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Hillary, SGIM, Glass Ceilings, and Transparency

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As I write this column, it is looking more and more as if Hillary Clinton will rise above our country's most visible glass ceiling to become president of the United States. There are so many reasons I hope she wins—reasons more important than the fact that she is a woman, although I've been thinking a lot about that fact. Maybe I just want to be able to say someday that she and I were both president at the same time. More seriously though, I've been thinking about the importance of a woman as president both because of some ongoing work I'm doing in my day job and because a host of recent research studies and articles in the lay press shows there is still a glass ceiling for women in medicine—or at least, there is still a lot of gender inequity in many parts of clinical and academic medicine. Lower pay for the same work, gender differences in National Institutes of Health funding, slower rates of academic advancement, and disproportionately low representation in leadership positions continue to be problems for women in academic medicine (and for minorities in many of the same ways, also) despite no difference in initial career aspirations.[1-5]

Just over two years ago, I was asked to "fix the women's problem" in my department of medicine. During lunch for a visiting professor, the frustration of a large group of women faculty was palpable. The professor then reported back to our department chair about the lunchtime conversation. He proceeded to assemble a group of women faculty he knew relatively well and asked us to work on the issues brought forward.

Until recently, I had not really looked at my work environment through a gender-oriented lens. My medical school class had 40% women, my primary care residency program was about half women, and in my first two faculty jobs there were many women role models and enough women leaders that I didn't feel a landscape or a future determined by my gender. My major professional society, SGIM, always seemed to have plenty of women members and leaders.

However, as I've advanced in years and in my career—or perhaps as I've picked my head up out of the sand—it has started to become obvious to me that the system is not always set up to encourage transparency and equity or to discourage bias. In my work in my home department, we have learned that most leadership jobs are given out without a "process." These are positions that don't require national searches but might be very substantial leadership roles with protected time and power. Examples include medical director of a practice, a division's research chief, or even a residency program director. A chair's convenience sample of potential candidates might not include the best or most innovative faculty member; jobs given out without a formal process can lead to the perception of bias even when the best candidate gets the job.

Like at many of your institutions, photos of former department chairs (all men), former chairs of the board (all men save one), and former hospital presidents (all men) line many of our boardrooms and corridors. These visual cues send implicit messages to women students and residents, not to mention faculty members. Even in speaking invitations for the residents' noon conference or the department's medical grand rounds, organizers can unintentionally contribute to unequal distribution of opportunity for advancement. My department's salary system relies on individual negotiation; raises typically come only to those who ask (and we know from many previous studies which gender asks more often). As we've tried to review salaries in the department, we have come to appreciate not only the complexity of our system and the many salary inputs but also the variety of resources that contribute to income, such as rooms, procedure suite time, or the assignment of fellows or nurse practitioners.

The combination of national politics and my own work-based political challenges around gender equity led me to wonder how SGIM, the Association of Chiefs and Leaders in General Internal Medicine (ACLGIM), and our organizations' members are doing in leadership achievement by gender. Many thanks to Kay Ovington and Jillian Gann from the SGIM office for pulling these data regarding the proportion of women who are members, professors, and division chiefs (Table 1, personal communication, August 12, 2016). Many division chiefs aspire to become department chairs; thanks to Bergitta Controneo and Sheila Costa for sharing information from the Alliance of Academic Internal Medicine (AAIM) about

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how many women (both generalists and specialists in AAIM) hold educational leadership positions (e.g. clerkship director, residency director) and who are department chairs (personal communication, August 8, 2016).

What do I take away from Table 1? First, about SGIM. Unexpectedly (at least to me), our society has continued to have substantial increases in the percent of members who are women since 2000. Women are now the majority of our members. In the early decades, men were the majority of members and held most leadership positions in the organization, but since 2000, nearly half of SGIM presidents have been women. It's great news that we are doing well with women as leaders; however, we have not done nearly as well with the winners of our major awards. Listed on the SGIM website are three "career achievement" awards—the Glaser (achievement across generalist domains), the Eisenberg (career achievement in research), and the Career Achievement in Medical Education awards.[6] Examination of the lists of past winners shows that a very small fraction of award winners has been women—even for awards begun in 1996 and 2001. In fact, the Career Achievement in Medical Education Award, an area where women have been leaders for many years, saw its first female awardee nearly 15 years after it was created in 2010.

ACLGIM's statistics are interesting. ACLGIM's name, "Chiefs and Leaders," suggests that membership is limited to those who are leaders of some variety; members must somehow self-identify as leaders and then join. Psychologists report that women often downplay their roles and take less credit than they are due. It's therefore encouraging that 40% of ACLGIM's members are women. However, it's disappointing that only 23% of members who are general internal medicine division chiefs are women.

AAIM is also an organization made up of leaders. Under the AAIM umbrella sit five member organizations, including the Association of Professors of Medicine (the organization of chairs of internal medicine departments), the Clerkship Directors, and the Association of Program Directors in Internal Medicine. It is encouraging to see the substantial proportion of educational leaders who are women. And although the number of women who chair departments of medicine is a small percentage, the absolute number is much higher than I had thought it would be.

How many future SGIM women will follow Wendy Levinson and Kat-

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Table 1. Representation of Women by Category: SGIM, ACLGIM, AAIM[6]

	Total	Number of Women	Proportion of Women
SGIM Members:			
2000	2,763	774	28%
2005	2,971	1,188	40%
2010	2,891	1,388	48%
2015	3,107	1,616	52%
SGIM Full Professors	487	218	45%
SGIM Presidents, 1978-	39	9	23%
SGIM Presidents, 2000-	17	8	47%
SGIM Career Achievement Awards Glaser 1986-	31	4	19%
Career in Med Ed 1996-	21	4	19%
Eisenberg 2001-	16	3	19%
ACLGIM Members	179	72	40%
ACLGIM Division Chiefs	73	17	23%
ACLGIM Presidents	15	6	40%
AAIM Members (MD only)	7,797	2,807	36%
AAIM Clerkship Directors	195	83	43%
AAIM Program Directors	415	135	33%
AAIM Chair/Interim Chairs Dept of Medicine	134	22	16%

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rina Armstrong—two SGIM leaders and former general medicine division chiefs who have gone on to chair major academic departments of medicine? To ensure a pipeline, our medical centers and departments still have a long way to go toward gender equity and the promotion and retention of women leaders.

There is a complex web of reasons why inequity persists, and there are no simple solutions. However, simple transparency plus cataloging and counting are places to start. Here are a few simple no-cost interventions that might make a difference where you work; they form the basis of some of my group's initial strategy within our department:

1. All positions that bestow title, money, or power should be offered publicly with a transparent selection process.
2. Every unit or division should commit to an annual salary review looking specifically at salary equity but also at space, equipment, and personnel if pertinent.
3. Visible signals matter; survey your hallways and conference rooms with fresh eyes, and be sure that what is on your walls sends the message you intend.
4. Be sure that each faculty member has appropriate named mentorship, and learn how to best reward and value those mentors.
5. Not everything that can be counted counts, but counting is a great first step. Develop an annual dashboard: number of applicants and demographics for each open position even if internal; proportion of grand rounds speakers who are women (and minorities); proportion of photos of women in your annual report and on your website; and number of women and men put up for promotion each year. Make the dashboard and its results transparent.

Hillary Clinton has announced that she plans to be sure at least half her cabinet members are women.[7] I'm not a big fan of that strategy—I would think she would want the best candidate for each of those jobs—and I bet a good number of those would be women. I hope she will use a fair, open, and transparent process to choose those cabinet members. And I hope that, after the election, we have a picture of a woman president to hang on the walls with all the paintings of men.

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