



#HerTimeIsNow

A Call to Healthcare Leaders:

Now is the Time to Focus on Ending Workforce Gender Disparities

"The future has always been considered an ideal time to address gender equity. That strategy has not worked well for half the world's population. Her time is now."

Julie K. Silver, MD
Associate Professor and Associate Chair
Department of Physical Medicine and Rehabilitation
Harvard Medical School
Spaulding Rehabilitation Network
Massachusetts General and Brigham and Women's Hospital
[#HerTimeIsNow](#)
[#BeEthical](#)
[#NeedHerScience](#)

What is the Her Time Is Now Campaign?

The Her Time Is Now Campaign focuses on the intersecting relationships with three of the gatekeepers to career advancement in academic medicine identified in the [Be Ethical Campaign report](#)—highlighting how structural and institutional gender bias, often combined with racial/ethnic or other types of discrimination, act synergistically to keep qualified women in medicine from achieving fair pay and being promoted to the highest levels. The three gatekeepers are: (1) medical schools/hospitals/healthcare organizations (i.e., employers or “home” institutions); (2) medical societies; and, (3) medical journals. In addition to the ethical aspects of diversity, equity, and inclusion (DEI) for women in academic medicine, the Her Time Is Now Campaign focuses on how financial issues may negatively limit or positively drive results. Thus, this report is written through the combined lens of how ethical conduct and financial support intersect in academic medicine.

Gender Disparities for Women in Academic Medicine

There is a robust body of evidence that women in medicine are not treated equitably compared to male counterparts. This campaign aims to be inclusive of all people who identify as women. Importantly, women with intersectional identities (i.e., they identify with underrepresented groups such as women of color, transwomen, women with disabilities) are at even greater risk for bias and discrimination. In this report, the term underrepresented in medicine (URiM) should be considered to be broad and inclusive of all women with intersectional identities. While the campaign is aimed at advancing gender equity for women in medicine, all workers regardless of gender should have equal opportunities to be hired, paid fairly, and advance in their careers.

This report cites publicly available data and research—much of which is focused on physicians and scientists—to provide examples of structural and institutional gender bias in academic medicine among the three gatekeepers previously described. The examples in this report are not intended to be all-inclusive or to explain every issue. Regarding the studies and data cited, although gender is not binary, research often treats it as such (for a variety of reasons beyond the scope of this report); therefore, it is reported in this manner. Unfortunately, data are limited when it comes to women with intersectional identities. In this report, some of the examples include an analysis of Black and Hispanic women—demonstrating the profound effect of gender bias combined with racial/ethnic discrimination. Importantly, though this report focuses on academic medicine, many of the same issues apply to women working in all healthcare settings and in fields beyond medicine.

Initiatives to address gender disparities should aim to be inclusive and account for the most marginalized women in the healthcare workforce. Gaps in data should not be construed as a lack of evidence that women in medicine—particularly individuals with intersectional identities—are unaffected by bias and discrimination. In fact, the opposite is likely true—the greater the gap, the more bias and discrimination the intersectional group likely faces. For example, there is no doubt that women physicians with disabilities are a marginalized group even though studies on this population are rare. [One study](#) conducted in 2019 found among 87 participating US allopathic medical schools respondents reported 2600 students with disabilities, representing 4.6% of the total enrollment (an increase of 69% from a prior study three years earlier and a proportion that may underrepresent actual numbers). A lack of data should not preclude immediate action in academic medicine that is aimed at supporting this growing group of talented people. Similarly, there are also few workforce disparity studies in academic medicine focused on health professionals who identify as LGBTQIA. However, a [survey study](#) reported that the “consequences of being out as LGBTQ+ included lack of promotions, gossip, refusals of tenure, and anti-LGBTQ+ comments and behaviors in the workplace.”

[Meeks LM, Case B, Herzer K, Plegue M, Swenor BK. Change in Prevalence of Disabilities and Accommodation Practices Among US Medical Schools, 2016 vs 2019. JAMA. 2019 Nov 26;322\(20\):2022-2024.](#)

[Altieri MS, Salles A, Bevilacqua LA, Brunt LM, Mellinger JD, Gooch JC, Pryor AD. Perceptions of Surgery Residents About Parental Leave During Training. JAMA Surg. 2019 Oct 1;154\(10\):952-958.](#)

[Eliason MJ, Streed C Jr, Henne M. Coping With Stress as an LGBTQ+ Health Care Professional. J Homosex. 2018;65\(5\):561-578.](#)

Gender Disparities for Women in Academic Medicine

Notably, there may be instances when women who have intersectional identities may not be considered by some criteria as underrepresented (e.g., Asian women) but still face barriers to fair pay and promotion—especially at the highest levels. Furthermore, the expected proportion of people from some groups who are URiM may be understandably very small due to their low representation in society (e.g., women who identify as Native Alaskan or Hawaiian); nevertheless, it is critically important to understand and acknowledge the many barriers they face.

[Adesoye T, Mangurian C, Choo EK, Girgis C, Sabry-Elnaggar H, Linos E; Physician Moms Group Study Group. Perceived Discrimination Experienced by Physician Mothers and Desired Workplace Changes: A Cross-sectional Survey. JAMA Intern Med. 2017 Jul 1;177\(7\):1033-1036.](#)

Two other issues deserve mention as research demonstrates they disproportionately affect women as compared to men and compound the deleterious effects of the gender-related disparities discussed in this report: (1) family roles, inclusive of child bearing/rearing responsibilities—and their associated gender-related bias and discrimination problems; and, (2) gender-related harassment, inclusive of sexual harassment. Though these are very important issues, they are beyond the scope of this report.

Whether or not data exist for various groups of marginalized people, particularly individuals with intersectional identities, it is absolutely crucial to understand that medicine, especially academic medicine, should lead the way—outpacing every other field—in equitably supporting its trainees and workforce. To ensure that happens, immediate action is needed. Her time is now, and no woman should be left behind.

“Women in medicine who also self-identify as disabled are some of the most marginalized in the field and encounter a multitude of barriers that slow career growth. It is difficult to know the true prevalence of women with disabilities working in medicine given that these data are rarely collected, and disability is still broadly under-reported. Persistent barriers include stigma and bias that devalue the quality of life and lived experience of women with disabilities, as well as underdeveloped systems to encourage disclosure and provide proactive accommodations. Women with disabilities are creative, resilient, and bring a critical perspective to medicine - #HerTimeIsNow.”

Cheri A. Blauwet, MD
Assistant Professor, Physical Medicine and Rehabilitation
Harvard Medical School
Chair, Mass General Brigham Disability Task Force
Director of Disability Access and Awareness, Spaulding
Rehabilitation Network

“Women in medicine and surgery with intersectional identities, including LGBTQIA+ in particular, have faced and continue to face amplified conscious and unconscious bias. There is a clamant need to recognize and reward — whether it be through awards, promotion, or salary—the contribution, abilities, and potential of all women in medicine. When would be a good time to implement recognition and reward? Now.”

Diane M. Radford, MD, FACS, FRCSEd
Associate Professor of Surgery
Cleveland Clinic Lerner College of Medicine of Case
Western Reserve University
Director, Breast Program, Cleveland Clinic Hillcrest
Hospital

Gender Disparities for Women in Academic Medicine

What are Structural and Institutional Gender Bias?

Definitions of these terms vary depending on the source. For the purposes of this report they are defined as follows:

Structural gender bias: The way that inequities in power and resources contribute to systemic gender bias.

Institutional gender bias: The way that people create and/or follow existing rules, procedures, practices, and social norms at their institutions which results in women being disadvantaged or devalued.

What is a Racist Policy?

Racist policy: "A racist policy is any measure that produces or sustains racial inequity between racial groups. An antiracist policy is any measure that produces or sustains racial equity between racial groups. By policy, I mean written and unwritten laws, rules, procedures, processes, regulations, and guidelines that govern people. There is no such thing as a nonracist or race-neutral policy. Every policy in every institution in every community in every nation is producing or sustaining either racial inequity or equity between racial groups."

Ibram X. Kendi, *How to Be an Antiracist*

What is an Inexorable Zero?

Inexorable zero: A true zero or near zero number or proportion that in United States (US) courts may serve ["as a telling symptom of hidden attitudes or hiring practices that work to exclude women or minorities from whole categories of jobs."](#)

"Our institutions, academic and others, should be a reflection of the diversity that characterizes our society. This is the best way to make sure that decisions are being made to benefit all and taking into account different opinions and points of view. There should be no question or discussion about the important role that women must play in these groups, on equitable terms and conditions. This should not be an issue for the future or long-term planning exercises. We are missing very important contributions by not supporting and including women. We need to act now!"

Walter R. Frontera, MD, PhD, FRCP
Professor
Department of Physical Medicine, Rehabilitation, and Sports Medicine
Department of Physiology and Biophysics
Former Dean, Faculty of Medicine
University of Puerto Rico School of Medicine

[Huang BJ. The 'Inexorable Zero'. Harvard Law Review. 2004 Feb 1;117\(4\):1215.](#)

Advancing Gender Equity: Questions for Leaders in Academic Medicine

<p>Since gender-related pay disparities persist despite being illegal as per US federal law and many states' laws, as well as general agreement in academia that it is also unethical...</p>	<p>What else can be done in academic medicine to ensure fair pay for women?</p>
<p>Since academic promotion is tied in part to resources and achievements at medical societies...</p>	<p>What can academic institutions (i.e., employers) do to ensure that women faculty are promoted fairly to assistant, associate, and full professor even if a specialty's medical societies are not equitably supporting women and/or women with intersectional identities?</p>
<p>Since women faculty who volunteer for gender or other equity initiatives at their workplace or at a medical society risk slowing their own academic promotion (as this work is often not highly-valued within promotions criteria), and their financial status may be negatively impacted by: already existing gender-related pay gaps; high educational debt that disproportionately affects people of color; and/or a loss of clinical or other income due to time spent volunteering...</p>	<p>What can academic institutions and medical societies do to ensure that women's time and effort in diversity, equity, and inclusion work is financially supported and given high priority for academic promotion?</p>
<p>Since academic institutions financially support medical societies and encourage their faculty members (many of whom have high levels of educational debt and may be inequitably compensated) to spend their own financial resources as well as time away from clinical or other responsibilities at work to participate in society-related activities...</p>	<p>What can academic institutions do to ensure that all of their faculty have equitable opportunities at medical societies, and that the societies have an equitable and diverse (inclusive of but not limited to race/ethnicity) representation of qualified women at every level of leadership, particularly at the highest administrative and governing levels?</p>
<p>Since there is a long and well-documented history of gender disparities on medical journal editorial boards particularly at the highest levels...</p>	<p>What can medical societies do to ensure that their affiliated journals are intentional about having an equitable and diverse (inclusive of but not limited to race/ethnicity) representation of qualified women at every level of leadership and they are financially supported?</p>
<p>Since influential external organizations provide ethical guidance to medical journals and gender equity is an ethical imperative...</p>	<p>What can be done to ensure that influential external organizations themselves have an equitable and diverse (inclusive of but not limited to race/ethnicity) representation of qualified women at every level of leadership and that they focus on ways for the journals they influence to advance gender and other forms of equity?</p>

Figure 1:
The Way Money Flows in Academic Medicine

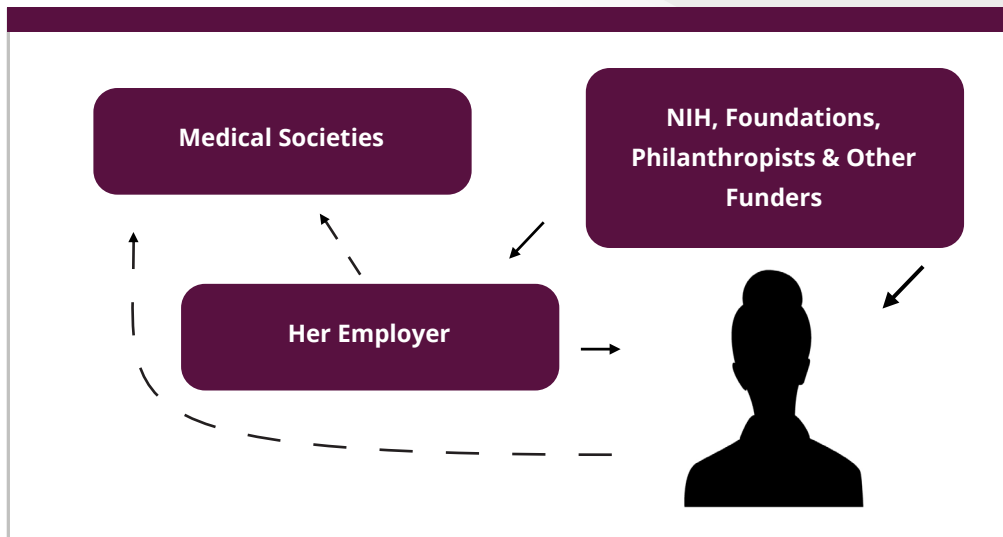


Figure 2:
Medical Societies and Women in Academic Medicine

Women in academic medicine may have:

- Symptoms of burnout
- Inequitable compensation
- Educational debt

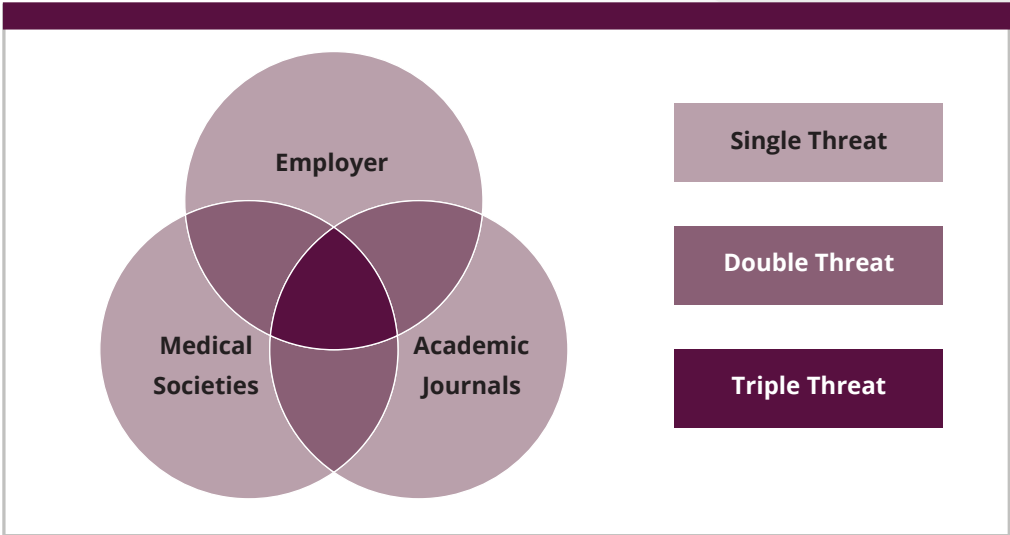
So, they may be reluctant to:

- Financially support medical societies that treat women unfairly
- Volunteer for duties, especially those that do not support academic promotion

"As a Black and Latina woman trainee, the structural and institutional biases within academic medicine remind me of a 'no-win' situation. If the status quo remains--or even advances slowly--the data show that my career advancement will be markedly limited due to my gender, race, and ethnicity. Obviously, the highly intelligent and qualified women with intersectional identities who have come before me have not been treated equitably. Prioritizing diversity, equity, and inclusion is non-negotiable. The time to act is now by holding our institutions and medical societies accountable."

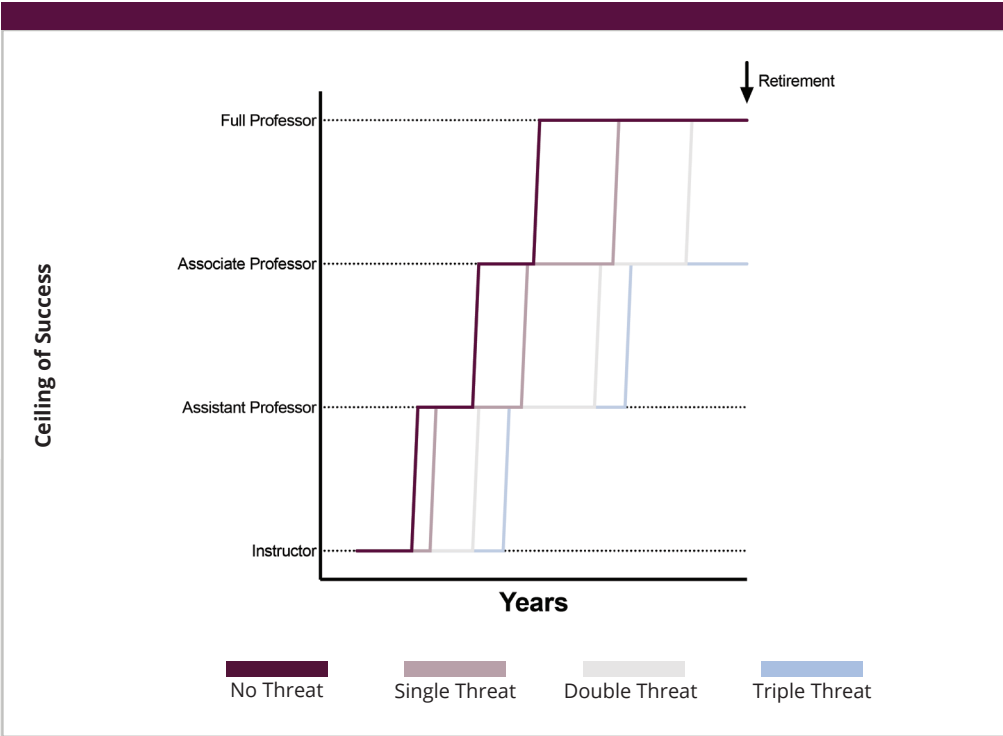
Varina R. Clark, ScB
 M.D. Candidate, David Geffen School of Medicine
 University of California, Los Angeles

Figure 3:
The Synergy of Structural and Institutional Gender Bias in Academic Medicine



This figure shows how women's careers in academic medicine are threatened by gender-related structural and institutional bias. The overlap of the circles demonstrate that the more entities involved in gender bias the more a woman's career is harmed. Each level of threat may be more profound for women with intersectional identities. The "leaky pipeline" in academic medicine is often attributed to individuals' choices to pursue other opportunities. However, a strong synergy of structural and institutional gender bias makes it very difficult for women in academic medicine to advance in their careers.

Figure 4:
Gender Bias: Influence on Academic Promotion Timeline and Trajectory

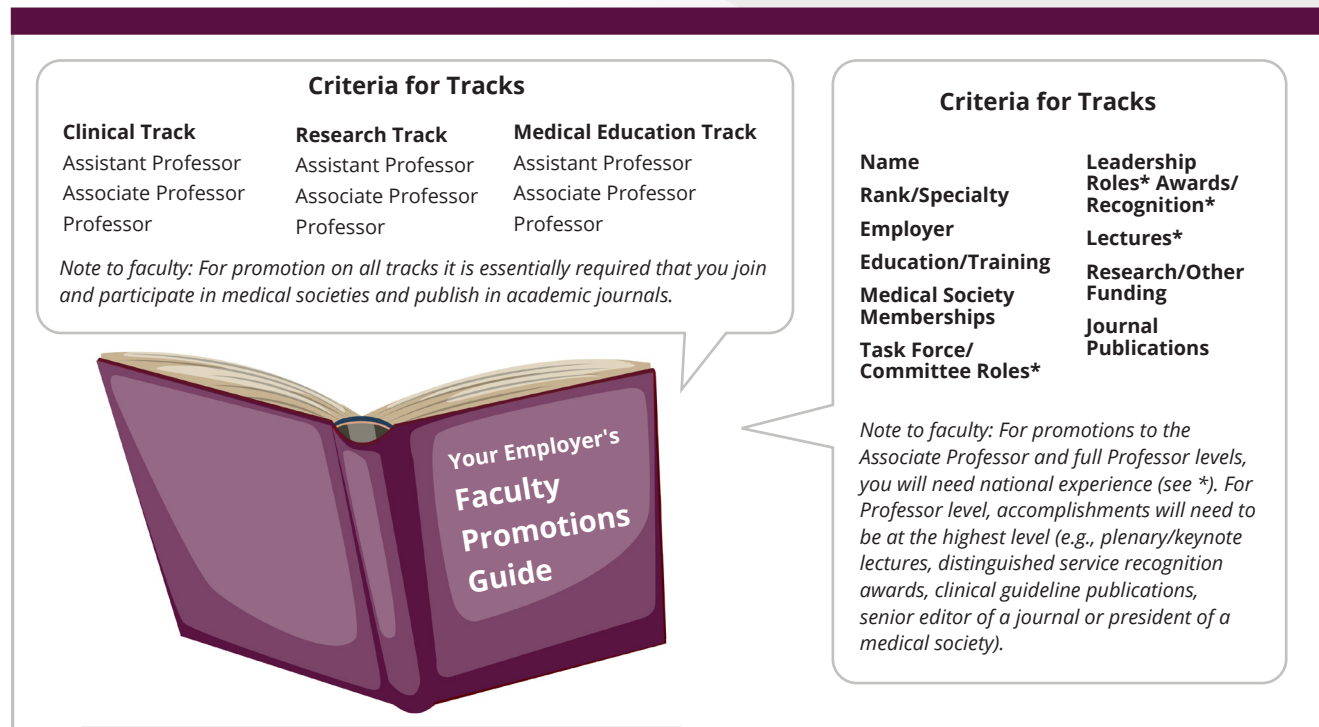


This figure demonstrates that when women faculty face structural and institutional gender bias from multiple organizations, this will compound threats to their career advancement and affect compensation.

"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."

Quinn Capers, IV, MD, FACC
Vice Dean for Faculty Affairs
The Ohio State University College of Medicine
Professor of Medicine
Division of Cardiovascular Medicine

**Figure 5:
Promotion Tracks and Criteria in Academic Medicine**



This figure demonstrates typical criteria for academic promotion in medicine. Academic promotion follows a formulaic process whereby all faculty who seek to be promoted are required to achieve certain accomplishments that are listed in a “guidebook”. Many of the accomplishments are available primarily or even exclusively at medical societies. For example, if women in a specialty are underrepresented by their medical societies on guideline publication committees, high level leadership positions and recognition awards, plenary and keynote speaker opportunities, and by the societies’ journals as senior editors, then they have many barriers to promotion to full professor. Notably, among different US medical schools, there is some variation in both tracks and criteria. For example, some medical schools require international accomplishments for promotion to the highest levels. Additionally, women faculty are often underrepresented for both tenure and endowed professorships, though these are not universally available at US medical schools.

"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*

#PayHer

The issue of fair pay for women in medicine has important ethical, legal, and financial ramifications. Compensation studies for women in medicine overwhelmingly demonstrate gender-related pay gaps. Pay gaps tend to be larger for women with intersectional identities, [such as women of color](#). [A study that examined gender-related physician compensation studies published from 2013-2019](#) found that they are disproportionately produced, cited, and disseminated by women. Furthermore, most of the studies were not funded, suggesting that many women are doing compensation research on their own time and at their own expense. This science is a subset of a much larger body of research that reveals pay disparities for women in almost every job and career category in the United States (US) and beyond. Compensating women less than men often [begins with their first job](#), [lasts throughout their career](#), and [results in an affected woman losing hundreds of thousands or even millions of dollars](#) in income, investments, and retirement savings. Paying women less than men for the same work is [unethical](#), as well as illegal under US federal law. [States](#) are increasingly passing and enforcing their own laws to ensure fair pay for women. Expecting people who identify with marginalized groups to negotiate fair pay has not been a successful strategy. Instead, this expectation and strategy has reinforced structural and organizational bias as well as racial/ethnic and other forms of discrimination. The authors of [one study explained](#) that even with negotiation training, it is not reasonable to expect women to negotiate their way to a fair wage: “New junior faculty are hardly in a position to ensure their own salary equity...Those doing the hiring and setting the salaries need to be sensitized both to the corrosive impact of salary inequity on faculty morale and to the importance of working to avoid even small inequities early in women’s careers, particularly given evidence that such inequities grow over time.”

High levels of educational debt compounds the issue of pay disparities for women in medicine. To put this in perspective, according to a [study on the distribution of medical education debt](#) by specialty, the mean educational debt for US medical students in the mid-1980s was approximately \$30,000 (estimated in the range of \$70,000 in today’s dollars). In 2016, mean medical educational debt was \$190,000—a nearly 3-fold increase overall. In the aforementioned study, researchers found that the proportion of medical students graduating with no debt is increasing. However, this seemingly positive trend actually suggests that debt is concentrated in fewer individuals. Although the study did not analyze demographic variables such as ethnicity, race, and gender, the results are concerning, especially for women with intersectional identities who are underrepresented in medicine (URiM), as they are more likely to have high levels of debt combined with pay disparities. In [another study described as the first of its kind](#), researchers included more than 27,000 early career faculty and examined their promotion and attrition as competing risks.

[Marcelin JR, Bares SH, Fadul N. Improved Infectious Diseases Physician Compensation but Continued Disparities for Women and Underrepresented Minorities. Open Forum Infect Dis. 2019 Feb;4:6\(2\):ofz042.](#)

[Larson AR, Cawcutt KA, Englander MJ, Pitt SC, Ansari E, Liu HY, Silver JK. Representation of Women in Authorship and Dissemination of Analyses of Physician Compensation. JAMA Netw Open. 2020 Mar 2;3\(3\):e201330.](#)

[Lo Sasso AT, Armstrong D, Forte G, Gerber SE. Differences In Starting Pay For Male And Female Physicians Persist: Explanations For The Gender Gap Remain Elusive. Health Aff \(Millwood\). 2020 Feb;39\(2\):256-263.](#)

[Mensah M, Beeler W, Rotenstein L, Jagsi R, Spetz J, Linos E, Mangurian C. Sex Differences in Salaries of Department Chairs at Public Medical Schools. JAMA Intern Med. 2020 Mar 2;180\(5\):789-92.](#)

[Silver JK. Understanding and addressing gender equity for women in neurology. Neurology. 2019 Sep 17;93\(12\):538-549.](#)

[Jagsi R, Griffith KA, Stewart A, Sambuco D, DeCastro R, Ubel PA. Gender differences in salary in a recent cohort of early-career physician-researchers. Acad Med. 2013 Nov;88\(11\):1689-99.](#)

[Grischkan J, George BP, Chaiyachati K, Friedman AB, Dorsey ER, Asch DA. Distribution of Medical Education Debt by Specialty, 2010-2016. JAMA Intern Med. 2017 Oct 1;177\(10\):1532-1535.](#)

[Jeffe DB, Yan Y, Andriole DA. Competing Risks Analysis of Promotion and Attrition in Academic Medicine: A National Study of U.S. Medical School Graduates. Acad Med. 2019 Feb;94\(2\):227-236.](#)

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They also assessed the variable of debt at graduation. This study found that over the entire sample, the 10-year probabilities of promotion were lower and probabilities of attrition out of academia were higher for URiM faculty and women. Faculty with \geq \$100,000 debt at graduation (versus no debt) had greater risk for attrition. For women, especially women who are URiM, the burden of disproportionately high educational debt combined with inequitably low compensation has negative financial repercussions that last their entire lives. For academic institutions that invest large sums of money on faculty recruitment and retention, it is irresponsible to ignore how structural and organizational gender bias—especially when combined with racial/ethnic or other discrimination—affects their institutional return on investment (ROI). Financially, it does not make sense for academic institutions to continue to support structural and organizational gender bias or any other form of discrimination.

“The projected shortage of health care professionals and the costs of faculty retention make salary equity a topic that academic medicine can’t afford to ignore.”

| [Association of American Medical Colleges Promising Practices for Understanding and Addressing Salary Equity at U.S. Medical Schools \(AAMC, 2019\)](#)

“Leaders must be knowledgeable about the varieties of compensation policies and best practices and their pros and cons, associated practical matters such as legal considerations and accounting, and how unconscious bias and other opportunity inequities can translate into compensation inequity. They should be held accountable for instituting transparent practices and providing educational resources.”

| [2019 ACC Health Policy Statement on Cardiologist Compensation and Opportunity Equity \(J Am Coll Cardiol, 2019\)](#)

“The evidence is clear that gender pay inequities exist in medicine and that women are underrepresented in leadership positions. Further, minority women face additional unique challenges in the workplace, such as a larger compensation gap and discrimination motivated by gender and race.”

| [Achieving Gender Equity in Physician Compensation and Career Advancement: A Position Paper of the American College of Physicians \(Ann Intern Med, 2018\)](#)

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"Underrepresented women have sacrificed and worked as hard as all other physicians, and it is important to make sure they are treated equitably in medicine today. Transparency and well defined metrics should support every step from recruitment of medical students all the way to the promotion at the Professor level and will be key to success in the next decade."

Sareh Parangi, MD
Professor of Surgery
Harvard Medical School
Chair of Surgery
Newton Wellesley Hospital

"Women are offered less in starting salary, negotiated pay, and other forms of compensation (e.g., resources and bonuses) than men despite equal effort, rank, training, and experience. As in other industries, salary inequity exists in academic medicine and is exacerbated by the complicated nature of compensation in our field. Additionally, distorted cultural narratives in academic medicine insist that women 'choose to work less.'"

[Association of American Medical Colleges Statement on Gender Equity \(AAMC, 2019\)](#)

"Women in medicine are just as knowledgeable, reliable, and effective as men. Yet, they are paid less. How does this make any sense?"

Ayushi Aggarwal, MPH
Scholar, Harvard Catalyst Visiting Research Internship Program
MD Candidate, University of Maryland School of Medicine

"Physician pay inequities by race, ethnicity, and gender begin upon signing the first contract out of residency. The onus is upon employers (often large health care organizations) to offer equivalent salary and benefits packages to all new physician hires regardless of personal identity characteristics. Institutions must correct disparities immediately by assessing pay equity of employed physicians via an independent audit. Routinely adjusting for pay disparities by increasing salaries for some will not automatically trigger pay cuts for others: a rising tide lifts all boats."

Michael S. Sinha, MD, JD, MPH
Research Fellow
Harvard Medical School



“As a chair of psychiatry, I have prioritized gender equity on my personal scorecard for performance. Leaders know that data can be the most eloquent argument for systems change, and I am honored to join leading women in medicine in researching and publishing on gender-related pay disparities. The data must be paired with persistent and vocal sponsorship of equity initiatives in discussions with the dean, hospital leadership, and other chairs. As chairs, we have an opportunity to step up and actively participate in gender and other equity research—supporting this with our knowledge, time, and financial resources—and then being relentless in using the published data to drive change.”

Howard Y. Liu, MD MBA
Chair and Professor with Tenure
Department of Psychiatry
University of Nebraska Medical Center

#PromoteHer

[Compared to men, women in academic medicine are not equitably promoted.](#)

According to the AAMC's report titled [The State of Women in Academic Medicine](#), for nearly two decades at US medical schools, women have matriculated in similar proportions to men. However, the overall proportion of full-time women faculty (which is now greater than 40%) remain grossly underrepresented overall, particularly in the top ranks. The report states that the proportion of full-time women faculty who identify with an underrepresented in medicine (URiM) race or ethnicity increased just one percent over a decade—from 12% in 2009 to 13% in 2018. At the highest levels, less than 20% of chairs and deans are women.

One of the easiest ways to demonstrate that hiring and promotion is not a meritocracy for everyone in academic medicine is to look at inexorable zeros. This is [a concept that has been used by US courts](#), including the Supreme Court, to infer that discrimination is a problem when there are zero or near-zero levels of people from an underrepresented group. A report titled [Where are the Women](#) used the inexorable zero concept and found that women physicians were essentially excluded as recipients of certain recognition awards from medical societies in 7 different specialties including anesthesiology, dermatology, neurology, physical medicine and rehabilitation, orthopedic surgery, head and neck surgery, and plastic surgery. Notably, small numbers of any group may be tokens and foster an illusion of inclusion.

Example: The proportion of Black and Hispanic women who have been hired or promoted to become chairs or full professors at US medical schools.

For the purposes of this example and consistent with the concept of the inexorable zero, 0-1%, will be the range for an inexorable zero. According to the AAMC's data, the percent of specialties with inexorable zeros for Black/African American women professors is 87% (20/23) [Table 1, Figure 6] and for Hispanic/Latina women professors it is 83% (19/23) [Table 2, Figure 7]. Five departments have a true 0% level for both Black/African American and Hispanic/Latina women professors: Anatomy, Anesthesiology, Neurology, Orthopedic Surgery, and Surgery.

Women are also markedly underrepresented as chairs overall (19%), and at the inexorable zero level for Black/African American and Hispanic/Latina women (1% for both) [Table 3, Figures 8A and 8B]. Notably, even above the inexorable zero level, women with intersectional identities, including Asian women, remain at inexplicably very low representative proportions in the highest ranks of academic medicine. The sheer number of inexorable zeros at the professor and chair level in aggregate at US medical schools provides evidence—especially in combination with a large body of scientific research on workforce gender and race/ethnicity disparities—that structural and institutional gender bias and racial/ethnic discrimination are influencing hiring and promotions in academic medicine.

[Carr PL, Raj A, Kaplan SE, Terrin N, Breeze JL, Freund KM. Gender Differences in Academic Medicine: Retention, Rank, and Leadership Comparisons From the National Faculty Survey. Acad Med. 2018 Nov;93\(11\):1694-1699.](#)

[The State of Women in Academic Medicine 2018-2019: Exploring Pathways to Equity \(AAMC, 2020\)](#)

[Huang BI. The 'Inexorable Zero'. Harvard Law Review. 2004 Feb 1;117\(4\):1215.](#)

[Silver JK, Slocum CS, Bank AM, Bhatnagar S, Blauwet CA, Poorman JA, Villablanca A, Parangi S. Where Are the Women? The Underrepresentation of Women Physicians Among Recognition Award Recipients From Medical Specialty Societies. PM R. 2017 Aug;9\(8\):804-815.](#)

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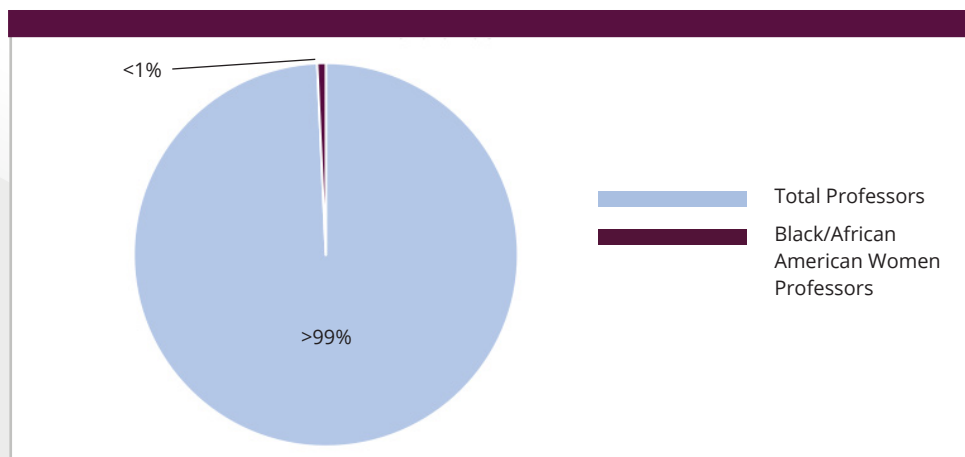
Table 1:

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

Department	Total Professors	Black/African American Women Professors	Percent of Total Professors
Anatomy	553	1	0%
Anesthesiology	1233	6	0%
Biochemistry	1045	4	0%
Microbiology	814	3	0%
Neurology	1437	4	0%
Orthopedic Surgery	892	0	0%
Otolaryngology	531	1	0%
Pathology-Basic	492	2	0%
Pathology-Clinical	1430	3	0%
Pharmacology	757	1	0%
Physical Med & Rehabilitation	238	1	0%
Physiology	638	2	0%
Surgery	4032	15	0%
Dermatology	359	2	1%
Emergency Medicine	632	7	1%
Internal Medicine	8797	62	1%
Ophthalmology	835	7	1%
Pediatrics	4214	48	1%
Psychiatry	1965	15	1%
Radiology	1919	16	1%
Family Medicine	729	16	2%
Obstetrics & Gynecology	1124	26	2%
Public Health & Preventive Medicine	177	8	5%

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.

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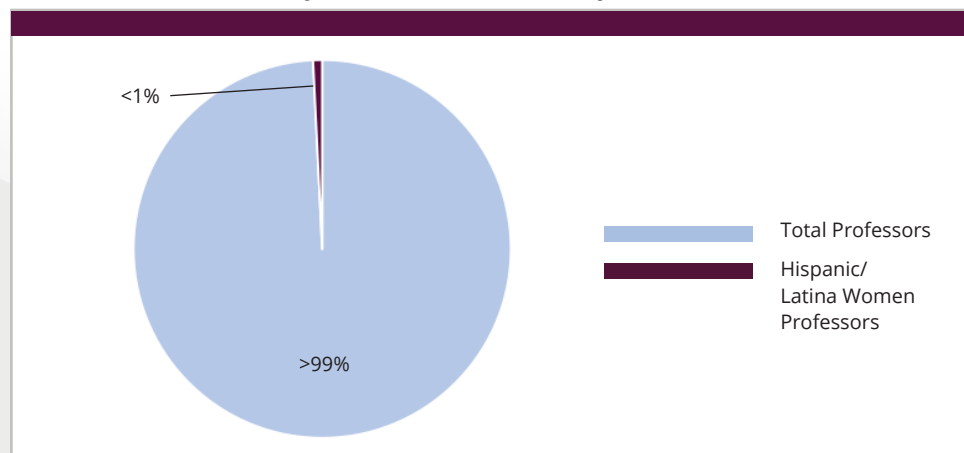
Table 2

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

Department	Total Professors	Hispanic/Latina Women Professors	Percent of Total Professors
Anatomy	553	1	0%
Anesthesiology	1233	3	0%
Neurology	1437	4	0%
Orthopedic Surgery	892	1	0%
Surgery	4032	11	0%
Biochemistry	1045	8	1%
Dermatology	359	5	1%
Emergency Medicine	632	4	1%
Internal Medicine	8797	51	1%
Microbiology	814	8	1%
Ophthalmology	835	7	1%
Otolaryngology	531	3	1%
Pathology-Clinical	1430	10	1%
Pharmacology	757	4	1%
Physical Medicine & Rehabilitation	238	2	1%
Physiology	638	7	1%
Psychiatry	1965	20	1%
Public Health & Preventive Medicine	177	2	1%
Radiology	1919	11	1%
Family Medicine	729	12	2%
Obstetrics & Gynecology	1124	23	2%
Pathology-Basic	492	8	2%
Pediatrics	4214	66	2%

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.

Table 3

US Medical School Chairs

Women Chairs (All; N=637)	Women Chairs (White; N=474)	Women Chairs (Asian; N=59)	Women Chairs (Black/African American; N=42)	Women Chairs (Hispanic/vLatina; N=33)
19%	14%	2%	1%	1%

Figure 8A

US Medical School Chairs

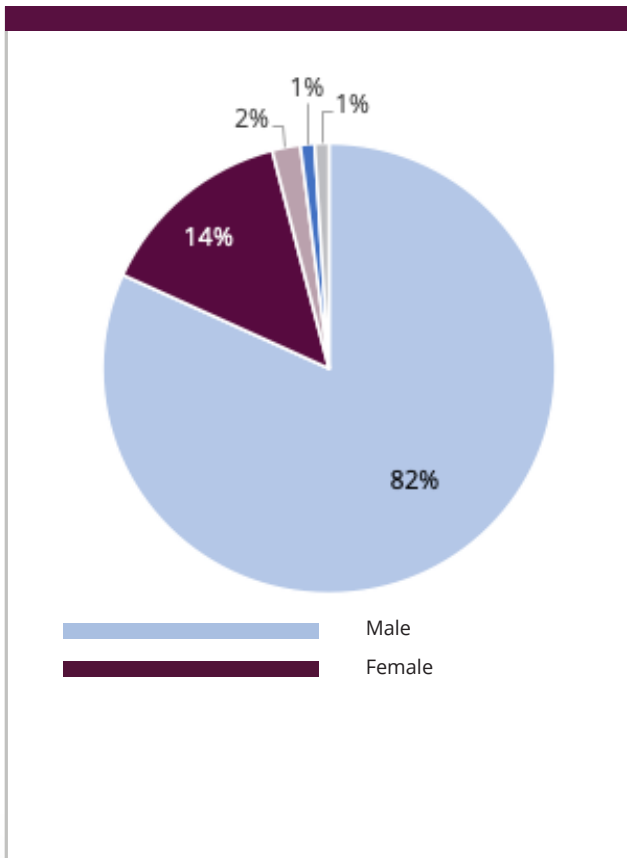
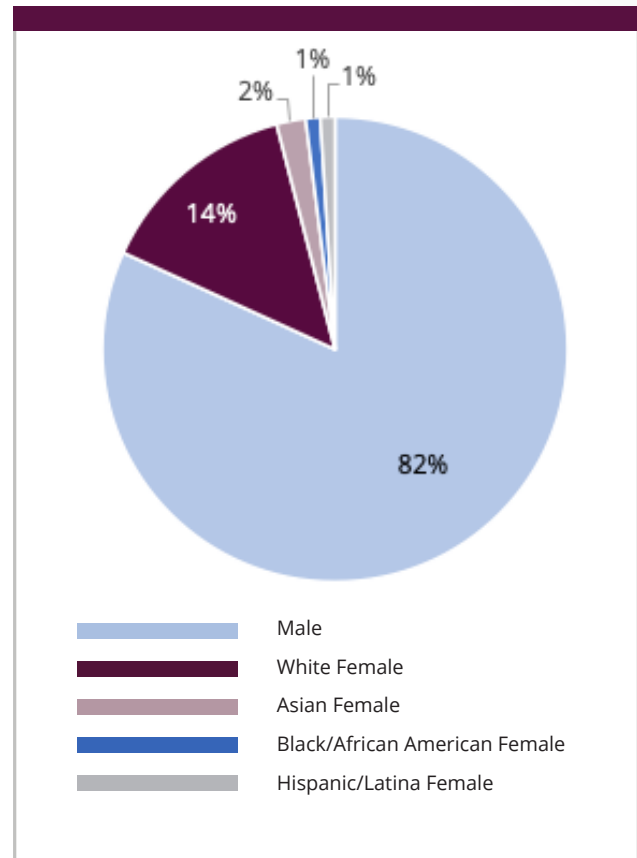


Figure 8B

US Medical School Chairs



Source: [AAMC Department Chairs by Department, Sex, and Race/Ethnicity 2019 \(Table C\)](#)

This table and figure use the categories designated by the AAMC. Multiple race is not included. Total chairs (N=3297).

More About the Inexorable Zero

"The Supreme Court first uttered the phrase 'inexorable zero' a quarter-century ago in International Brotherhood of Teamsters v. United States, a landmark Title VII case. Ever since, this enigmatic name for a rule of inference has echoed across legal argument about segregation, discrimination, and affirmative action...[A]mici in support of the respondents in Grutter v. Bollinger imported Justice O'Connor's reasoning into the domain of admissions decisions at elite professional schools... Allegations including the exclusion of women as referees in the National Basketball Association (NBA), racial segregation at a Coca-Cola bottling plant, and the reputation of a famous Miami Beach restaurant for hiring only men as servers have in recent years continued to inspire federal trial courts to invoke the inexorable zero, citing Teamsters. They have done so not only in Title VII systemic disparate treatment or 'pattern and practice' cases such as Teamsters, but also in cases involving disparate impact, individual disparate treatment, and other employment discrimination statutes...These district courts are scattered in their readings of the rule but tend to center on a core understanding: based on a plaintiff's showing that an employer has hired zero or a negligible number of women or minorities, and assuming that at least some women or minorities were available for the job in question, a court may draw a prima facie inference of discriminatory motive against the employer. This central tendency at the trial level tracks the intuition among some circuit courts that evidence of an inexorable zero can serve as a telling symptom of hidden attitudes or hiring practices that work to exclude women or minorities from whole categories of jobs."

| [The 'Inexorable Zero' \(Harvard Law Review, 2004\)](#)

"In analyzing disparities, the number zero is particularly powerful and its presence is sometimes referred to as an inexorable zero."

| [Where Are the Women? \(PM&R, 2017\)](#)

"It is discouraging to pursue the highest levels of leadership in academic medicine when I see an inexorable zero percent of leaders look like me. It is time to make the career aspirations of all women a reality."

| Laura Flores, BA
MD/PhD Scholar
University of Nebraska Medical Center

“As an academic physician scientist, the inexorable zero that is present throughout medical schools in the United States is highly disconcerting and demeaning. The statistics reinforce how I am made to feel every day as a Black woman. I am undervalued, underpaid, and underpromoted. If I feel this way, I am confident that it is commonplace among my Black women physician academic colleagues. My time is now.”

*Fatima Cody Stanford, MD, MPH, MPA, FAAP, FACP, FAHA, FTOS
Assistant Professor of Medicine and Pediatrics
Obesity Medicine & Nutrition, Massachusetts General Hospital/ Harvard
Medical School*

"The 'pipeline' can no longer be used as an excuse for the lack of gender equity in medicine. We have the data to show that there are enough women with excellent qualifications. We cannot continue to advocate the bias of promoting and hiring of individuals who look, act, talk, and think the same. It is time to intentionally advance the careers of women with strategic initiatives and funding to increase compensation, promotion, and representation."

Grace Shih, MD

Professor and Director of Obstetric Anesthesiology

Department of Anesthesiology

Joy McCann Professor, Women in Medicine and Science

University of Kansas Health Systems

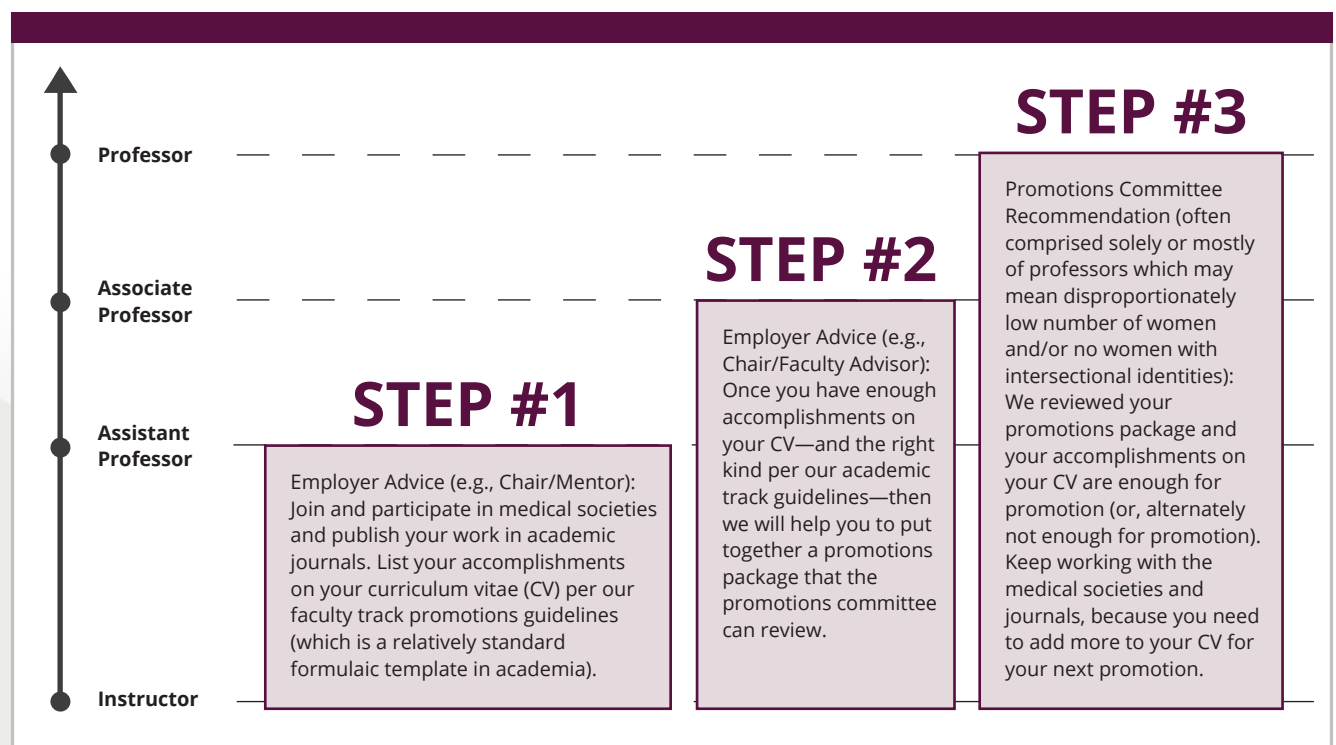


Immediate Positive Strategy to Address Inexorable Zeroes at the Professor Level

1. Change the faculty promotions criteria—at all levels from assistant professor through full professor—to place high value on documentable scholarly and community work in DEI.
2. Assess all faculty promotion committees to ensure they are appropriately diverse.
3. Educate everyone involved in faculty promotions—especially promotion committee members—about the changes to the promotions criteria. Importantly, focus on the fact that these new criteria appropriately acknowledge faculty members’ extremely important contributions to DEI work over the course of many years. Work that for far too long has been undervalued and largely the burden of those who are underrepresented—promoting and perpetuating structural and institutional gender bias and racial/ethnic discrimination which has resulted in inexorable zeroes that must be addressed immediately (for reasons inclusive of but not limited to their ethical and legal implications).
4. Provide additional administrative resources to assist all faculty who have participated in DEI work with updating their curricula vitae (CV) to reflect the value now placed on this crucial academic work—past and present. Notably, for many faculty members DEI accomplishments are already listed on their academic CV, but historically this work has not been considered by promotions criteria to be high-value scholarship. Therefore, faculty members who make important contributions to DEI are not promoted even when their accomplishments are documented.
5. Fast-track promotions—especially to the Professor level for faculty who have spent many years and countless hours on DEI work—if they meet the revised criteria.

Figure 9:

Advice Given to Faculty Regarding the Process for Each Level of Academic Promotion



"We will never live up to our obligations to our learners or to our patients until our leadership includes individuals with the right balance of experiences and perspectives. We have focused on diversity and gender equity among our department chairs and endowed professors, who represent our most important thought leaders and role models. It all starts with a balanced mix of voices at the leadership table."

Terence R. Flotte, M.D.

Celia and Isaac Haidak Professor

Dean, Provost and Executive Deputy Chancellor

University of Massachusetts Medical School

#PublishHer

There is a substantial and growing body of research (refer to the [Be Ethical Campaign report](#)) which demonstrates that for decades medical societies and the academic journals they own or are affiliated with have been supporting each other in ways that promote structural and institutional gender bias and almost certainly contribute to discrimination inclusive of but not limited to racial/ethnic discrimination. As the [Be Ethical Campaign report](#) explained, medical societies and journals are two key gatekeepers in academic medicine. In order to be promoted (i.e., instructor, assistant professor, associate professor, and professor), faculty members must demonstrate to promotions committees at their home institutions—via their CV—that they have met certain metrics [Figure 5 and 9]. These metrics include publishing in journals and other critical opportunities controlled, directly or indirectly, by medical societies (e.g., recognition awards, guideline authorship). Structural and institutional gender bias at medical societies and journals is well-documented. Though less well-characterized, disparities in medical societies and academic journals are reportedly even more profound for women with intersectional identities.

Medical societies—which receive financial support from women physicians and scientists, their allies, and employers—need to focus on the way that these organizations contribute to structural and institutional gender bias. Furthermore, gender bias synergies may be present at academic journals they own or are with which they are affiliated. Employers of women physicians and scientists, such as medical schools and academic medical centers, invest large sums of financial and other resources to support them, and the attrition of women in academia (“the leaky pipeline”) results in profound financial losses for employers. Thus, institutions that employ women in academic medicine have a financial stake in ensuring equitable treatment for them at the level of medical societies and journals.

Although there are many published examples of gender disparities, bias, and discrimination at the level of medical societies and journals, likely the most well-documented and arguably most intractable one is the underrepresentation of women as journal editors, especially in the highest ranking positions [Figure 10]. To date, numerous external organizations that focus on ethical issues in journal publishing have provided inadequate responses to the historical and current lack of diversity and inclusion among leaders at the journals they influence.

"Achieving gender equity for women in medicine today requires enhanced resources and dedicated commitment from leaders now."

Nicole B. Katz
MD Candidate, Class of 2021
Lewis Katz School of Medicine at Temple University

Figure 10

Published Reports on the Underrepresentation of Women as Medical Journal Editors





This figure demonstrates that for more than two decades there have been studies and reports in medical journals documenting the underrepresentation of women on editorial boards of medical journals. This is a simple and straightforward disparity to fix. Medical societies should ensure that the journals they are affiliated with address this issue immediately. This is not a complete list; there are many other published reports focused on gender equity at journals, inclusive of editorial boards.

"The issue of gender inequity is due to a mix of individual, institutional, and systemic factors. Change will not happen until we truly acknowledge and listen to those suffering from it. Her time is now to speak up and be heard."

Priscila Rodrigues Armijo, MD
Assistant Professor of Surgery
University of Nebraska Medical Center

Medical Journals Must Tackle Gender Bias

- Journal owners, some of which are medical societies, have an obligation to tackle both conscious (explicit) and unconscious (implicit) bias.
- Firewalls often exist between medical society owners and their journals. These are in place to avoid conflicts of interest but they do not prevent owners from ensuring their journals are fair and that senior editors are held accountable for proactively uncovering and tackling gender bias.
- Perpetuating gender bias is unethical. The International Committee of Medical Journal Editors has [codified owner obligations](#), which include ensuring editors act in a manner that is compatible “with a position of trust.”
- Although one cannot assume that equitable representation of women among editors or on editorial boards positively impacts other journal level gender disparities, there is no justification for perpetuating an easily solvable inequity.
- As the [Need Her Science Campaign](#) pointed out, before hitting “submit” women and allies might ask themselves if there is evidence that the journal is focused on treating women fairly.
- When women physicians and scientists face barriers to publication and journal leadership, the pace of discovery slows and critical perspectives are lost.
- Patients may also be affected as they are relying on researchers with the brightest minds—many of whom are women—to advance the science that will help them overcome disease and disability.

[Silver JK. Medical Journals Must Tackle Gender Bias. BMJ. 2019 Oct 8;367:l5888.](#)

Gender Equity on Journal Editorial Boards

- Among the many inequities for women in academic medicine, one in particular has been documented for more than 20 years: inequity on editorial boards.
- Barriers at the level of editors may contribute to disparities in publishing, which in turn affect future grant funding, academic promotion, and compensation—slowing the advancement of women and preventing them from reaching their full potential.
- As deans and chairs are increasingly investing in a diverse workforce, barriers to the inclusion of women faculty members diminish their returns on investments.
- External organizations that are beyond the direct control of medical schools and academic medical centers, but nevertheless affect the promotion and advancement of doctors and scientists in medicine, including journals, medical societies, and funding agencies, must be held responsible for the ethical inclusion of all.
- Gender equity on journal editorial boards is long overdue and should be identified as a core component of professionalism and ethical conduct in medicine.

[Silver JK. Gender Equity on Journal Editorial Boards. Lancet. 2019 May 18;393\(10185\):2037-2038.](#)

Critical Thinking Errors

There are many [critical thinking errors, some of which have been described](#) in the medical literature. Debunking critical thinking errors is beyond the scope of this report. However, to illustrate how they maintain structural and organizational gender bias and support the discrimination of people URiM, consider the example below:

Critical thinking error: Women physicians and scientists should be grateful to receive an invitation to be an editor at a medical journal.

Outdated policies and practices:

Early medical journals such as *The New England Journal of Medicine* and the *Journal of the American Medical Society* were founded in the 1800's and other journals such as *Annals of Surgery*, *Anesthesiology*, and *Pediatrics*, were founded in the mid twentieth century. Some of the same policies and practices that have been used for decades are still in place today. However, much has changed, and the recruitment and retention of journal editors should take into account the issues that are practically and culturally relevant to the 21st century physician and scientist workforce. For example, as explained earlier in this report, women in medicine may have different financial considerations (e.g., high educational debt and/or pay disparities) than male colleagues.

Consider a well-intentioned editor-in-chief of a medical journal who invites two physicians who are assistant professors to serve as junior editors. The first person is a man who does not identify with an URiM group and who has no educational debt and is equitably compensated by his academic institution. The second is a woman who is part of an URiM group. She is equally talented but has more than \$200,000 in educational debt and is not equitably compensated by her academic institution. Both invitees are experts in statistical analysis, and so the man considers his odds for promotion to professor, becoming editor-in-chief of a medical journal (which is a financially lucrative position at some journals). He realizes that for all three of these high-level career aspirations, his likelihood for success are better than any other demographic group. The woman, equally skilled in statistical analysis, recognizes that at all three positions—professor, top level dean, and/or editor-in-chief of a reputable academic journal—her odds are much lower. In fact, data to date shows “inexorable zero” levels for all of these positions for URiM women. While it is true that both junior editors will likely serve in a volunteer capacity, the financial risks and rewards are not the same. Based on the history of prestigious journals affiliated with medical societies, the system appears to work well for the group for whom it was initially set up (men). However, for women in medicine, particularly women who are URiM, the current system may contribute to sustaining and even promoting structural and organizational bias.

[Silver JK, Rowe M, Sinha MS, Molinares DM, Spector ND, Mukherjee D. Micro-inequities in Medicine. PM R. 2018 Oct;10\(10\):1106-1114.](#)

[Shillcutt SK, Silver JK. Barriers to Achieving Gender Equity. J Cardiothorac Vasc Anesth. 2019 Jul;33\(7\):1811-1818.](#)

Critical Thinking Errors

Proposed new policies and practices:

Medical societies and their affiliated journals will need to consider many different options to change the status quo. One important consideration is whether to pay junior editors. Depending on the journal, the editor-in-chief and senior editors receive compensation. At the high end of compensation for some journals this can be in the range of hundreds of thousands of dollars. For example, according to their [Internal Revenue Service \(IRS\) Form 990](#), in 2017 the American College of Surgeons paid \$610,205 to the editor-in-chief of *Selected Readings in General Surgery*. The American Society of Plastic Surgeons, reported on [Form 990 for the year 2017](#) that they paid \$513,878 to the editor-in-chief of their affiliated journal *Plastic and Reconstructive Surgery*. On their [Form 990 for the year 2018](#) the *Radiological Society of North America* reported two independent contractors under the title “Editor Honorarium”—one was paid \$437,940 and the other was paid \$291,910. Although the American Academy of Pediatrics did not specifically list payments to journal editors on their [Form 990 for 2017](#), they did report membership revenue of approximately \$26 million and medical journal revenue of \$25 million. Furthermore, they reported an additional \$12 million from other publications and \$8 million for national meetings—indicating that journal and other publishing revenue outpaces membership and national meeting revenue for this medical society.

To better assess whether there is already money within a given organization that might be used to pay junior editors (thereby making it easier to recruit the talented woman in the example), refer to Table 4. Notably, paying junior editors does not solve all equitable inclusion issues, but inviting women to work for free with essentially no reasonable chance of promotion to the highest level—or even senior levels below the editor-in-chief—is ethically and financially problematic.

Table 4 provides information about 22 US medical societies associated with major specialties and their relationships with medical journals. It is clear from Table 4 that individually and collectively, these medical societies have deep financial resources. For example, the total one year revenue for the 22 societies is more than \$1.4 billion; current net assets are approximately \$1.8 billion; and the total salaries for 22 individuals who are the highest ranking administrators is \$16.6 million and their average yearly compensation is more than \$750,000. In general, these societies comprise some of the largest in the US, and there are many smaller societies that are not listed in Table 4. Furthermore, the financial information presented should not be taken as representative of other societies or journals, particularly those that are smaller and have fewer resources. Financial information about the journals and their top-ranking officials is often unavailable for a variety of reasons including that some journals are separate for-profit entities. However, medical societies are generally non-profit organizations, and their financial information is publicly available. In Table 4, total yearly medical society revenue is listed (versus net revenue after expenses), as some of the total revenue may need to be reallocated if a medical society aims to financially prioritize DEI within its organization.

Table 4

Profiles of Medical Societies and Their Affiliated Journals

Medical Society	Affiliated Journal ¹	Information about the journal on the medical society's website	Medical society total revenue current year*	Medical society net assets end of current year*	Compensation for medical society's highest ranking administrator (e.g., CEO, Executive Director) / gender ⁵
College of American Pathologists (CAP)	Archives of Pathology and Laboratory Medicine	"journal of the College of American Pathologists, is the most highly read journal/periodical title among US practicing pathologists"	\$224.9M (2018)	\$50.0M	\$875K / Man
American College of Surgeons (ACS)	Journal of the American College of Surgeons	Described as the official journal for the ACS	\$141.7M (2017)	\$395.0M	\$1.4M / Man
American Academy of Pediatrics	Pediatrics	"the most-cited journal in pediatric medicine, and among the top 100 most-cited journals in all of science and medicine"	\$121.4M (2017)	\$60.0M	\$665K / Woman
American College of Cardiology (ACC)	Journal of the American College of Cardiology	Described as the official journal for the ACC	\$115.1M (2018)	\$94.3M	\$1.1M / Man (2017)
American Academy of Family Physicians (AAFP)	American Family Physician	"The AAFP's peer-reviewed, evidence-based clinical journal"	\$91.5M (2017)	\$65.9M	\$877K / Man
American College of Physicians	Annals of Internal Medicine	"the most cited general internal medicine journal and one of the most influential journals in the world"	\$86.0M (2017)	\$86.4M	\$747K / Woman
American Society of Hematology	Blood	"the most cited peer-reviewed publication in the field of hematology"	\$76.5M (2017)	\$162.2M	\$707K / Woman
American College of Obstetricians and Gynecologists (ACOG)	Obstetrics & Gynecology (Green Journal)	"the most complete and reliable source of information on current developments in women's health care"	\$64.4M (2018)	\$11.0M	\$703K / Man
American Academy of Ophthalmology (AAO)	Ophthalmology	Described as the official journal for AAO	\$60.1M (2018)	\$63.7M	\$1.0M / Man
Radiological Society of North America (RSNA)	Radiology	"highest quality research in the field of radiology... Published regularly since 1923"	\$56.1M (2018)	\$150.0M	\$652K / Man
American Society of Anesthesiologists (ASA)	Anesthesiology	"Promoting scientific discovery and knowledge in perioperative, critical care, and pain medicine to advance patient care"	\$54.2M (2018)	\$68.5M	\$757K / Man
American Psychiatric Association (APA)	The American Journal of Psychiatry	Described as the official journal for APA	\$60.0M (2018)	\$93.3M	\$660K / Man
American Academy of Orthopaedic Surgeons (AAOS)	Journal of the American Academy of Orthopaedic Surgeons	"the #1 most read journal in orthopaedics"	\$47.6M (2018)	\$98.7M	\$833K / Man

American College of Gastroenterology (ACG)	American Journal of Gastroenterology	Described as the official journal for the ACG	\$34.8M (2018)	\$194.6M	\$847K / Man
American Society of Plastic Surgeons (ASPS)	Plastic and Reconstructive Surgery	Described as the official journal for the ASPS	\$27.5M (2017)	\$21.8M	\$503K / Man (2016)
American Academy of Neurology (AAN)	Neurology	“Read the AAN's prestigious medical journals”	\$27.2M (2018)	\$61.6M	\$757K / Woman
Infectious Diseases Society of America	Journal of Infectious Diseases	“Published continuously since 1904...the premier global journal”	\$23.6M (2018)	\$33.9M	\$487K / Man
American Society for Radiation Oncology (ASTRO)	International Journal of Radiation Oncology, Biology, Physics (Red Journal)	“ASTRO publishes three top-notch journals”	\$22.2M (2018)	\$27.3M	\$729K / Woman
Society of Critical Care Medicine (SCCM)	Critical Care Medicine	“the Society of Critical Care Medicine's (SCCM) premier peer-reviewed publications”	\$18.8M (2017)	\$29.6M	\$576K / Man
American Academy of Dermatology (AAD)	Journal of the American Academy of Dermatology	Described as the official journal for the AAD	\$13.1M (2018)	\$7.5M	\$828K / Woman
American Association of Clinical Endocrinologists (AACE)	Endocrine Practice	“Clinical endocrinologists worldwide rely on Endocrine Practice, the official journal of the AACE”	\$13.1M (2018)	\$7.6M	\$417K / Man
American Academy of Physical Medicine and Rehabilitation	PM&R	“The goal of the publication is to advance education and impact the specialty”	\$12.7M (2018)	\$15.0M	\$479K / Man

These are examples of medical societies associated with major specialties in the US. The way that medical societies and journals structure their relationships with one another varies—some societies do not have relationships with journals. However, for those societies that do have affiliated journals, it is important for these entities to work together to address gender equity. Financial information is provided to assist readers in considering the issue of whether societies have resources to address gender equity for their members. Note that some medical societies have multiple chapters and filings for the same year, so the table in this report may underestimate revenue and assets.

^All information in this chart is publicly available; United States Internal Revenue Service Form 990 for non-profit organizations are open to public inspection; K=thousand; M=million

+Some medical societies own or are affiliated with more than one journal

*Reported in Part I on lines 12 and 22 of the most recent Form 990 available; accessed July 2020 on US Internal Revenue Service website: <https://apps.irs.gov/app/eos/>, ProPublica Nonprofit Explorer : <https://projects.propublica.org/nonprofits/>, or Candid 990 Form Finder: <https://candid.org/research-and-verify-nonprofits/990-finder>

\$Reported on Form 990 in Part VII Section A with a combined amount from columns D-F

#Highest ranking administrator listed

Financially Prioritizing Diversity, Equity, and Inclusion

Meaningful change will only come when DEI roles and initiatives become a financial priority. An important ethical and financial consideration for academic employers is the way in which structural and organizational policies and practices aimed at solving gender disparities and other DEI problems, inclusive of but not limited to racial/ethnic discrimination, may be well-intentioned but actually contribute to less compensation and slower career advancement for their faculty. This is especially important for women and URIM faculty who do much of this work on a volunteer basis. Employers should not only be engaged in prioritizing, funding, and recognizing the scholarship of DEI work at their institutions, but also recognize that the medical societies that they and their faculty financially support need to demonstrate a similar commitment to financial prioritization. Just as gender equity research is woefully underfunded, the number of DEI task forces and committees that have little or no funding offer a good example of the disconnect in financial prioritization.

Low financial prioritization of gender equity and other DEI efforts is a long-standing and well-documented issue. For example, the previously mentioned [study on gaps in physician compensation](#) noted, “[W]omen are significantly overrepresented as producers and disseminators of compensation studies that include gender data. Furthermore, most of this area of research is unfunded. These findings are important because women may be more engaged and knowledgeable about pay disparities, while men are disproportionately represented in leadership roles and better positioned to fix disparities. If women are primarily producing this mostly unfunded research, a cycle can develop in which women lose additional income (eg, clinical revenue) and do not receive appropriate academic credit for promotions (eg, grant funding).” A recent [article](#) characterized the gender equity work that women physicians are doing as the “third shift” that is in addition to their usual work (first shift) and their home and/or childcare responsibilities (second shift). The authors explained, “[D]iversity and equity work is a required ‘third shift’ for women physicians, and it is magnified even more so for women physicians with intersectionality...Women leaders across academic medicine issue a call for the creation of paid positions to advocate for and implement gender equity initiatives in medical centers throughout the country.”

Although financial prioritization of DEI is not a new recommendation, it would behoove current leaders in academic medicine to re-examine their financial investment in all faculty and consider how best to protect that investment. For example, in her perspective titled [“Why Black Doctors Like Me are Leaving Faculty Positions in Academic Medical Centers”](#), Uché Blackstock, MD wrote, “In addition to the typical obligations of academic faculty, they are often expected or told to execute “diversity efforts” such as chairing diversity committees, mentoring minority trainees, and the like, and then are rarely recognized or compensated for this invaluable work.”

[Larson AR, Cawcutt KA, Englander MJ, Pitt SC, Ansari E, Liu HY, Silver JK. Representation of Women in Authorship and Dissemination of Analyses of Physician Compensation. JAMA Netw Open. 2020 Mar 2;3\(3\):e201330.](#)

[Santhosh L, Keenan BP, Jain S. The “Third Shift”: A Path Forward to Recognizing and Funding Gender Equity Efforts. J Womens Health. 2020 Jul 31.](#)

Financially Prioritizing Diversity, Equity, and Inclusion

Another perspective written by Kali Cyrus, MD, MPH titled [“Why I Gave Up My Dream of Leading Diversity Efforts”](#) states, “What we need is real change and programs backed by solid funding for them...If we don’t make these changes, minority members like me who once hoped to educate trainees and support patients will leave as they find they cannot shoulder the burden alone.”

Medical societies, too, should re-examine their financial commitments to DEI efforts. Ruth Shim, MD, MPH explained why she recently left the American Psychiatric Association (APA) in an article titled [“Structural Racism is Why I’m leaving Organized Psychiatry”](#). Dr. Shim wrote, “Although there is adequate representation of Black psychiatrists on the APA’s board of trustees, there are no people of color on the executive committee of the board of trustees, the highest level of leadership in the organization...I look forward to a time in the future when APA leadership truly understands that the structural racism that pervades the organization must be dismantled. There are clear steps that can be taken...What is needed now is financial commitment, coupled with accountability, to implement action to begin to systematically dismantle structural racism in organized psychiatry.”

In an effort to better understand Dr. Shim’s experience and her comments, keep in mind that financial prioritization is the privileged responsibility of people who hold leadership positions at the highest level of medical societies, though certainly individuals at lower levels may exert some influence. According to the AAMC [women in academic psychiatry comprise greater than 50%](#) of people in the field and of these women [nearly one out of four identify as a person who is from a racial/ethnic minority group](#). In contrast, the APA’s board of trustee’s executive committee currently consists of six individuals—two of whom are women (33%)—and none of whom (based on appearances which are not always accurate) are people of color (0%). The APA recently announced a new task force focused on structural racism, and the [medical society’s website](#) highlights a number of objectives that will require substantial funding if they are to be successful. Regarding the strategy behind dismantling structural racism at the APA there are two critical questions for deans of medical schools, chairs of psychiatry departments, and APA members to ask (because they all financially support the APA):

1. *What is the budget for the newly formed APA’s Structural Racism Task Force?*
2. *Do the task force members who are the APA’s experts at dismantling structural racism—the majority of whom identify as URiM; including women with intersectional identities—have control of the budget?*

Financially Prioritizing Diversity, Equity, and Inclusion

Why these two questions are crucial: Diversity structures such as task forces, may make things worse—not better—as they may reassure leaders that something is being done when in fact things are not progressing. This issue has been described in the literature and is of utmost importance for leaders to recognize:

“[W]ell-intentioned individuals or groups may be at particularly high risk for overestimating their diversity inclusion efforts. For example, organizations may implement ‘diversity structures’ (inclusive of training programs, committees, and strategies) that project an ‘illusion of fairness’ but may counterintuitively undermine diversity efforts. Within this context, high status members of the organization may erroneously perceive the structures as indicators of efficacy, even when data clearly suggest otherwise.”

Diversity structures are unlikely to produce significant change unless they have a sophisticated strategy and funding that reflects high prioritization. Furthermore, the experts on the task force, especially the leader(s), should be in charge of the budget and should have the financial resources to hire consultants (e.g., biostatistician, research assistant, medical/technical writer). This model is similar to how other high priority initiatives are often supported at medical societies. The long-standing strategy of establishing DEI task forces at medical societies (and medical schools/hospitals) that are underfunded or do not have any funding at all has clearly not worked, and drains the time and resources of the task force members—potentially putting them at risk for loss of work-related compensation and slowing their own career advancement. Moreover, to continue the historically unsuccessful practice of establishing underfunded DEI task forces—often in lieu of insisting that leadership at the top level is intentionally inclusive—is fraught with ethical concerns.

Obviously, this example relates to psychiatry—a specialty that is experiencing a lot of unfavorable national attention including media exposure around these issues—but it is important to consider the highest level leadership at every medical society and view it through the lens of diversity and inclusion. This example as well as many others underscore two critical ethical issues that medical societies must address:

1. A lack of diverse and inclusive leadership at the top level of a medical society is itself a disparity, and it almost certainly contributes to structural and organizational gender bias as well as racial/ethnic discrimination throughout the organization; and
2. Inviting women and URiM members to volunteer on medical society DEI task forces that do not have high priority financial funding which is controlled by the DEI experts who are leading the task force's work is unlikely to be a successful strategy and may make things worse.

[Silver JK, Bhatnagar S, Blauwet CA, Zafonte RD, Mazwi NL, Slocum CS, Schneider JC, Tenforde AS. Female Physicians Are Underrepresented in Recognition Awards from the American Academy of Physical Medicine and Rehabilitation. PM R. 2017 Oct;9\(10\):976-984.](#)

"As executive director of the Executive Leadership in Academic Medicine (ELAM) program, I have met and worked with hundreds of the most respected and most qualified senior-level women leaders in academic medicine in the United States. And they all share a common story of the roadblocks they have encountered in achieving equitable representation at the highest levels of leadership at their institutions and in their professional societies as well as gaining equitable compensation compared to male peers. These issues are not hard to fix, but we need to move away from superficial and poorly funded diversity, equity, and inclusion efforts. The time is now for organizations to back up their pledges by addressing diversity and inclusion at the highest level of their organization and dedicating substantive funding for efforts to implement real and measurable change."

Nancy D. Spector, MD
Professor of Pediatrics
Executive Director, Executive Leadership in Academic Medicine
Vice Dean of Faculty
Drexel University College of Medicine

A Positive Example: The Journal *Neurology's* Commitment to Address Gender Bias

"Excluding women from the most visible roles in medical journals deprives the field of their expertise and perspective and, moreover, may perpetuate gender biases that affect the process and outcome of peer-review. Membership of Editorial boards is a prestigious achievement in academic medicine and an opportunity to network. Excluding women limits their opportunities for career advancement and may adversely affect their future research funding and even financial future. In addition, it decreases the visibility of women role models for future generations, signaling that the research community does not sufficiently value contributions from women."

[Merino JG, Worrall BB, Baskin PK, Ciccarelli O. Neurology's Commitment to Address Gender Bias in Neurology Journals. Neurology. 2020 Aug 4;10.1212/WNL.0000000000010539.](#)

The journal *Neurology* will increase the proportion of women:

1. on the editorial board to 50%
2. among editors on the masthead to 50%
3. as editors of the Resident & Fellow Section to 50%
4. as peer reviewers to 50%
5. invited to write editorials and commentaries to 50%

"While these interventions focus on the gender disparities, we will implement similar policies to ensure proportionate representation of people from racial and ethnic groups that are underrepresented in medicine, and in the future, we will make a separate announcement about these specific measures."

"As a trainee, I have only just arrived at the base camp of my career. I crane my neck upward to take in the daunting splendor that are my academic, physician-scientist aspirations. The road ahead is arduous for all comers, but as a woman and someone from an underrepresented in medicine background, my path is riddled with extra barriers and hazards that threaten my ability to reach the highest summit. I am inspired by and committed to follow in the footsteps of women trailblazers and the #HeForShe allies who are working tirelessly to demolish gender bias and gatekeepers that exist in institutions, medical societies, journals, and funding agencies. Leaders need to be ethical and dismantle the systems in place that limit how women are paid, published, and promoted. Succeeding in academic medicine is hard enough without gender inequity. Cheers to a future where all women can reach the summit of their career aspirations. Her time is now!"

Jacelyn Peabody Lever
MD/PhD Candidate, GS4/MSTP6
NIH Medical Scientist Training Program
University of Alabama at Birmingham

Focusing on Diversity, Equity, and Inclusion as a Core Component of Professionalism

At the end of the 20th century, the Accreditation Council for Graduate Medical Education (ACGME) identified and defined professionalism as one of six core competencies for resident physicians. Subsequently, the American Board of Medical Specialties (ABMS) adopted these as principles, and they are now incorporated into their Maintenance of Certification (MOC) programs. Though [social justice issues](#) have long been identified as central to professionalism, frequently in reports and didactics that cover professionalism, workforce and patient care DEI issues are not addressed. Given the importance of DEI and social determinants of health, everyone involved in medical education should consider how to bring evidence-based and best practices DEI information into the curricula, especially as a topic of high priority in professionalism training.

“Professionalism in medicine is universally embraced, and it is the foundation for core competencies in medical education, clinical practice, and research.”

[Silver JK, Cuccurullo S, Weiss LD, Visco C, Oh-Park M, Karimi DP, Frontera WR, Fleming TK, Bosques G, Bhatnagar S, Ambrose AF, Nguyen VQC. The Vital Role of Professionalism in Physical Medicine and Rehabilitation. Am J Phys Med Rehabil. 2020 Apr;99\(4\):273-277.](#)

“It is imperative to emphasize the pivotal value of diversity, equity, and inclusion in upholding professionalism...Inclusion is not only limited to the way we serve our patient population, but also extends to the way we approach each other in the work environment.”

[Singhal D, Ansari E, Ghalib R, Corriel D, Girgis L, Silver JK. The Interconnectivity of Professionalism, Workforce Diversity, and Healthcare Equity. Ann Fam Med. 2020 Feb 24.](#)

“The Accreditation Council for Graduate Medical Education (ACGME) core competencies guide resident training programs in preparing physicians for independent practice...The six core competencies are: practice-based learning and improvement, patient care and procedural skills, systems-based practice, medical knowledge, interpersonal and communication skills, and professionalism...Addressing gender inequity is a vital component of professionalism in any residency training program.”

[Erdahl LM, Chandrabose RK, Pitt SC, Radford DM, Strong SA, Silver JK. A Call for Professionalism: Addressing Gender Bias in Surgical Training. J Surg Educ. 2020 Jul-Aug;77\(4\):718-719.](#)

Focusing on Diversity, Equity, and Inclusion as a Core Component of Professionalism

“The health care system and institutions have traditionally been hierarchal, and despite increasing evidence that blatant and implicit discrimination and inequities persist, institutions have not made enough significant structural changes to effectively mitigate inequities. Efforts to address these gender inequities and conscious (explicit) or unconscious (implicit) bias as well as gender-related and sexual harassment must include women at all stages of their careers to make a meaningful difference. Changing the culture of medicine is essential and systems must make significant structural changes to prevent the propagation of unprofessional environments. In health care, it is essential to end the culture of discrimination as a systemic problem by implementing meaningful policy and social changes. Our call to action dovetails with the tenets of professionalism. Additional research on senior women physicians, curricular changes that address men and women physicians’ careers across the lifespan, and system changes that address the integration of work and other aspects of life are critical.”

[Jain S, Englander MJ, Gebhard RE, Moeschler SM, Sharkey KM, Silver JK. Re: "Issues Faced by Senior Women Physicians: A National Survey." by Templeton K, et al. J Womens Health. 2020 May 21.](#)

“A new model of organizational professionalism requires sustainable governance policies and procedures that address workplace climate, harassment, explicit and implicit biases, cultural sensitivity, organizational well-being, and workforce equity (including gender equity)... We urge organizations to incorporate DEI principles as they seek to implement new models of medical professionalism at every level—from undergraduate medical education to the executive suite. The time is now.”

[Chin EL, Britto VM, Parekh R, Parangi S, Silver JK, Spector ND. Diversity and Medical Professionalism. Health Aff. 2020 Apr;39\(4\):722.](#)

“There are many potential adverse outcomes of prioritizing financial imperatives over those related to professionalism...We recommend that institutions thoughtfully reassess their mission statement to prioritize professionalism and its inherent implications for diversity, equity, and inclusion.”

[Larson AR, Oxentenko AS, Schoenthaler R, Kowalski AM, Verduzco-Gutierrez M, Silver JK. Impact of financially driven health care models on tenets of medical professionalism including workforce equity, diversity, and inclusion. J Eval Clin Pract. 2020 Jun;26\(3\):707-708.](#)

“Promoting growth in workforce diversity, equity, and inclusion is essential to appropriate professional behavior toward patients, colleagues, and the public. Focusing on these components of professionalism will help to foster a culturally sensitive and competent health care environment that models professional and ethical behavior. These values create the psychologically safe culture that is vital to the well-being of our patients and to the well-being of our medical workforce.”

[Rider EA, Diekman S, Doshi TL, Gautam M, Silver JK. Answering the Challenge: Diversity, Equity, and Inclusion as a Key to Professionalism. Am J Med. 2020 Jun;133\(6\):e333.](#)

Structural and Institutional Gender Bias Across the Span of Women’s Careers

Early Career

“A lack of role models for combining career and family responsibilities, frustrations with research (funding difficulties, poor mentorship, competition), work-life balance, and the institutional environment (described as noncollaborative and biased in favor of male faculty) emerged as key factors associated with a decision to leave academic medicine for respondents.”

[Levine RB, Lin F, Kern DE, Wright SM, Carrese J. Stories From Early-career Women Physicians Who Have Left Academic Medicine: A Qualitative Study as a Single Institution. Acad Med. 2011 Jun;86\(6\):752-8.](#)

Mid Career

“[W]e describe a multifactorial phenomenon whereby academic women physicians become invisible in the mid-career stage. Barriers, both small and large, cause a cumulative inequity effect, and women may leave academic medicine...a situation created where women become discouraged and disillusioned...We examine the contributing and causative processes and offer suggestions on how to promote equity among highly qualified mid-career women as they graduate from training and move beyond the early career stage.”

[Lewiss RE, Silver JK, Bernstein CA, Mills AM, Overholser B, Spector ND. Is Academic Medicine Making Mid-Career Women Physicians Invisible? J Womens Health. 2020 Feb;29\(2\):187-192.](#)

Late Career

“[T]his is the first study to look in detail at the careers of older women physicians and the first article in decades to focus on this population... The changing demographics in medicine mandate that we gain a better understanding of the issues and needs of all women physicians at every stage of their careers...Our findings of continuing difficulties and unmet needs are even more disturbing as they are reported by the “survivors”—older women who navigated challenges, persisted, and generally reported overall success and satisfaction with their careers...[C]hanges in the culture and functioning of medicine and health care systems are needed to better align with the values and to support the careers of women physicians of all ages. These include remedying the gender pay gap, enhancing and supporting professional advancement, and eliminating gender bias and sexual harassment...We owe it to ourselves, our patients, and society to optimize the careers of all women physicians at every age.”

[Templeton K, Nilsen KM, Walling A. Issues Faced by Senior Women Physicians: A National Survey. J Womens Health \(Larchmt\). 2020 Jul;29\(7\):980-988.](#)

"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

"With the current backdrop of social unrest and increasing awareness of disparities, it is important to remember the importance of diversity, inclusion, equity, and justice. All four are important. Diversity is representation, not mere tokenism. Inclusion is creating environments where any individual or group is welcomed, respected, and supported. Equity is ensuring all have access to information and resources. Finally, there is justice. When we recognize that each person has value to contribute, then there is no question that we must address current barriers and historical factors that have led to unfair conditions for marginalized populations."

Thomas K. Varghese Jr., MD, MS, FACS
Executive Medical Director (Interim) & Chief Value Officer – Huntsman Cancer Institute
Section Chief – General Thoracic Surgery
Program Director – CT Surgery Residency Program
Professor (Tenure Track) of Surgery

"We need male academics to recognize these gaps and join with our women colleagues in these efforts to assure parity. However, embracing the #HeforShe ethos cannot be just tacit support for women in academic medicine or awareness of these issues, we must speak up and be advocates for change in how universities and medical centers support talented women physicians and scientists. Importantly, this should extend beyond salary, and address other important inequities that exist in research time, laboratory space, leadership opportunities, and institutional support as these help assure equal pathways to promotion."

Steven A. Pergam, MD, MPH
Associate Professor, Vaccine and Infectious Diseases Division
Fred Hutchinson Cancer Research Center
Associate Professor, Department of Medicine
University of Washington

"The small numbers of women who identify with underrepresented in medicine racial and ethnic minority groups at the professor and chair level were shocking to me as I rose to that level myself. To be the third Latina full Professor in the whole country (including Puerto Rico) in my specialty this year was a call to action for me. I will continue to evoke change, speak up, and empower colleagues so they know that her time is now."

Monica Verduzco-Gutierrez, MD
Professor and Chair
Department of Rehabilitation Medicine
Joe R. and Teresa Lozano Long School of Medicine
University of Texas Health, San Antonio

"Her science is a critical part of all of our futures. The next steps in science and healthcare must be shaped by the dynamic input of women-led research and innovation. Empowering women in medicine is a global responsibility that will enhance the greater common good. However, it starts at our home institutions with strategy and resources that match the gaps in diversity and inclusion. The time is now to ensure this ethical obligation is met."

Ross Zafonte, DO
Earle P. and Ida S. Charlton Professor and Chair
Department of Physical Medicine and Rehabilitation
Harvard Medical School
Senior Vice President of Medical Affairs, Research and Education
Spaulding Rehabilitation Network
Chief, Physical Medicine and Rehabilitation
Massachusetts General Hospital
Chief, Physical Medicine and Rehabilitation
Brigham and Women's Hospital

"Women of intersecting marginalized identities are often tasked to lead tasks forces, mentor students, and essentially do the work to make our institutional spaces less oppressive. However, their efforts are rarely rewarded with the same promotion, award, and research opportunities as cis-gendered white men. The time is now to acknowledge these inequities and do the work to uplift the talents and contributions of all women. This includes women whose voices have been traditionally overshadowed in feminist movements—including women who self-identify as disabled, BIPOC, and/or LGBTQ. A powerful movement must be intersectional."

LaShyra "Lash" Nolen
Student Council President
Harvard Medical School '23

"What happens when academic medicine loses strong women leaders because of unequal pay, workplace microaggressions, and outright gender-based discrimination? Our patients lose compassionate clinicians, our trainees lose inspirational educators and our profession loses committed colleagues who could have made invaluable contributions to the future of medicine. Let this be the definite time when we do better by our patients, trainees, and ourselves by creating structures that allow women to survive—and thrive—in all phases of the academic medical journey."

Stella Safo, MD, MPH
Strategic Advisor, Premier Inc
Assistant Professor, Mount Sinai Health System

"Spaulding is fully committed to creating an inclusive environment and culture for our patients and for our staff at all levels. Gender equity is an essential component of this commitment, and we applaud the extraordinary work of the Her Time Is Now Campaign to eradicate disparities."

David E. Storto, MA, JD
President
Partners Continuing Care and Spaulding Rehabilitation Network

"The Her Time Is Now report documents women's lived experience and comes at a critical inflection point demanding organizations meet the moment. We all need to do the difficult reflection, engagement with colleagues, learning and listening, then acting. The barriers that keep voices of marginalized communities classified by gender, disability, race or anything else that has limited their inclusion in leadership and opportunities have to be taken down. Diversity will only make organizations stronger and should become the guiding way forward to ensure that all people have equal access to opportunity. This report is an important resource for everyone involved in leading diversity and inclusion initiatives, particularly for individuals leading these efforts within healthcare."

Oswald Mondejar
Senior Vice President, Mission and Advocacy
Spaulding Rehabilitation Network
Partners Healthcare at Home

"Recognition is not enough. Raising awareness is not enough. Changing curricula is not enough. Institutions must functionally stand behind policies, procedures, and funding to dispel gender biases."

Rachel Pham, BS
MS3
Creighton University School of Medicine

"As a soon to be physician who is a first-generation Mexican-American woman, it is harrowing to see the data showing how much the odds are truly against people like me. Women with intersectional identities pursuing academic careers experience cumulative and synergistic biases from employers, medical societies, and academic journals. The effect of these combined biases on our ceiling of success is deeply disturbing. We are often disadvantaged from the time we enter school as young children, and instead of opportunities becoming more equitable as we advance our education, the disparities become even more apparent at higher educational levels. The time is now to tackle these disparities."

Rachel Esparza, BS
Fourth-Year Medical Student
Yale School of Medicine

"Paving the future for women in medicine means systematically evaluating barriers. Closing gaps in the recruitment and advancement of women in medicine is the responsibility of admissions committees, program directors, department chairs, and other institutional leaders. Now is the time to demonstrate that diversity and inclusion is a priority, and to put resources behind statements of solidarity."

Michelle Guo, BA

Fourth-Year Medical Student

Perelman School of Medicine

University of Pennsylvania

"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

"We cannot and should not expect women in medicine to solve the problem of inequity by themselves. This problem belongs to all of us. As a child of immigrants and having grown up in places where people did not look like me, I know what it is like to be an outsider. Outsiders have no power to change the system. This is where allies come in. We can all be allies. Those of us who head departments can create an inclusive culture and prioritize hiring a diverse workforce. We can be mentors, coaches, and sponsors to women trainees and faculty. We can use our influence within professional organizations and editorial boards to change policies and practices that discriminate against women. We can actively recruit women for projects, endorse women for speaking opportunities, nominate women for awards, and promote women for leadership positions. We can establish diversity, equity, and inclusion as core values in our societies, boards, and departments. We can do all of these things because we have the power, and that power needs to be shared. Her time is now."

Edward R. Mariano, MD, MAS

Chief, Anesthesiology and Perioperative Care Service

Veterans Affairs Palo Alto Health Care System

Professor of Anesthesiology, Perioperative and Pain Medicine

Stanford University School of Medicine



"As women, we have been looking for the opportunity to lead for so long. We have developed the skills and have been eager to use them. We often wait until it is the right time and the perfect fit. That may not always exist. We can lead in so many ways. Our time is now."

Amy S. Oxentenko, MD, FACP, FACG, AGAF

Professor of Medicine

Chair of Medicine

Mayo Clinic Arizona

The Her Time Is Now Campaign was developed by Julie K. Silver, MD. Dr. Silver is an Associate Professor and Associate Chair in the Department of Physical Medicine and Rehabilitation at Harvard Medical School. She is the director of the Harvard Medical School women's leadership course titled "Career Advancement and Leadership Skills for Women in Healthcare". Campaign partners include the American Medical Women's Association (AMWA) and Executive Leadership in Academic Medicine (ELAM), a core program of Drexel University College of Medicine. Find out more about this campaign at SheLeadsHealthcare.com.

