance policy for sexual harassment towards HCPs, 0/55 contained NASEM recommended specific language against patient perpetuated sexual harassment or abuse (Vigilanti et al, JAMA Network Open, 9/20)
- Emerging data around increasing prevalence of personal attacks and sexual harassment of physicians on Social Media(SoMe), with women reporting significantly more online sexual harassment than men 16.4 vs. 1.5% (Pendergrast et al, JAMA Network Open 1/21)

Resident Physician Experiences With and Responses to Biased Patients
Shalila S. de Bourmont, et al, JAMA Network Open, 11/20



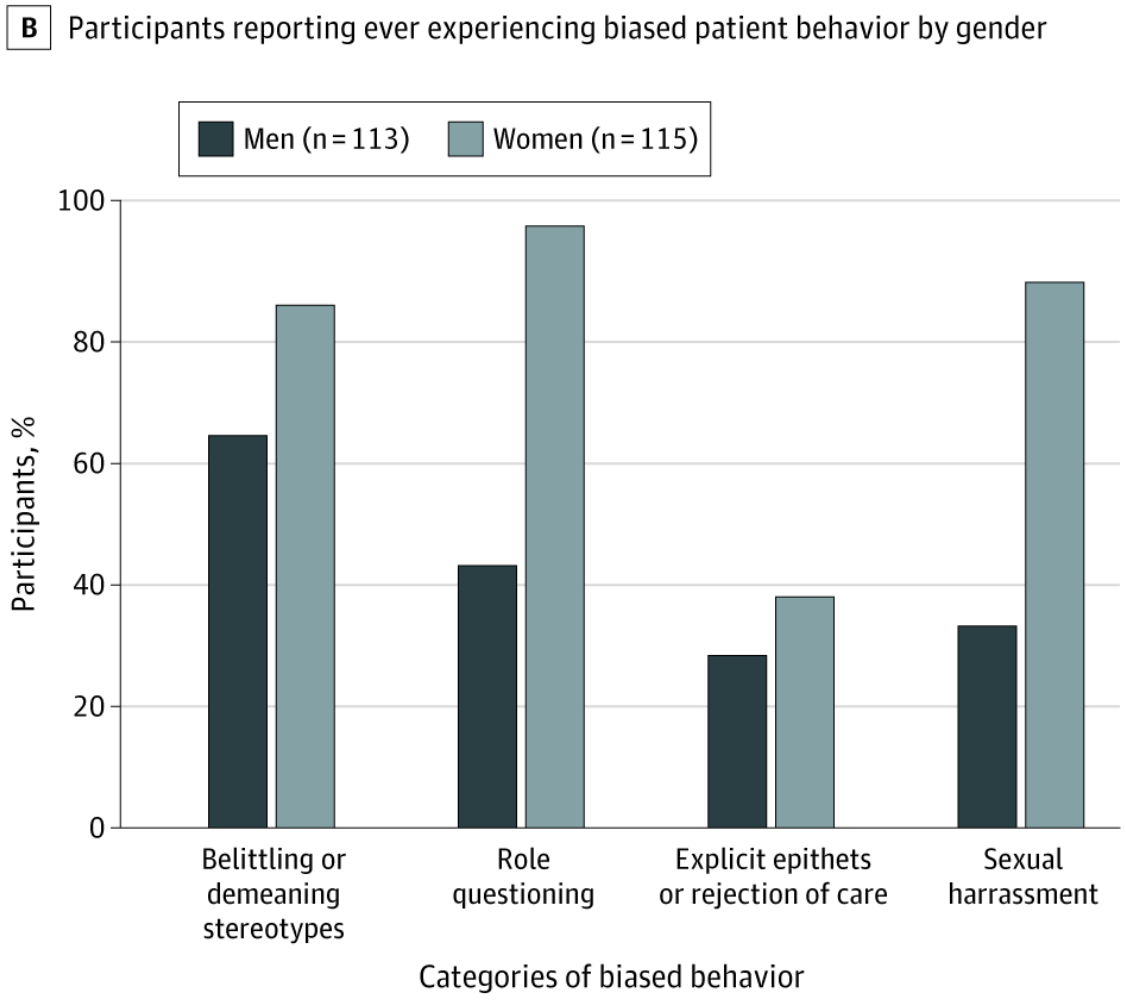


Table 2. Prevalence of Direct Experiences of Types of Biased Patient Behavior in the Last Year

Type of behavior	Respondents, No./total No. (%) (n = 231)[a]			
	Never	Sometimes	Often	Very often
Belittling or demeaning stereotypes[b]				
Belittling comments	47/230 (20)	64/230 (28)	87/230 (38)	32/230 (14)
Inquiries into racial/ethnic origins	77/231 (33)	68/231 (29)	75/231 (33)	11/231 (5)
Generalizations about social identity	41/231 (18)	105/231 (46)	70/231 (30)	15/231 (7)
Confusing team members of the same race/ethnicity	53/231 (23)	91/231 (39)	65/231 (28)	22/231 (10)
Nonverbal disrespect	95/230 (41)	111/230 (48)	22/230 (10)	2/230 (1)
Role questioning[b]				
Credential or ability questioning	37/230 (16)	91/230 (40)	77/230 (34)	25/230 (11)
Assumption of nonphysician status	77/230 (34)	48/230 (21)	67/230 (29)	38/230 (17)
Addressing intern or student because of social bias toward senior resident	98/228 (43)	69/228 (30)	49/228 (22)	12/228 (5)
Sexual harassment[b]	92/230 (40)	98/230 (43)	38/230 (17)	2/230 (1)
Explicit epithets or rejection of care[b]				
Epithets	139/230 (60)	79/230 (34)	11/230 (5)	1/230 (0.4)
Refusal of care	161/230 (70)	65/230 (28)	4/230 (2)	0
Request to change physicians	168/229 (73)	59/230 (26)	2/230 (1)	0

[a] *Sometimes* was defined as 1 to 2 or a few times per year, *often* was defined as once or more than once per month, and *very often* was defined as once per week or more.

[b] Because of missing data, the total No. was less than 231 and ranged between 228 and 230.

Table 3. Frequency of Responses Used to Address Biased Patient Behavior

Type of response	Respondents, No./total No. (%) (n = 227)			
	Never	Sometimes	About half the time	Frequently[a]
1-on-1 Limit setting	22/227 (10)	93/227 (41)	45/227 (20)	67/227 (30)
Debriefing				
With friends or family	36/227 (16)	77/227 (34)	34/227 (15)	80/227 (35)
With team members[b]	11/225 (5)	72/225 (32)	65/225 (29)	77/225 (34)
Creating team response plan[b]	104/226 (46)	79/226 (35)	23/226 (10)	20/226 (9)
Reporting to attending physician or chief resident	106/227 (47)	74/227 (33)	20/227 (9)	27/227 (12)
Reporting to institution[b]	191/226 (84)	29/226 (13)	2/226 (1)	4/226 (2)
Switching patient to another team member[b]	176/226 (78)	41/226 (18)	6/226 (3)	3/226 (1)
Not addressing the incident[b]	47/225 (21)	120/225 (53)	29/225 (13)	29/225 (13)

[a] *Frequently* was defined from survey categories as occurring most of the time or always.

[b] Because of missing data, the total No. was less than 227 and ranged between 225 and 226.

Table 4. Factors Impeding Residents From Responding to Biased Patient Behavior

Factor	Impact, No. (%) (n = 227)			
	None	Minimal	Some	Significant
Prioritizing the clinical care of the patient	16 (7)	45 (20)	90 (40)	76 (34)
Feeling unsupported by the team, senior physicians, or institution	84 (37)	88 (39)	50 (22)	5 (2)
Lack of knowledge or skills about how to properly respond	33 (15)	69 (30)	97 (43)	27 (12)
Perceived ineffectiveness of responding	27 (12)	41 (18)	94 (41)	56 (25)
Feeling emotionally overwhelmed	42 (19)	71 (31)	77 (34)	37 (16)

What Lies Beneath- The Catastrophic Iceberg

Characteristics of Faculty Accused of Academic Sexual Misconduct In The Biomedical and Health Sciences

- Characterized faculty accused of sexual misconduct resulting in institutional or legal actions that proved or supported guilt at U.S. higher educational institutions in biomedical/health services
- Authors performed internet searches of Misconduct database (https://academic-sexual-misconduct-dadatbase.org) and top 500 search results were reviewed 11/18-4/19
- Authors abstracted characteristics of alleged perpetrators, their targets, and outcomes by “Assault”, “Harassment”, “Consensual Relationships”, “Exploitation”

Characteristics of Faculty Accused of Academic Sexual Misconduct In The Biomedical and Health Sciences

- Identified 125 faculty sexual misconducts in 1982-2019 affecting at least 1668 targets
- 34% in U.S. News and World Report top 50 rated colleges/universities
- 98% perpetrators male, and 92% of targets were only females
- 72% of perpetrators targeted subordinates
- 19% targeted clinical trainees
- 51% Full Professors, 17% Department Chairs/Directors/Deans
- 30% committed sexual assault, 56% sexual harassment
- 49% resigned/retired, 21% terminated, 9% sanctioned by funding sources or boards governing clinical practice

Characteristics of Faculty Accused of Academic Sexual Misconduct In The Biomedical and Health Sciences

- 50 accused faculty remained in academia, 60% remained at same institution, 40% at a different institution
- 6/50 terminated by 1st institution, 15/50 resigned or retired
- Domains: 40 Research, 34 Medical, 30 Psychology, 6 Dental, 4 Nursing,11 “Other”
- Limitations- lack of transparency/standardized database and reporting expectations

-**Espinoza, Hsiehchen, JAMA,4/21/20**

Role Of U.S. Healthcare Accreditation, Credentialing, Licensing, and Rating Organizations

- AAMC's commitment to DEI and gender equity- GWIMS and now CWAMS- www.aamc.org, www.cwams.org
- ACGME 2019 Common Program Requirements and CLER requirements around DEI and training environments free of harassment and discrimination- www.acgme.org
- The Joint Commission's commitment to quality and safety of patient care - www.jointcommission.org
- Roles of state licensing and health boards
- Role of healthcare institutional rating systems
- Role of other credentialing orgaizations

ACGME CPRs 2019

- Section I.C. discusses diverse/inclusive aims –”The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative staff members, and other relevant members of its academic community. (Core)”
- Section I.D.2.includes the requirement for lactation facilities and disabilities accommodation- “clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)” and “accommodations for residents with disabilities consistent with the Sponsoring Institution’s policy. (Core)”

Championing A Cause…

ACGME CPRs 2019

- Section VI. has a strong introduction about the learning/working environment with specific details in VI.C on wellbeing-”evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)
- Background and Intent: This requirement emphasizes the responsibility shared by the Sponsoring Institution and its programs to gather information and utilize systems that monitor and enhance resident and faculty member safety, including physical safety. Issues to be addressed include, but are not limited to, monitoring of workplace injuries, physical or emotional violence, vehicle collisions, and emotional well-being after adverse events”

ACGME CLER 2019

Professionalism Finding 1

In many clinical learning environments, graduate medical education and executive leadership expressed intolerance for behaviors that are considered unprofessional. Across some clinical learning environments, residents, fellows, and clinical staff described witnessing or experiencing incidents of disrespectful or disruptive behavior on the part of attending physicians, residents, fellows, nurses, or other clinical staff. These findings ranged from descriptions of isolated incidents to reports of disrespectful behavior that was persistent or chronic in nature.

Joint Commission

- LD.03.01.01 EP 5: Leaders create and implement a process for managing behaviors that undermine a culture of safety.
- EC.02.01.01 EP 1: The hospital implements its process to identify safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities. Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts.
- EC.02.01.01 EP 3: The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment.

Safety and Quality Are Inextricably Linked With An Organization's Culture

Putting Teeth Into Racial Justice and Equity

Dr. Quentin Youmans… “Allyship Is No Longer An Option”

“Ensuring gender equity must be a goal for all of us in medicine, not solely a select few. This requires that we all lend both our voices and our influence in support of women colleagues when we see or hear of inequities. Allyship can no longer be an option, but an imperative.”

Quentin R. Youmans, MD Fellow, Cardiovascular Disease Northwestern University Feinberg School of Medicine

7 Tips For Men Who Want To Support Equality

- Challenge the likability penalty
- Evaluate performance fairly
- Give women credit
- Get the most out of meetings
- Share the office housework
- Make work work for parents
- Mentor women and offer equal access

Top Ten Catalyzers To Get To A JEDI Healthcare Environment And Become An Antiracist Organization

- Perform foundational work- review your organization's mission, vision, and goals with a JEDI and anti-racist lens, modify accordingly, discuss and publicize the elevator story widely
- Review your policies and procedures for governance of your organization to remove explicit and implicit bias in all recruitment, retention, appointment, promotion, leadership, educational, and advancement processes
- Ensure that your organization has JEDI, anti-harassment and discrimination policies (including those for patients/family members/visitors) and accessible mechanisms for activation of processes to enforce these policies. Get granular
- Establish a body for ensuring a JEDI/ anti-racist in your organization that is empowered, has teeth in education and enforcement, can actively intervene in a rapid response fashion with individual , group and allyship training, as well as have oversight with all governance and other germane policies relevant to establishing and maintaining a JEDI/Anti-racist environment
- Review the allocation and prioritization of financial and other critical supporting resources to ensure that allocations prioritize creating/sustaining/augmenting a JEDI/anti-racist environment

Top Ten Catalyzers To Get To A JEDI Healthcare Environment And Become An Antiracist Organization

- Institute deliberate practice in transparent data collection and review to assess your organization's cultural environment, with a focus on safety, quality, JEDI and anti-racist principles, get specific and granular and avoid broad statements about harassment and discrimination
- Review and actively track total compensation, recruitment, appointment, advancement, awards and leadership positions and benchmark to rank and file of your organization and patient characteristics (if applicable)
- Transparently publicize your organization's data regarding your review of data in total compensation, recruitment, appointment, advancement and leadership in your organization
- Educate all in the organization regarding the benefits of a JEDI/anti-racist environment in terms of human and financial outcomes, safety and quality. Start with your organization's Board
- Review all local, regional, national licensing, accreditation, certification JEDI/anti-racist standards and ensure that your organization is adhering to them (eg AAMC, ACGME, Joint Commission, state/local licensing boards and health departments)


she's someone's
sister/mother/
daughter/wife

And May The Force Be With All Of You!


“
There is always light, if only we’re brave enough to see it. If only we’re brave enough to be it.
Amanda Gorman
The youngest inaugural poet in US history
USA TODAY

Thank you . . . Follow us @ACPinternists @ DarilynMoyer

…for your continued support of ACP and your commitment to internal medicine.