ADOPTED by the AMA House of Delegates, June 2008

The following is adopted and the remainder of the report is filed:

1) That our American Medical Association encourage medical associations and other relevant organizations to study gender differences in income and advancement trends, by specialty, experience, work hours and other practice characteristics, and develop programs to address disparities where they exist (Directive to Take Action);

2) That our AMA support physicians in making informed decisions on work-life balance issues through the continued development of informational resources on issues such as part-time work options, job sharing, flexible scheduling, reentry, and contract negotiations (Directive to Take Action);

3) That our AMA urge medical schools, hospitals, group practices and other physician employers to institute and monitor transparency in pay levels in order to identify and eliminate gender bias and promote gender equity throughout the profession (Directive to Take Action);

4) That our AMA collect and publicize information on best practices in academic medicine and non academic medicine that foster gender parity in the profession. (Directive to Take Action), and

5) That our AMA provide training on leadership development, contract and salary negotiations and career advancement strategies, to combat gender disparities as a member benefit.

REPORT 19 OF THE BOARD OF TRUSTEES (A-08)
Gender Disparities in Physician Income and Advancement
EXECUTIVE SUMMARY

This report is prepared and pursuant to AMA Policy D-525.995, "Investigating the Continued Gender Disparities in Physician Salaries," stemming from a concern that there is a continuing gender gap in salary and professional advancement that negatively impacts female physicians.

Despite the increasing number of women physicians, gender-based discrepancies in income and professional advancement exist in the medical profession. Many factors, including specialty, experience (age), work effort, and part-time work status have been cited by researchers as causes of the lower average salary and relative lack of professional advancement for female physicians as compared to male physicians. Also playing a role in gender disparities are career choices made to balance work and family goals and the lack of mentors and senior role models for women in medicine.

However, researchers have found that gender disparities persist even when studies are controlled for age, specialty and practice characteristics. These remaining disparities are attributed to a degree of gender discrimination and gender bias that remains in the profession.

This report reviews the literature on gender-based practice/professional differences, noting that research studies have focused primarily on physicians in academic settings and that more data is needed on physicians in the non-academic practice environment. The report discusses the underlying causes and contributing factors to gender disparities and recommends that the AMA and the profession continue to study these issues and provide information and physician support for achieving equity in the profession.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 19-A-08

Subject: Gender Disparities in Physician Income and Advancement

Presented by: Edward L. Langston, MD, Chair

Referred to: Reference Committee C
(David M. Lichtman, MD, Chair)

Resolution 306 (A-07), "Investigating the Continued Gender Disparities in Physician Salaries," adopted by the House of Delegates, directed "that our American Medical Association, in collaboration with any appropriate affiliate bodies or professional organizations (e.g., the Women Physicians Congress), study gender disparities in physician salaries and professional development (e.g., promotions, tenure), the causes of the disparities; and report back at the 2008 Annual Meeting with recommendations on how best to advocate to eliminate the disparities identified."

This Board of Trustees report, developed with the Women Physicians Congress, presents a review of the relevant literature and research data, identifies factors that impact gender disparities and includes recommendations for eliminating gender disparities in the medical profession.

INTRODUCTION

The number of women in medicine has grown dramatically over the past three decades. In 2006, women comprised 27.8 percent of the physician workforce and 48.3 percent of U.S. medical students (AMA Physician Characteristics and Distribution in the U.S. 2006).

However, despite the growing numbers of women in medicine, female physicians have consistently lagged behind their male counterparts in advancement in the medical profession as well as in salary and income levels.

According to the 2000 U.S. Census Bureau report, female physicians earned 63 percent of male physician median income. The AMA identified similar differences through its Socioeconomic Monitoring System (SMS) surveys and Patient Care Physician Surveys (PCPS). Income data from 1990-2000 indicated that the median income of female physicians was consistently less than male physicians, with females earning 62 percent of male physician median income in 2000.

Gender disparities in medicine can be attributed to a certain degree to gender differences in specialty choice, age/experience, practice characteristics and life style choices. However, evidence also suggests that gender bias and discrimination continues to exist in medicine, resulting in career advancement barriers for women.

The underlying issues of gender discrimination in medicine are reflective of those in the society as a whole, including gender stereotyping in expectations and opportunities and the challenges of balancing the demands of both family and professional lives. However, such issues are difficult to document. Although research data can show evidence of the fact of discrimination, this may not get to the underlying causes which inevitably involve interpretations of conscious and unconscious intent, issues that call for more complex research studies. Nevertheless, evidence strongly suggests that there may be gender-based challenges that are specific to medicine and that

gender discrimination in medicine, while having dissipated somewhat, continues to be related to discrepancies in salary and professional advancement that negatively impact women physicians.

OVERVIEW OF EXISTING RESEARCH

For the preparation of this report, the AMA Women Physicians Congress (WPC) contacted specialty medical societies represented in our Federation to assess data on gender disparities in the profession by specialty. Of the respondents, most indicated that their organizations did not collect salary information (73 percent) and/or data on promotion and career advancement issues (91 percent), delineated by gender. A breakdown of responses is available in Appendix B.

Some societies reported specialty-specific research. The American Academy of Pediatrics (AAP) shared research citing that female physician income was reported to be consistently lower for both pediatric generalists and sub specialists compared with males, a difference that persisted even when controlling for employment status, and noted that female pediatricians faced significant barriers in achieving advancement in academic medicine.

In other research, McMurray et al. *(Journal of General Internal Medicine,* 2000) found similar income and advancement disparities when studying the combined specialties of pediatrics, family medicine and internal medicine.

A number of widely circulated studies in the last decade have been conducted by Wallace and Weeks and published in various specialty journals. Addressing the role of gender in income, study results in general indicated that significant gender disparities in salary exist even after controlling for work effort, provider characteristics, and practice characteristics. In some studies, it was asserted that gender alone was associated with the lower net annual incomes of women physicians within various specialties.

However, some researchers have expressed concern that design flaws in these studies yielded results that do not support an accurate depiction of the female-male income differential. A considerable portion of this research pools AMA Socioeconomic Monitoring System data for 1992-2001, without accounting for two significant factors during that time period: 1) the percentage of women physicians increased from 18 percent to 25 percent and 2) the growth in physician income was nearly flat across the board for all physicians. Without properly controlling for year in this type of analysis, it is difficult to assess how the female-male income differential changed over time.

Another researcher, in "The Differences in Earnings Between Male and Female Physicians" (Baker, *New England Journal of Medicine*, 1996), studied the female-male physician income differential, testing the following hypotheses, whether or not the differential: 1) is different at two points in time for similar cohorts of physicians; 2) changes over time for a cohort as the study participants age; and 3) is different for participants in different cohorts at a single point in time.

The Baker study used data from the 1987 and 1991 Young Physician Surveys (physicians under 40 and 45, and within 2-5 and 2-9 years of practice, respectively) and the 1991 AMA Socioeconomic Monitoring System (physicians with at least 10 years of experience). When all other variables were controlled for, including education, board certification, and personal characteristics, the data indicated that the income differential between female and male physicians was negligible and that income differentials may be diminishing with each new graduating class.

However, Baker cautioned against attributing specialty choice and practice setting solely to physician preference without exploring the possibility that women physicians may have fewer opportunities to pursue higher paying specialties. He acknowledged that continued attention to differences in earnings among female and male physicians is warranted, particularly in view of evidence of a persistent gender earning gap among older physicians. Baker acknowledged that commentators have argued that discrimination continues to be an issue in the careers of women physicians and that the results of his study should not be interpreted as evidence that discrimination is not problematic.

GENDER DISPARITIES IN ACADEMIC MEDICINE

The majority of research on gender variances in salary and advancement has focused on physicians in academic settings. The Association of American Medical Colleges (AAMC) has collected data for decades on academic rank and other indicators of advancement, stratified by gender. It is clear from the data that disparities exist.

According the AAMC, the percentage of medical faculty who are women increased from 26 percent in 1997 to 33.2 percent in 2007 (29 percent of basic science faculty and 34 percent of clinical faculty). Of faculty receiving tenure, 27 percent were women physicians. While the percent of female assistant professors exceeded that of male physicians in 5 of 11 clinical departments, the percent of men in the ranks of associate professor and full professor exceeds that of women in all specialties. Women physicians chair only about 11 percent of all medical school departments and only 12 percent of medical school deans are women.

Research on academic physicians, while important, does not translate directly to the much larger community of physicians in the non-academic practice setting. Extrapolating conclusions from one to the other is of limited value because of differences in function, structure and institutional culture.

Nevertheless, it is useful to look first at factors in the academic setting that influence gender disparities in income and advancement and affect job satisfaction and work productivity. For physicians on the tenure track, physician value to the institution is measured primarily by the number of scientific articles published in peer-reviewed journals and grants obtained to support the research which are considered revenue for the institution. Advancing from assistant to associate professor (with tenure) can take up to six to ten years.

Inherent in the unwritten rule of "publish or perish" is the expectation that one devote attention to work, research and writing for an uninterrupted, substantial period of time. Physicians on the tenure track can lose their standing with the institution if tenure is not achieved within the designated time frame. This requirement may create conflicts for women with childbearing intent and be a factor leading women to choose the nontenure, clinical route for their academic careers. The disproportionate representation of women on the nontenure clinical track suggests that obstacles such as inflexible work schedules, lack of portability, and gender biased work environments may be factors in this decision. Research findings have supported that women believe that their professional opportunities are more limited than those of their male colleagues.

Gender disparities also exist in medical research. As noted in studies by Kaplan et al. (*New England Journal of Medicine*, 1996) women researchers tend to receive less financial support and less assigned research space than men. The authors found that female physicians generally publish fewer original scientific papers and report fewer research efforts than male physicians,

and are more likely than male physicians to have had little or no research training. These factors are significant contributors in the academic rankings of men and women physicians. Additional data from the Kaplan study indicate that significantly fewer women than men attained the rank of associate professor or higher, which was attributed to lower rates of academic productivity (publications and grants), allocation of time spent in teaching and patient care, compared to research, and lower rates of specialization in highly paid subspecialties.

At each academic rank, men faculty members reported significantly higher annual salaries than women faculty members. After adjusting for productivity, full-time or part-time work status and institutional support for research and family responsibilities, salary disparities were shown to persist.

The AAMC has encouraged institutions to develop flexible tenure policies designed to increase research and publishing options for medical school faculty, such as pre-tenure probationary periods, clock-stopping policies, part-time tenure, and other paths to advancement. However, the AAMC acknowledges that progress has been slow in the implementation and promotion of such policies, due in large part to institutional culture.

FACTORS CONTRIBUTING TO GENDER DISPARITIES

A variety of factors influence income and advancement disparities between male and female physicians. Research to date has often focused on the impact of specialty, age, and part-time work on the careers of women physicians. However, other variables, including gender bias, have been attributed to these gender disparities.

Experience (Age and Years in Practice)

Until the 1970s, women comprised less than five percent of all medical students. By the 1990s, this percentage had increased dramatically. Between 1996 and 2006, the percentage of medical school graduates who were women grew from 42.6 percent to 48.3 percent.

This relatively recent influx of women into the profession means that on average women physicians are younger and have been in practice for a shorter time than their male counterparts. Therefore, women physicians are less likely to have reached their peak earning years. For example, in 2006, while only 4.7 percent of office-based male physicians were younger than 35 years of age, 11.5 percent of female office-based physicians were younger than 35.

Researchers have pointed to this relative youth of women physicians as a major factor in gender disparities in medicine. However, there are conflicting reports on the extent of this impact.

Baker found that the gender earnings gap among young physicians may be narrowing. Citing data from two study groups, earning levels were almost equal for male and female physicians with two to five years of experience as well as six to nine years of experience. Whereas for a third group, physicians with 10 or more years of experience, male physicians earned 17 percent more per hour than their female counterparts.

However, McMurray et al. found a $22,000 gender gap in income for women physicians after controlling for age and hours worked among pediatricians, family medicine physicians and internal medicine physicians. Particularly troubling according to the authors, was the persistence of this income difference among younger physicians.

Mirroring the McMurray studies, Ash and Carr, in a study cohort of full-time faculty members, found that as the members increased in age, gender differences in compensation also increased. After adjusting for faculty characteristics including specialty, seniority, hours worked and number of peer reviewed publications, female physicians earned nearly $12,000 less than male physicians. Salaries of female chairs and division chiefs were found to be $17,800 less than their male counterparts, and female physician faculty experience greater deficits with greater seniority.

Specialty

Women physicians continue to be overrepresented in lower-paying, primary care disciplines. A report from the Center for Studying Health System Change, a nonpartisan policy research organization funded by the Robert Wood Johnson Foundation, states that women physicians make up 49.5 percent of the primary care workforce but earn 22 percent less than their male counterparts in primary care. There may be many factors driving this migration toward the lower-paying specialties, including the availability of role models and mentoring, the environment in other specialties, lifestyle/family expectations, and family responsibilities.

However, gender disparities in salary among the higher-paying specialties have also been cited. For example, Baker found that within gastroenterology, the adjusted hourly wage for male physicians was 26 percent higher than for female physicians. Burke et al. also found significant income disparities for both academic and non academic gastroenterologists within their first five years of practice.

Work-Life Balance

Gender may also influence physician differences in work attitudes and experiences and how career decisions are made to accommodate childbearing and domestic responsibilities. Although male physicians, particularly young physicians, are increasingly expressing interest in flexible family leave and work options, female physicians continue to bear the larger amount of responsibility for the daily family upkeep and may therefore face greater challenges in aligning their career goals with family needs.

In a 2006 AAMC/AMA Survey of Physicians Under 50, 66 percent of male physicians and 82 percent of female physicians expressed that having the ability to balance time for family and personal life was an important consideration. Compared to women, male physicians reported being more concerned about career advancement, practice income and long term earning potential than female physicians.

Efforts by the medical profession to assist physicians in identifying and evaluating opportunities for part-time work and reduced/flexible hours have been limited. The AMA Women Physicians Congress has attempted to fill that gap with its project on Explorations in Work/Practice Options, which includes resources and profiles of physicians who share their experiences.

Work Effort

For this discussion, the term work effort is used to refer to the number of hours worked or number of patient visits completed. Work effort has been identified as a contributing factor for the income differential between male and female physicians although, again, existing data have focused on academic physicians with little data available on the effect of work effort differentials on advancement in clinical, non-academic settings.

As already discussed, work effort in academic medicine is measured primarily by research grants and scholarly publications which are closely associated with advancement. However, in academic as well as non-academic settings in particular, productivity in the form of number of patient visits is also an important factor. Female physicians typically conduct fewer patient visits than male physicians per week, which reduces the amount that can be billed and collected as revenue to the practice.

AMA survey data have shown consistently over time that female physicians work fewer hours and see fewer patients than male physicians. Data from the 2001 Patient Care Physician Survey showed that women work on average 52 hours per week and conduct 95 visits per week, compared to men who work 59 hours per week with 110 weekly patient visits.

Part-Time Work Status

Part time employment status contributes to income differentials between male and female physicians since women are more likely to seek part-time positions.

The AMA Women Physicians Congress partnered with the AAP in 2006 to explore trends in part-time/reduced hours employment for physicians and bring into sharper focus the implications for physician workforce projections and policy.

Utilizing the AMA Patient Care Physician Survey, questions sought to obtain information on the frequency of part-time work and on how part-time employment is defined (in number of hours worked) across specialties. The data demonstrated an increased interest in part-time/reduced hours employment.

Among respondents who were currently or had previously worked part time, part-time employment was defined as 25 hours per week by male physicians and 27 hours per week by female physicians. Overall, the data demonstrated that female physicians are more likely than male physicians to have worked part-time but that among all physicians who have worked part-time, there is no significant difference in patient care hours worked between male and female physicians.

In a 2006 joint AAMC/AMA survey of physicians under 50 years of age, 24 percent of female physician respondents reported working part-time, compared to 2 percent for male physicians. Female physicians working full time reported working 4.5 fewer hours on average than male physicians.

Little research has been undertaken to assess the underlying factors in selecting part-time work or identify ways in which the medical profession can be supportive of physicians who make that choice.

Re-entry

Physicians who take a leave of absence from practice, or limit certain aspects of their practice, can face barriers in returning to practice. This may disproportionately affect women physicians. According to AAP survey data, 71 percent of female pediatricians take extended leave compared to 14 percent of male pediatricians. Re-entry into practice, especially after an extended period, poses challenges for physicians with regard to state licensure, board certification, hospital privileges, and advancement. These issues are being studied currently by the AMA and the AAP to identify solutions to facilitate re-entry for inactive physicians.

Burnout

Burnout is characterized by "emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness" (Andolsek and Cefalo, developers of the LIFE curriculum: Learning to Address Impairment and Fatigue to Enhance Patient Safety). According to AMA Council on Medical Education Report 8-A-07 on "Intern and Resident Burnout," women physicians are 60 percent more likely to report burnout than men physicians. This may be reflected in the disproportionate number of women physicians who choose part-time or reduced hours work as a means to balance professional and personal life.

Mentoring

Career advancement can be positively impacted through the guidance of good mentors, especially for young physicians. However, with a limited number of female physicians to serve as mentors and role models, female physicians may encounter fewer opportunities than male physicians to develop mentoring relationships. As a result, they may experience professional isolation that can undermine their sense of confidence and belonging.

While both men and women can act as mentors for female physicians, it has been theorized that women look to senior female physicians for examples of how to successfully combine career, family and personal life, as well as for career sponsorship.

Lack of mentoring is often cited by women faculty members as a barrier to their academic advancement. According to the AAMC, a comparatively small number of women physicians are being mentored for leadership positions, contributing to a perceived narrow pipeline of future women leaders.

Other Factors

Female physicians are less likely to be self employed, 44.2 percent are practice owners, in comparison to male physicians, 66.2 percent of whom are practice owners, according to Kane and Loeblich (Physician Income: The Decade in Review Physician Socioeconomic Statistics, 2003).

Board certification may also influence gender disparities in pay since board certification is associated with higher earning potential, as well as self employment. Based on 2006 AMA Physician Masterfile data (not stratified by age), 71 percent of male physicians were board certified, compared to 65 percent of female physicians.

Gender Bias

Women in medicine continue to encounter subtle and overt forms of discrimination during their training and careers that impact advancement, job satisfaction and career advancement. Studies have found that disparities in income exist even after adjusting for variables such as specialty and years in practice.

Gender/sex discrimination refers to "behaviors, actions, policies, procedures, interactions, etc., that adversely affect a woman's work due to a disparate treatment, disparate impact, or the creation of a hostile or intimidating work or learning environment." (Lenhart and Evans, *JAMA*, 1991). Rowe has described the discrimination encountered most often by women as "micro-inequities" reflected in the attitude and behavior of others and often personified as unconscious

and conscious slights, an inference of invisibility, exploitation and excluding women from informal peer networks.

In medicine, examples include assigning women in disproportionate numbers to clinical positions that offer little hope of academic advancement; attitudes that categorize pregnancy as a disservice to the department, discouraging women from entering certain fields by questioning their stamina or disparaging their professional commitment because of their family responsibilities.

Results from a 1995 survey administered by Carr et al. showed that 80 percent of female faculty who reported being sexually harassed also reported that they perceived gender bias in their academic environments; 72 percent reported experiencing gender bias in professional advancement. Similarly, Arlow et al. (*American Journal of Gastroenterology*, 2002), in a longitudinal study on the selection and training of female and male gastroenterology fellows from 1993 and 1995, found that 39 percent of female respondents perceived the existence of gender discrimination and 19 percent perceived sexual harassment.

Gender bias can have a harmful affect on the professional experiences of women, affecting their ability to form productive relationships with male colleagues and mentors and their likelihood of salaries and opportunities for advancement commensurate with men physicians.

CONCLUSION

According to AMA projections, women will comprise 30 percent of the physician workforce by the year 2010. To accommodate this growing number of women physicians, it is important for the medical profession to improve the work environment for women and address the underlying causes of gender-based disparities in the profession.

Research on women in medicine has focused primarily on gender disparities in academic medicine. More research is needed to determine the status of gender disparities in the non academic physician workforce.

Medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Transparency in pay scale and promotion criteria is also necessary to promote gender equity. Medical school deans, department chairs, hospital and practice administrators should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether or not the criteria are discriminatory in effect.

Policies should be implemented in academic medicine that extend tenure decisions or provide options to reinstate, retrain, or otherwise accommodate committed physicians who seek the flexibility needed to meet family obligations.

Resources should be developed and policies implemented that foster effective mentoring and role modeling. Programs such the AMA-WPC Physician Mentor Recognition Program acknowledge the efforts of those who mentor and highlight the importance of mentoring in professional advancement.

The AMA should support research efforts that contribute to a better understanding of gender disparities in income and advancement such as the AMA-WPC Joan F. Giambalvo Memorial

Scholarship Fund program, which provides grants for research on women in medicine professional issues.

RECOMMENDATIONS

Therefore, the Board of Trustees recommends that the following be adopted and the remainder of the report be filed:

1) That our American Medical Association encourage medical associations and other relevant organizations to study gender differences in income and advancement trends, by specialty, experience, work hours and other practice characteristics, and develop programs to address disparities where they exist (Directive to Take Action);

2) That our AMA support physicians in making informed decisions on work-life balance issues through the continued development of informational resources on issues such as part-time work options, job sharing, flexible scheduling, reentry, and contract negotiations (Directive to Take Action);

3) That our AMA urge medical schools, hospitals, group practices and other physician employers to institute and monitor transparency in pay levels in order to identify and eliminate gender bias and promote gender equity throughout the profession (Directive to Take Action); ~~and~~

4) That our AMA collect and publicize information on best practices in academic medicine and non academic medicine that foster gender parity in the profession. (Directive to Take Action), and

5) That our AMA provide training on leadership development, contract and salary negotiations and career advancement strategies, to combat gender disparities as a member benefit.

Fiscal Note: Staff costs estimated at less than $1000 to implement.

Complete references for this report are available from the Department of Special Groups, Women, Minorities, and GLBT Issues.

1

APPENDIX A: Relevant AMA Policy

D-525.995 Investigating the Continued Gender Disparities in Physician Salaries
Our AMA, in collaboration with any appropriate affiliate bodies or professional organizations (e.g., the Women's Physician Congress), will study gender disparities in physician salaries and professional development (e.g., promotions, tenure), the causes of the disparities; and report back at the 2008 Annual Meeting with recommendations on how best to advocate to eliminate the disparities identified. This study shall be stratified by age, specialty, practice type and academic vs. non-academic employment. (Res. 306, A-07)

H-65.987 Gender Exploitation in the Workplace
Our AMA declares it is opposed to any exploitation and discrimination in the workplace based on gender. (Res. 195, A-90; Reaffirmation A-00; Reaffirmation A-05)

E-9.035 Gender Discrimination in the Medical Profession
Physician leaders in medical schools and other medical institutions should take immediate steps to increase the number of women in leadership positions as such positions become open. There is already a large enough pool of female physicians to provide strong candidates for such positions. Also, adjustments should be made to ensure that all physicians are equitably compensated for their work. Women and men in the same specialty with the same experience and doing the same work should be paid the same compensation. Physicians in the workplace should actively develop the following: (1) retraining or other programs which facilitate the re-entry of physicians who take time away from their careers to have a family; (2) on-site child care services for dependent children; and (3) policies providing job security for physicians who are temporarily not in practice due to pregnancy or family obligations. Physicians in the academic medical setting should strive to promote the following: (1) extension of tenure decisions through "stop the clock" programs, relaxation of the seven year rule, or part-time appointments that would give faculty members longer to achieve standards for promotion and tenure; (2) more reasonable guidelines regarding the appropriate quantity and timing of published material needed for promotion or tenure that would emphasize quality over quantity and that would encourage the pursuit of careers based on individual talent rather than tenure standards that undervalue teaching ability and overvalue research; and (3) fair distribution of teaching, clinical, research, administrative responsibilities, and access to tenure tracks between men and women. Also, physicians in academic institutions should consider formally structuring the mentoring process, possibly matching students or faculty with advisors through a fair and visible system Where such policies do not exist or have not been followed, all medical workplaces and institutions should create strict policies to deal with sexual harassment. Grievance committees should have broad representation of both sexes and other groups. Such committees should have the power to enforce harassment policies and be accessible to those persons they are meant to serve. Grantors of research funds and editors of scientific or medical journals should consider blind peer review of grant proposals and articles for publication to help prevent bias. However, grantors and editors will be able to consider the author's identity and give it appropriate weight. (II, VII) Issued June 1994 based on the report "Gender Discrimination in the Medical Profession," adopted June 1993 (Women's Health Issues. 1994; 4: 1-11)

D-65.998 Elimination of Discrimination of Women
Our Board of Trustees believes that existing AMA policy addresses the need for equitable treatment of men and women, and recommends an examination of AMA policy to the extent that gaps exist in this area. (BOT Rep. 21, I-01; Reaffirmation A-05)

APPENDIX B: AMA Federation Survey, Women Physicians Congress, January 2008

Organization Name	Data/Reports on Professional Issues	Data Collection on Physician Salaries by Gender	Data Collection on Promotions and Career Advancement by Gender	Description of Source
American Academy of Family Physicians*		Yes		www.aafp.org/online
American Academy of Ophthalmology	No	No	No	Article from *Ophthalmology* entitled "Gender Differences in Ophthalmologists' Annual Incomes" – Discussed research findings on gender pay disparities among ophthalmologists.
American Academy of Pediatrics	Yes	Yes	No	www.aap.org/womenpeds www.aap.org/workforce for the Committee's Technical Report, "The Pediatrician Workforce: Current Status and Future Prospects" www.aap.org/research/periodicsurvey
American Academy of Physical Medicine and Rehabilitation	Yes	Yes	Yes	Article from *Archives of Physical Medicine and Rehabilitation* entitled "How Gender Impacts Career Development and Leadership in Rehabilitation Medicine: A Report From the AAPM&R Research Committee."
American Academy of Sleep Medicine	No	No	No	n/a
American College of Gastroenterology	Yes	Yes	No	Article in *American Journal of Gastroenterology* entitled "Gastroenterology Training and Career Choices: A Prospective Longitudinal Study of The Impact of Gender and of Managed Care." Highlighting gender differences in selection and training of gastroenterology fellows. Article in *American Journal of Gastroenterology* entitled "Gender disparity in the practice of gastroenterology: the first 5 years of a career." – Highlighting gender differences in practice type, earnings, board certification, professional characteristics, and personal characteristics within the first 5 years of practice.

APPENDIX B: AMA Federation Survey, Women Physicians Congress, January 2008
Page 2

American College of Emergency Physicians	No	No	No	n/a
American College of Obstetrics and Gynecology*		Yes		Report on Financial Trends in Ob-Gyn Practice, 1991-2002 - Providing data on trends in net income and practice revenues/ expenses. Profile of Ob-Gyn Practice – Providing an overview of demographics, practice characteristics, workload, and trends 1991-2003
American College of Phlebology	No	No	No	n/a
American College of Surgeons	Yes	No	No	Referred to the Journal of the College of Surgeons
American Osteopathic Association	No	No	No	n/a
American Society of Anesthesiology	Yes	No	No	n/a
Society of Thoracic Surgeons	No	No	No	n/a

** Respondents provided information through means other than the Federation survey.*

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