Collateral Damage: How COVID-19 Is Adversely Impacting Women Physicians

Yemisi Jones, MD[1,2]*, Vanessa Durand, DO[3,4], Kayce Morton, DO[5], Mary Ottolini, MD, MPH, MEd[6,7], Erin Shaughnessy, MD, MSHCM[8,9], Nancy D Spector, MD[3,10], Jennifer O'Toole, MD, MEd[1,2,11,12], on behalf of the ADVANCE PHM Steering Committee

[1]*Department of Pediatrics, University of Cincinnati College of Medicine, Cincinnati, Ohio;* [2]*Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio;* [3]*Department of Pediatrics, Drexel University College of Medicine, Philadelphia, Pennsylvania;* [4]*Section of Hospital Medicine, St. Christopher's Hospital for Children, Philadelphia, Pennsylvania;* [5]*Department of Pediatrics, University of Missouri School of Medicine, Columbia, Missouri;* [6]*Department of Pediatrics, Tufts University School of Medicine, Boston, Massachusetts;* [7]*Department of Pediatrics, The Barbara Bush Children's Hospital, Maine Medical Center, Portland, Maine;* [8]*Department of Pediatrics, University of Arizona College of Medicine–Phoenix, Phoenix, Arizona;* [9]*Division of Hospital Medicine, Phoenix Children's Hospital, Phoenix, Arizona;* [10]*Faculty Development, Drexel University College of Medicine, Philadelphia, Pennsylvania;* [11]*Department of Internal Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio;* [12]*University of Cincinnati Medical Center, Cincinnati, Ohio.*

The coronavirus disease of 2019 (COVID-19) pandemic has affected every facet of our work and personal lives. While many hope we will return to "normal" with the pandemic's passing, there is reason to believe medicine, and society, will experience irrevocable changes. Although the number of women pursuing and practicing medicine has increased, inequities remain in compensation, academic rank, and leadership positions.[1,2] Within the workplace, women are more likely to be in frontline clinical positions, are more likely to be integral in promoting positive interpersonal relationships and collaborative work environments, and often are less represented in the high-level, decision-making roles in leadership or administration.[3,4] These well-described issues may be exacerbated during this pandemic crisis. We describe how the current COVID-19 pandemic may intensify workplace inequities for women, and propose solutions for hospitalist groups, leaders, and administrators to ensure female hospitalists continue to prosper and thrive in these tenuous times.

HOW THE PANDEMIC MAY EXACERBATE EXISTING INEQUITIES

Increasing Demands at Home

Female physicians are more likely to have partners who are employed full-time and report spending more time on household activities including cleaning, cooking, and the care of children, compared with their male counterparts.[5] With school and daycare closings, as well as stay-at-home orders in many US states, there has been an increase in household responsibilities and care needs for children remaining at home with a marked decrease in options for stable or emergency childcare.[6] As compared with primary care and subspecialty colleagues who can provide a large percentage of their care through telemedicine, this is not the case for hospitalists who must be physically present to care for their patients. Therefore, hospitalists are unable to clinically "work from home" in the same way as many of their colleagues in other specialties. Increased childcare and schooling obligations, coupled with disproportionate household responsibilities and an inability to work from home, will likely result in female hospitalists struggling to meet family needs while pandemic-related work responsibilities are ramping up.[7] In addition, women who are involved with administrative, leadership, or research activities may struggle to execute their responsibilities as a result of increased domestic duties.

Many hospitalists are also concerned about contracting COVID-19 and exposing their families to the illness given the high infection rate among healthcare workers and the shortage of personal protective equipment (PPE).[8,9] Institutions and national organizations, including the Society of Hospital Medicine, have partnered with industry to provide discounted or complimentary hotel rooms for members to aid self-isolation while providing clinical care.[10] One famous photo in popular and social media showed a pulmonary and critical care physician in a tent in his garage in order to self-isolate from his family.[11] However, since women are often the primary caregivers for their children or other family members and may also be responsible for other important household activities, they may be unable or unwilling to remove themselves from their children and families. As a result, female hospitalists may encounter feelings of guilt or inadequacy if they're unable to isolate in the same manner as male colleagues.[8]

Exaggerating Leadership Gap

One of the keys to a robust response to this pandemic is strong, thoughtful, and strategic leadership.[12] Institutional, regional, and national leaders are at the forefront of designing the solutions to the many problems the COVID-19 pandemic has created. The paucity of women at high-level leadership positions in institutions across the United States, including university-based, community, public, and private institutions, means that there is a lack of female representation when institutional policy is being discussed and decided.[4] This lack of representation may lead to policies and procedures that negatively affect female hospitalists or, at best, fail to consider the needs of or support female

*Corresponding Author: Yemisi Jones, MD; Email: yemisi.jones@cchmc.org; Telephone: 412-965-9630; Twitter: @YJonesMD.

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physicians. For example, leaders of a hospital medicine group may create mandatory "backup" coverage for night and weekend shifts for their group during surge periods of the pandemic without considering implications for childcare. Finding weekday, daytime coverage is challenging for many during this time when daycares and school are closed, and finding coverage during weekend or overnight hours will be even more challenging. With increased risks for older adults with high-risk medical conditions, grandparents or other friends or family members that previously would have assisted with childcare may no longer be an option. If a female hospitalist is not a member of the leadership group that helped design this coverage structure, there could be a lack of recognition of the undue strain this coverage model could create for women in the group. Even if not intentional, such policies may hinder women's career stability and opportunities for further advancement, as well as their ability to adequately provide care for their families. Having women as a part of the leadership group that creates policies and schedules and makes pivotal decisions is imperative, especially regarding topics of providing access and compensation for "emergency childcare," hazard pay, shift length, work conditions, job security, sick leave, workers compensation, advancement opportunities, and hiring practices.

Compensation

The gender pay gap in medicine has been consistently demonstrated among many specialties.[13,14] The reasons for this inequity are multifactorial, and the COVID-19 pandemic has the potential to further widen this gap. With the unequal burden of unpaid care provided by women and their higher prevalence as frontline workers, they are at greater risk of needing to take unpaid leave to care for a sick family member or themselves.[6,7] Similarly, without hazard pay, those with direct clinical responsibilities bear the risk of illness for themselves and their families without adequate compensation.

Impact on Physical and Mental Health

The overall well-being of the hospitalist workforce is critical to continue to provide the highest level of care for our patients. With higher workloads at home and at work, female hospitalists are at risk for increased burnout. Burnout has been linked to many negative outcomes including poor performance, depression, suicide, and leaving the profession.[15] Burnout is documented to be higher in female physicians with several contributing factors that are aggravated by gender inequities, including having children at home, gender bias, and real or perceived lack of fairness in promotion and compensation.[16] The COVID-19 pandemic has amplified the stress of having children in the home, as well as concerns around fair compensation as described above. The consequences of this have yet to be fully realized but may be dire.

PROPOSED RECOMMENDATIONS

We propose the following recommendations to help mitigate the effects of this epidemic and to continue to move our field forward on our path to equity.

1. Closely monitor the direct and indirect effects of COVID-19 on female hospitalists. While there has been a recent increase in scholarship on the pre–COVID-19 state of gender disparities, there is still much that is unknown. As we experience this upheaval in the way our institutions function, it is even more imperative to track gender deaggregated key indicators of wellness, burnout, and productivity. This includes the use of burnout inventories, salary equity reviews, procedures that track progress toward promotion, and even focus groups of female hospitalists.

2. Inquire about the needs of women in your organization and secure the support they need. This may take the form of including women on key task forces that address personal protective equipment allocation, design new processes, and prepare for surge capacity, as well as providing wellness initiatives, fostering collaborative social networks, or connecting them with emergency childcare resources.

3. Provide a mechanism to account for lack of academic productivity during this time. This period of decreased academic productivity may disproportionately derail progress toward promotion for women. Academic institutions should consider extending deadlines for promotion or tenure, as well as increasing flexibility in metrics used to determine appropriate progress in annual performance reviews.

4. Recognize and reward increased efforts in the areas of clinical or administrative contribution. In this time of crisis, women may be stepping up and leading efforts without titles or positions in ways that are significant and meaningful for their group or organization. Recognizing the ways women are contributing in a tangible and explicit way can provide an avenue for fair compensation, recognition, and career advancement. Female hospitalists should also "manage up" by speaking up and ensuring that leaders are aware of contributions. Amplification is another powerful technique whereby unrecognized contributions can be called out by other women or men.[17]

5. Support diversity, inclusion, and equity efforts. Keeping equity targets at the top of priority lists for goals moving forward will be imperative. Many institutions struggled to support strong diversity, inclusion, and equity efforts prior to COVID-19; however, the pandemic has highlighted the stark racial and socioeconomic disparities that exist in healthcare.[18,19] As healthcare institutions and providers work to mitigate these disparities for patients, there would be no better time to look internally at how they pay, support, and promote their own employees. This would include actively identifying and mitigating any disparities that exist for employees by gender, race, religion, sexual orientation, ethnicity, age, or disability status.

6. Advocate for fair compensation for providers caring for COVID-19 patients. Frontline clinicians are bearing significant risks and increased workload during this crisis and should be compensated accordingly. Hazard pay, paid sick leave, medical and supplemental life insurance, and strong workers' compensation protections for hospitalists who become ill at work are important for all clinicians, including women. Other long-term plans should include institutional interventions such as salary corrections and ongoing monitoring.[20]

SUMMARY

The COVID-19 pandemic will have long-term effects that are yet to be realized, including potentially widening gender disparities in medicine. With the current health and economic crises facing our institutions and nations, it can be tempting for diversity, equity, and inclusion initiatives to fall by the wayside. However, it is imperative that hospitalists, leaders, and institutions monitor the effects of the COVID-19 pandemic on women and proactively work to mitigate worsening disparities. Without this focus there is a risk that the recent gains in equity and advancement for women may be lost.

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