COMMENTARY

Family Medicine is Not Immune to Racial and Gender Wage Gaps

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The race and gender gap in American wages is well known and documented. This has been attributed to multiple potential causative factors, including differences in time demands between men and women at home, contract negotiating differences between the sexes, implicit bias of employers and executives, socioeconomic intersection with race, and more. Anderson et al focuses specifically on the salary gaps in family medicine.[1] The authors posit potential causes and recommend additional studies to further elucidate underlying factors.

Income disparities are deeply rooted in the health care system and across all specialties.[2] Residency programs must fulfill ACGME requirements to maintain accreditation, but there is variability in practice management teaching guidelines, and oftentimes practice management is pushed to a condensed period at the end of training. Residency practice management curriculums aim to provide residents with the tools needed to succeed with job applications and early career decision-making. However, negotiating techniques are not standardized. Although practice management curriculums originated within the specialty of family medicine, family medicine graduates have varying skills in negotiating. There are known differences in how men and women tend to negotiate across various specialties, with women often expecting lower salaries than men.[2] Residencies can and should prioritize mentoring and other avenues to advance negotiating skills and delineate strategies for residents to dissect contracts, balance schedules and flexibility, and receive fair compensation. A 2018 report published by the American Association of University Women and based on data from the 2017 US Census and the Bureau of Labor Statistics revealed the wage gap for women physicians is approximately $19 billion less annually than men.[3] By prioritizing training in negotiation and inequities across specialties, improvement in the gender wage gap may follow.

Gender pay disparities in the study are not connected to hours worked. And as the disparities start within 3 years of graduation, the differences are not secondary to seniority.[4] Although the gap is narrowing, there remain large imbalances in the proportion of household duties completed by gender. Women may work fewer days due to maternity leave or the demands of childrearing. In addition, more women are caregivers for their aging parents. Women physicians often spend more time with patients and completing charts, thus seeing fewer patients per day. In a fee-for-service world, there are inherent challenges as physicians aim to maintain a healthy work–life balance while achieving financial goals. Salary inequities in the early career can be a challenge in achieving salary equity as careers advance. This in turn can contribute to many women deciding to delay pregnancy to help offset costs such as student loan payments, saving for a home, and even potentially influencing family planning and fertility.

Diversity directly impacts the populations we serve. Women physicians have been shown to spend

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more time with their patients than men.[3] Outcomes data highlight hospital mortality and readmission rates were lower of women compared with men, and on average, women addressed medical conditions using evidence-based medicine and patient-centered approaches to care in an outpatient setting.[2] Minority physicians are more likely to work in underserved communities and provide care for minority and poor patients.[5,6] In addition, minority patients often seek providers of their same race, particularly if they have had poor experiences with providers who may not be able to relate to them in the same ways. Patients seek providers who speak their natural language, including native Spanish speakers and physicians of Asian descent. Patient satisfaction scores are higher with congruent racial and ethnic backgrounds.[7] Thus, a more diverse physician population is associated with improved patient satisfaction and care. Transparency among institutions can help narrow the wage gap.[3] Ensuring that there are individuals that are determining the best practices in identifying ways to help create more equity in pay is essential. Employers should value what a physician is able to bring to a practice, including the value of cultural understanding and communicating in a patient's language of origin.

The authors note the limited pool of data, rising from the 2019 and 2020 data from the American Board of Family Medicine National Graduate Survey. The survey is limited to graduates 3 years after residency completion. It would be helpful to have more longitudinal data that go beyond the first 3 years after training to examine compensation comparisons at each year following residency. More high-powered studies are needed to fully elucidate the myriad causes of the pay gap. In addition, there is variability in compensation depending on geographic location. Student loan forgiveness should be considered in a compensation package. Given these are self-reported data, there may also be limitations such as the ability to be introspective when self-reporting hours per week worked.

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