

# Women leaders in medicine: Seeking equal pay for equal work

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In an ideal world, men and women would get equal pay for equal work, and everyone would receive the work benefits they need to live happy and healthy lives. But female physicians will discover that things rarely play out ideally, and the COVID-19 pandemic has only heightened the challenges they face.

In the second of two “AMA Moving Medicine” podcast episodes featuring a panel discussion from the AMA Women Physicians Section, the panel members touch on nontraditional paths in medicine, as well as how to negotiate things like fair compensation and benefits. Neha Siddiqui moderates the panel with Joanna Bisgrove, MD, Marilyn Heine, MD, and Donna Woodson, MD.

Below is a lightly edited full transcript of the 2019 presentation. You can tune in on Apple Podcasts, Google Play or Spotify.

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## AMA Moving Medicine

### Women leaders in medicine, part 2

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**Siddiqui:** Are there any nontraditional routes to medicine that you've taken? Or maybe something unique you've done along your path in medicine? Dr. Woodson, do you want to start with that?

**Dr. Woodson:** I think mine was nontraditional because there weren't many women. I guess I had a good posse around me that encouraged me to go on. Others have gone very nontraditional. I did go to graduate school, as I said. At University of Oregon Medical School, there were 100 M1s applying and one female. I knew before I even applied that I would have to have some other background than working in graduate school. So, I didn't apply there.

I was moving back here, and this was touted as a community of scholars. That really appealed to me because I remember having some tough teachers for 12 years. It was an all-girl school, and that made it even tougher. When I got that leadership award—I looked back in this little box that was from the nuns, and there was a little cross that said “excellence in leadership”—then I thought I could do it. I also thought I could really do physics, and I would've loved to do engineering, because they're the problem solvers.

**Siddiqui:** You went from an all-girls school to being one of the few in your medical school class?

**Dr. Woodson:** Yeah.

**Siddiqui:** How did you make that transition? Did you even notice it?

**Dr. Woodson:** Well, I thought it was wonderful. What's not to like about that? And my two kids, interestingly, haven't been raised in a Catholic all-girls school. My two best friends in medical school were two Jewish fellows. We studied together every weekend and they were wonderful. So, it was the opportunity. But here, there's opportunity to meet others from all across the country, and you'd be

amazed. I've seen, over the years, many friendships that have survived and lasted many, many years.

Some of the great names in medicine are here and you can meet them. If I don't know them, but you want to meet them, we'll figure out some way. And you can say, "Remember when I shook your hand? I met you, we were together and blah-blah-blah." That's always a good start to anything. Whenever you can shake someone's hand and have somebody take a picture of that, you're golden.

**Dr. Heine:** And post it. Post it on social media.

**Dr. Woodson:** Oh, absolutely. Not my social media, but I give it to some of my friends here. They know how to do that.

**Siddiqui:** Dr. Bisgrove, do you have any nontraditional routes to medicine that you may have taken? The engineering?

**Dr. Bisgrove:** Yeah. I think the main thing that was nontraditional for me, at my time, was that there still were not a lot of women in heavy physics science.

By the time I got to medical school, it was half women. There were almost half women at our medical school class at Rush when we graduated in 2003. But Rush really was an early adopter of trying to mix the genders and get a lot of women and make it more gender equal and gender neutral. Rush was very ahead of that.

But most of my fellow classmates did biology. They did more traditional studies. This whole idea of coming from the hard sciences, there was still a lot of block on that. And there still is, to a lot of degree. Women are still very, very much discriminated against in the hard sciences and engineering.

The thing that was fortunate for me is that at my high school ... I happened to have a physics teacher who was part of this advanced program. But he wanted his two daughters to be physics teachers. They became English teachers. So, to make up for that, he was pushing every single woman he could into the hard sciences, and he loved it.

I came in to get my grade, and he would come out and give me a hug. He's like, "You did so great on the test."

I'm like, "Well, what did I get?" But he was really supportive.

It was his idea for me to go to Cornell. I'd never really heard of Cornell, but we were involved in a nationwide supercomputing competition that our school happened to win every year. We had this access to Cornell and he's like, "Go." I applied, and I got in and got a small scholarship. I was like, "Wow."

The engineering is actually funny to some degree. All my friends would laugh at me because engineering was going to be my backup if I didn't get to medical school.

And they're all going, "Engineering's a backup?" Like, yeah, it's a good career, why not? Especially at that time, the concept of engineering being a backup to anything was just bizarre. But to me, I thought medical school was going to be hard to get into.

Then I took a year off between college and med school. I've learned sign language, I worked as an interpreter. It was just that one year off, but going that hard sciences route in the early to mid-'90s was a little nontraditional. It's less so today.

**Dr. Heine:** Mine was actually more traditional, although I did the soft sciences. Psychology was my major. After my high school, after the day was done, I would go and teach in a parochial program. That was a love as well because I could actually work with first and second graders, and I would be able to help coach them. That was another way to actually just be involved with younger folks and get them enthused in something.

It was really interesting because one of the things that they said to me was that I was supposed to be the support teacher. For example, there were regular classes going on and then they would say, "We have these children, they're really not engaged," or, "They're really bored," or, "They're really advanced." But then we'd take them out of that particular classroom, bring them in and do really more dynamic and fun things, and they would learn.

I'm thinking they all basically just wanted to be engaged. You have to appeal to them. When they had engagement, they all did phenomenally well, which is really great. I also taught during other times that I wasn't going in the college classroom. Obviously, it wasn't on Sunday, so I was able to teach then also.

I think that was helpful just to get a little bit more engagement in doing different activities. But advocacy's always been a passion of mine for years, ever since I was much younger. I think that also is really helpful. It helps a lot in medicine because there's so much. Joanna was talking about advocacy she had been experiencing from many years before, as well.

I think that passion to actually help others advance a cause that's really important and find out how you actually can get something accomplished, or at least raise the profile, is really helpful. That's definitely not classic medicine. And a lot of our colleagues aren't involved so much in that. We have to explain to them that you can have phenomenal education, but if the legislators are going to dictate what we can or cannot do, it's incumbent upon us to advocate for our patients. Not just at the bedside, but also in the halls of our legislatures, both at the federal and state level.

That means getting other people and colleagues involved and trying to inspire them. And grassroots activities. I just sent out something the other day on that. That's an issue that's being addressed in Pennsylvania. Sometimes there are nontraditional ways of getting into medicine, but you can also go through the course of medicine and have a much richer experience.

I had two uncles who were in medicine. One was in family medicine, the other cardiology, and they both were phenomenal individuals in terms of relating to the patients, putting the patients first and being great educators. And one uncle, in particular, was really a very big proponent of being involved in organized medicine. He thought that would be a really helpful and fulfilling activity.

But he also said, "Whatever you do, make sure it's a little diverse." Not just clinical, although I love working with the patients. He said, "Experience organized medicine. Research, if you're interested. Teach. Just kind of mix it up a little." The diversity of your career portfolio, so to speak, actually keeps you going and keeps you feeling that it's a really exciting process that you're going through.

**Siddiqui:** A lot of women physicians often cite having difficulty navigating with their employers and their residency programs, in making sure that they're treated well, that they're compensated well, that they get the same vacation days, that they get the same health leave or maternity leave. How have you, in the past, negotiated with employers on this? And how do you suggest that women physicians navigate this?

**Dr. Woodson:** Here's how you negotiate: You go into private practice. You are your own boss; you talk things over with your partners; you see patients the way you want to see them, and then you get paid for what you've done. I was invited over to my medical college start a center for women's health. But they thought I had millions of dollars to build a building, and I didn't. There's no building there, and I didn't promise that.

But what happened then is that I had to negotiate. I am going into academic medicine, which was exciting to me because I'd always loved teaching—students would be in my office for a month, that was the best part—and teaching every patient you have. I thought, "That's going to be delightful."

But when you go into the world of academia, and that's most of what you have been exposed to so far, guess what sticks its head under the tent? Politics. Academia is quite a different world. So, I had no idea.

When I had my very first medical job, it was with a very successful physician who had built a medical center next to a brand-new hospital in our community. He came to me—he knew me, I saw his patients in the hospital—and asked me if I'd like to consider working for him. So, I went out to this beautiful new office. He was a great businessman. I just wanted enough to buy high heels, that's all.

Marilyn's the same way, I think. She's got to have the right shoes. Right? I always admire her shoes.

When we finished touring, he said, "Now if you would join me, this could be your office." It wasn't huge, but it was beautiful, had full glass windows and looked down to a little pond.

So, I said, "Oh, this is really nice."

And he said, "Well, when could you start?"

And I said, "Tomorrow." The one thing I never asked him is, "How much are you going to pay me?" I was just blown away by the fact that I had my first job. I didn't have to worry about it then.

He said, "We'll pay you 50% of what you earn, and we'll do this and that. If you become board certified, we'll pay you more."

My first job was in berry fields when I was nine, and it was a pretty interesting job. I made two very important decisions then about my entire life. We rode an hour and a half early morning to get to the fields. It was cold and the sun was coming up one day. I had this beautiful row of strawberries. They were huge. I knew it wouldn't take long to earn the 13 cents I would get when I filled up that carrier.

I felt something on my back, and it was one of the teenage boys that was on our team. I was nine, he was probably 17. He liked that row of strawberries, too. He kicked me off that row onto the next row of strawberries.

I really, truly remember that event in my life because I thought, exactly, "I am never going to work in anybody's garden but my own, and I'm going to be my own boss." And, you know, that stuck.

That was one of the dreams or aspirations I stuck with. When times get tough, I look back on that. Of course, I had my little bank account at the end of the summer. I'd earned \$61, and I was going to go out and buy something other than clothes, because you wear uniforms.

I said to my mother, "I think you're going to take me out."

And she goes, "Well, honey, I have something to tell you."

And I go, "Oh, what's that? When can we go?"

She goes, "Well, the money's gone."

And I said, "What do you mean my money's gone? I had a little bank book, and it says \$61.25."

And she goes, "Well, we had to spend it."

I said, "On what? You don't have any new clothes. You never wear any new clothes." Of course, she gave me the money to get new clothes.

And she said, "We had to spend it on food."

How selfish we are when we're young. I never forgot that either, but I didn't blame her for it because she was so unselfish. But as you go on, you find that there are other ways you get around things that make a difference. I think those things are what make you persevere, because you've had that dream or aspiration. Those are the things that started me out. So, I'm anxious to hear what you have to say.

**Dr. Bisgrove:** In terms of being my own boss and owning my own practice, that was always a concept that terrified me. The idea of owning my own practice? I'm not going to do that. I would be constantly worrying about the money. I'm not good at telling people, "You're bad; you have to do this or that," or disciplining. It's not my thing. I'd much more like to be the positive person. Employed medicine or a larger multispecialty group, where there's other people doing the HR stuff, was always going to be my place to go.

You have to navigate in that because we each have our own practice organizations that are going to work for us. I have operated in a large, previously physician-owned group that then got bought out by SSM. ...

But in reality, a lot of times SSM has actually been better for us. ... SSM has pointed out all the ways that our group has not been good to each other and has actually, in a lot of ways, opened up the ability for me to start advocating for gender equity in pay.

One thing just happened recently. We've had this payment model in place for a long time that is complicated to explain, even to people who are under it. In multiple different ways, it is unfair to a lot of different people. One of the groups that it's unfair to is part-time physicians, and everybody knew that. I went, "Wait a minute. Most of the time there are a lot more women that are part-time physicians than men."

So, I raised the question that people had brought up for years, that this is not fair to part-time physicians; we cannot do this, and they just got blown off. But I brought up the question a different way. I brought it up in terms of the issue with women being part-time physicians. Because then I brought up the Equal Pay Act. This is when it's helpful to be involved in policy, because you know health care policy and you know the law.

One of the things you're going to need in order to get through any kind of difficulty, the thing that helps you, is solid evidence. Things that you can throw. It's not a them-versus-us argument. You've got data. You've got transparency. We have the internet now. There is data everywhere. What does the average physician make in this field? That's one of the things we're trying to beat down quite a bit for



anyone in terms of gender equity and equity in pay.

It isn't just about women. It's about everybody, because gender equity in the workplace benefits everybody that's there: men, women, transgender, whomever. Back to the issue I raise. After years of being pushed aside by someone who was from our old system, SSM and the new system said, "OK, let's do the deep dive." And this was important because we're working on developing a new model that's going to be implemented Jan. 1, 2020, and they talked about wanting to take components of the old model.

They did the deep dive. We discovered a couple of things. We actually have a lot of men that are part-time, for whatever reason. We also have leadership positions that are part-time clinical, and there's a number of men that are leaders. And the leaders, even though they're full-time, they get hit by this weird quirk. But, because of that, men and women were affected about equally.

So, my argument fell. But at the same time, it made it very clear what was wrong with the payment model and how it could affect gender, especially with knowing that more women could become part-time in the future, and how it really hurt people in general. That's gone. We are no longer touching any part of an old model in our new model. Being able to bring forth the study, and get the data, and make things transparent, made it clear what we had to do.

Data always brings things light. Transparency is always important. No employer should ever ask you, "What did you make at your last job?" If they do, you do not answer. And if they are asking you that, maybe that's not the place for you to work, because you should be able to negotiate on your own skills. It should be about what the other physician of your skill level is making, at your skill level, at your hours, regardless of gender.

**Siddiqui:** Any quick thoughts, Dr. Heine?

**Dr. Heine:** I just think that there's more data that's out there now. You can check ... to find out, like what Joanna said, where you should stack up in comparison based on location. A lot of times it's regional in terms of what the salaries or the earning potential is. But if you look at where you want to be in practice, and the data showing what the earning potential is out there, at least you'll have an idea.

Just be aware of the fact that there's a possibility that you might not get the same income reimbursement, and also the same salary compared to a male. You should try to find ways to actually explore that and really hold other people accountable to make sure that they give you the straight scoop. Tell them that you want to have the information, whether if it's private practice, accounts receivable, a salary position, academics, or whatever.

Try to get the data online to start with, but then also explore these other avenues, and speak up for yourself so that you don't feel like they're hoodwinking you. Be aware that there could be a differential that you do not feel is warranted.

**Dr. Woodson:** Can I make just a sidebar to your comments? I'm glad you mentioned, when you talked about gender equity, that it's not just women. Because that's the thought, isn't it? When you say gender equity, I think most people immediately think that, for years, it has been mainly focused on women not having equal pay or equal hours.

In the Organized Medical Staff Section, there was a physician who had come for the first time, an ob-gyn chair for a department, talking about a group that a hospital had hired a couple of years ago that was all female. And, whether it makes a difference or not, they were all DOs, so they knew each other. And along comes a male ob-gyn who wants to get into the group, at least to share call. He's on the hospital staff. They absolutely refused him. Absolutely refused him.

We need to make sure, while we're dealing with the inequities of the past, as you alluded to, that we don't forget that men may now be having—believe it or not, but it's true—some of the same problems women have had. So, I want you to use that kinder self down in there. If they may be going through it, instead of saying, "Well, how do you like it now?" say, "This is not fair to either." ...

And one other thing. There's a little book—this is how I got through asking for a salary when I joined academia. Somebody told me about it. I don't think it was a doctor; it may have been a PhD. She said, "If you're in academia ,you can get the data."

And it wasn't well known then that you could find out how much each level of professorship got when you went into academic medicine, or in a PhD in a university setting, and a lot of the different centers that you do clinical work, and they make a lot of money on that.

The book was *Women Don't Ask*. ... Please try to find it; it's small. We still don't do that. Somehow, we withdraw. We don't realize our own worth, but that's true for men too. It's important to get your worth out there. You have to have the numbers, just like you mentioned. If you go in and think you can just tell them how wonderful you are, it's not going to work. You've got to have the numbers. Think about that in any situation. You can do it in a way that isn't being obnoxious, and not being too saccharine, and being too traditional, but very matter of fact.

Make sure you know your own numbers, and it is different in academia. The other thing I looked at is, "Hmm, I've been a volunteer faculty for years and years. I'm going in at a different level." And that's what I said. "I'm going in." Of course, it was a different dean then. I've known our dean for a long time, and I said, "I feel that I have the credentials to go in as a full professor." So, I got two professorships in different departments. You never know until you ask. But have the data. Thank you for that.

**Dr. Heine:** Set the bar high. You might get it.

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Read about the firstpart of their discussion and the three paths to physician success as a woman leader in medicine.