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EDITORIALS

We Specialize in Change Leadership: A Call for Hospitalists to Lead the Quest for Workforce Gender Equity

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From a new concept to 44,000 practitioners in just 18 years,[1] there is no doubt that the word "hospitalist" is synonymous with innovation, leadership, growth, and change. Yet 2 articles in this month's *Journal of Hospital Medicine* prove that even our new field faces age-old problems. Although women comprise half of all academic hospitalist and general internal medicine faculty, Burden et al.[2] showed that female hospitalists are less likely than male hospitalists to be division or section heads of hospital medicine, speakers at national meetings, and first or last authors on both research publications and editorials. This is made more concerning given that women are more likely to choose academic hospital medicine careers,[3] as they represent one-third of all hospitalists but half of the academic hospitalist workforce.[2,3] Findings in general internal medicine were similar, except that equal numbers of women and men were national meeting speakers and first authors on research publications (but not editorials). Weaver et al.[4] shed even more light on this disparity, and found that female hospitalists made $14,581 less per year than their male counterparts, even after adjusting for relevant differences. Weaver and colleagues also found other gender-specific differences: women worked more nights and had fewer billable encounters per hospitalist shift than men.

Unfortunately, these trends are not new or limited to hospital medicine. For decades, almost equal numbers of women and men have entered medical school,[5] yet women are under-represented in high status specialties,[6] less likely to be first or senior authors on original research studies compared to men,[7] less likely to be promoted,[8] and women physicians are consistently paid less than men across specialties.[9,10] Simple analyses have not yet explained these disparities. Compared with men, women have similar leadership aspirations[11,12] and are at least as effective as leaders.[13–15] Yet equity has not been attained.

Implicit bias research suggests that gender stereotypes influence women at all career stages.[16–18] For example, an elegant study conducted by Correll et al. identified a "motherhood penalty," where indicating membership in the elementary school parent-teacher organization on one's curriculum vitae hurt women's chances of employment and pay, but actually helped men.[19] Gender stereotypes exist, even among those who do not support their content. The universal reinforcement of such stereotypes over time leads to implicit but prescriptive rules about how women and men should act.[20] In particular, "communal" behaviors, including being cooperative, kind, and understanding, are typically associated with women, and "agentic" behaviors, including being ambitious and acting as a leader, are considered appropriate for men.[21] This leads to the "think leader, think male phenomena," where we automatically associate men with leadership and higher status tasks (like first authorship or speaker invitations).[22,23] Furthermore, acting against the stereotype (eg, a woman showing anger[24] or negotiating for more pay[25] or a man showing sadness[26]) can negatively impact wage and employment. Expecting social censure for violating gender norms, women develop a "fear of the backlash" that alone may shape behavior such that women may not express interest in having a high salary or negotiate for a raise.[27–29]

The specific system and institutional barriers that prevent female hospitalists from receiving equal pay and opportunities for leadership are not known, but one can surmise they are similar to those found in other specialties.[10,30,31] The findings of the studies of Burden et al.[2] and Weaver et al.[4] invite investigation of new questions specific to hospital medicine. Why are women in hospital medicine working more night shifts? Does this impact leadership or scholarship opportunities? Why are women documenting less productivity? Are they spending more time with patients, as they do in other settings?[32] What influences their practice choice? We would like to believe that there is something about hospital medicine that can explain the gender differences identified in these 2 studies. However, these data should prompt a serious and thorough examination of our specialty. We must

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accept that despite being a new specialty and a change leader, hospital medicine may not have escaped systematic gender bias that constrains the full participation and advancement of women.

But we believe that hospitalists—innovators and change leaders in medicine—will be spurred to action to address the possibility of gender inequities. We do not need to know all of the causes to begin to address disparities, of every type, on an individual, institutional, and national level. As individuals, we can acknowledge that there are implicit assumptions that influence our decision making. No matter how unintentional, and even conflicting with evidence, these assumptions can lead us to judge women as less capable leaders than men or to automatically envision a "high salary" for a woman and man as different amounts. However, these automatic gender biases function as habits of mind, so they can be broken like any other unwanted habit.[33] Institutionally, we can also hold ourselves accountable for transparency in mentorship, leadership, scholarship, promotions, and wages to ensure diverse representation. We should routinely examine our practices to ensure the equitable hiring, pay, and promotion of our workforce.[18] National organizations and their respective journals should actively pursue diverse representation in leadership and membership on boards and committees, award nominees and recipients, and opportunities for invited editorials. Hospital medicine—being young, innovative, and committed to change—is uniquely well suited to lead the charge for workforce equity. We can, and will, show the rest of medicine how it is done.

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