

Gender Disparities in Urology: How Can We Close the Gap?



Women in urology are a growing fraction of our workforce with 2017 American Urological Association (AUA) census data revealing 8.8% of practicing urologists and approximately 36% of urology trainees are female.¹ While this growth is encouraging, women are historically known to have decreased rates of promotion, compensation and receive fewer opportunities leading to career advancement.² The aforementioned census data reveal that women are infrequently represented as full professors in comparison to men in academic settings.

Recent data reveal that the representation of women at the AUA annual meeting has begun to match the national average. However, it is still less than expected in certain arenas including course instructors and course directors.³ Women are generally well represented in leadership roles across urology however underrepresented in the American Board of Urology, the AUA board of directors and as Urology department chairs.⁴ In regards to compensation disparity, a survey of AUA members found that female urologists receive median salary of \$81,587 less compensation compared to their male counterparts with a persistent disparity of \$76,321 less after adjusting for work hours, call frequency, age, practice type, and practice setting (Fig. 1).⁵ Several areas for improvement in gender equality within urology exist. (Table 1)

Women bring increasing value to training programs and for patient care. Having a diverse faculty allows women trainees to have accessible female mentors from whom they can seek advice and guidance for concerns related to child-bearing, negotiation of maternity leave, and navigation of issues related to gender equity. Women's approach to patient management is often distinctly different from that

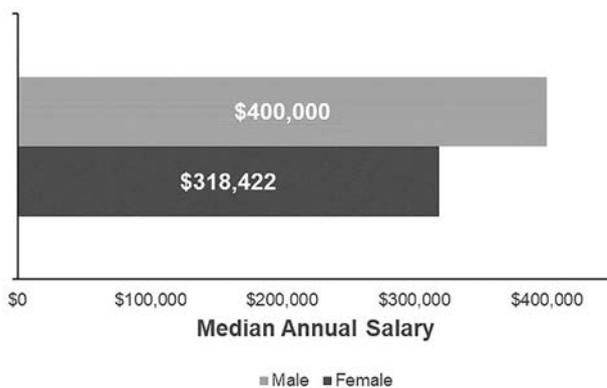


Figure 1. Compensation disparity based on gender*.
*Data from Spencer ES, et al, J Urol 2016.

Table 1. Areas for improvement in gender disparity in urology.

Compensation
Increase representation of female course instructors/directors at the AUA annual meeting.
Increased representation in specialty society board of directors (ie, AUA, ABU).
Promotion of junior and midcareer female faculty in academic medical centers.

of their male counterparts which is associated with reduced readmissions and patient mortality.⁶

Despite the clear benefits of gender diversity in urology, gender bias still exists. Implicit bias, or bias that exists but is unaware to oneself, is one key factor. This is often demonstrated when disregarding women candidates for promotion or higher level opportunities. As the proportion of women in urology continues to rise, we have an obligation to implement system-wide change within our institutions/practices that supports gender equity. Below is a list of actionable items to consider.

1. *Implicit bias training:* Implement implicit bias training mandatory for your practice or department, including organizational leadership, physicians, and other health care providers. Ensure this training is concise to minimize burden and maximize efficacy. Recognize implicit bias in letter of recommendations written for females.
2. *Encourage transparency:* Consider transparent reporting of RVUs, collections, salary, and bonus structure for all faculty/partners. Allow for annual or biannual salary and career reviews available to all employees. Review the gender salary equity statement published by the American College of Surgeons⁷
3. *Consider flexible promotion/partnership tracks:* Consider offering alternative tracks for academic promotion including "clinical educator track" and clearly address the impact of parental leave on time to promotion or partnership. Make criteria for promotion or partnership explicit with clear trackable and achievable goals.
4. *Have clear parental leave policies:* Conduct clear discussions with new hires in regards to length of paid/unpaid leave, the use of Female Medical Leave Act (FMLA) and length of time one needs to be employed prior to utilizing this policy. Specify how leave will impact productivity goals, promotion track and overhead costs. Institute policies that allow for adequate parental leave for men and women, create on-site lactation rooms that are accessible with necessary accommodations to optimize productivity. Create on-site childcare services. Consider allowing flexible schedules upon return from leave to optimize employee satisfaction and reduce burnout.
5. *Sponsor women:* Consider women for leadership or speaking opportunities. Encourage equal gender representation

on committees, panels, and board of directors. Recognize and amplify accomplishments and contributions of women in your practice or department. Speak up when you see implicit or overt gender bias.

6. *Increase funding opportunities for women*: Recent investigations reveal a gender disparity in the amount of NIH funding received by first time female and male principal investigators with a mean difference of \$39,106.⁸ Consider targeted funding opportunities for women and formalized mentoring programs. Consider using nongendered terms in applications for funding.⁹

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References

1. American Urological Association: The state of urology workforce and practice in the United States 2017. 2018. Available at: <https://www.AUAnet.org/common/pdf/research/census/State-Urology-Workforce-Practice-US.pdf>, accessed June 22, 2018.
2. Valsangkar N, Fecher AM, Rozycki GS, et al. Understanding the barriers to hiring and promoting women in surgical subspecialties. *J Am Coll Surg*. 2016;223: 387-398.e2.
3. Souders C, Wong D, Anger J, et al. MP02-19 speaking roles of women urologists at annual aua meetings: a proposed index of gender representation. *J Urol*. 2018;199:e19–e20. Available at: <https://www.jurology.com/doi/abs/10.1016/j.juro.2018.02.145>. accessed January 24, 2019.
4. Cancian Madeline, Aguiar Liza, Thavaseelan Simone. The representation of women in urological leadership. *Urol Pract*. 2018;5:228–232.
5. Spencer ES, Deal AM, Pruthi NR, et al. Gender differences in compensation, job satisfaction and other practice patterns in urology. *J Urol*. 2016;195:450–455.
6. Tsugawa Y, Jena AB, Figueroa JF, et al. Comparison of hospital mortality and readmission rates for medicare patients treated by male vs female physicians. *JAMA Intern Med*. 2017;177:206–213.
7. August 2 O and 2017: Statement on gender salary equity. Am Coll Surg Available at: <https://www.facs.org/about-acs/statements/101-gender-salary-equity>, accessed January 25, 2019.
8. Oliveira DFM, Ma Y, Woodruff TK, et al. Comparison of National Institutes of Health Grant Amounts to first-time male and female principal investigators. *JAMA*. 2019;321:898–900.
9. Alvarez SNE, Jaggi R, Abbuhl SB, et al. Promoting gender equity in grant making: what can a funder do? *Lancet*. 2019;393:e9–e11.

striving to hire and retain female urologists. In fact, well-defined leave benefits, productivity targets, salary components, bias training, and other examples a fair employee treatment should be provided to all urologists when considering joining a practice, not just women. Such clearly explained benefits are common place in federal and academic practices which may explain, in part, why women urologists gravitate toward these jobs despite lower compensation.

For practices eager to hire women urologists, whether academic, hospital-based, or independent practices, awareness of the contractual issues that can be perceived as unfair and biased is critical to successful recruitment. For practices already fortunate enough to have women urologists among their ranks, consider what measures can be taken to retain those individuals.

The responsibility also falls on those urologists, both male and female, that are seeking employment or considering renegotiating a contract. Asking for clarification on benefits and expectations for promotion or partnership is appropriate. If a potential employer is unwilling to provide such clarification, that fact should send a strong message regarding how the urologist will be treated by that employer.

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<https://doi.org/10.1016/j.urology.2019.05.060>

UROLOGY 133: 3, 2019. © 2019 Elsevier Inc.

EDITORIAL COMMENT



The authors point out many gender disparities in the field of urology. Many are being rapidly addressed in our field. One example is the focused effort by organizers of the American Urological Association Annual Meeting to include women as expert panelists and presenters of meeting highlights. Similarly, the Trustees of the American Board of Urology are 17% female even though the proportion of urologists that trained 20-25 years ago to have reached the level of eligibility for Trustee is only approximately 6% female.

The authors provide an excellent outline of contract components that should be considered by practices

AUTHOR REPLY



The field of urology is certainly making strides to address gender disparity. However, there continue to be outstanding concerns of implicit bias that mitigate efforts toward gender equality and continue to impact women and underrepresented minorities in the workplace even after contractual negotiations are undertaken. Both men and women participate in unconscious behaviors and beliefs that are biased against women¹ and subsequently contribute to significant delays in

time to promotion, decreased publication productivity, grant funding, societal awards, and mentorship for women in comparison to men.²⁻⁴

One example of implicit bias is microaggressions or “subtle snubs, slights, and insults directed towards minorities, women and other historically stigmatized groups, that implicitly communicate or at least engender hostility.”^{5,6} While many of these overt expressions of bias and discrimination are limited, microaggressions are pervasive and can have significant impact on whether a person feels welcome. These can be as simple as referring to a woman physician by her first name rather than the title “Dr.” or promoting the “myth of meritocracy, which is the belief that hard work pays off and that race or sex play no role in determining a person’s success.”⁵

While transparency in policy may exist in some academic centers, it is often skewed toward the promotion and success of men physicians who more often pursue traditional academic research endeavors while women physicians may focus more on education and service to the university. There are multiple influences on men and women’s career paths, including differing mentorship, sponsorship, and home responsibilities. Ultimately, it’s important for all to continue to recognize and understand unconscious behaviors such as microaggressions and respond to them appropriately.

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References

1. Salles A, Awad M, Goldin L, et al. Estimating implicit and explicit gender bias among health care professionals and surgeons. *JAMA Netw Open*. 2019;2. e196545-e196545. <https://doi.org/10.1001/jama-networkopen.2019.6545>.
2. Ellinas E, Rebello E, Chandrabose R, Shillcutt S, Hernandez M, Silver J. Distinguished service awards in anesthesiology specialty societies: analysis of gender differences. *Anesth Analg*. 2019. <https://doi.org/10.1213/ANE.0000000000004132>. Publish Ahead of Print.
3. Oliveira DFM, Ma Y, Woodruff TK, Uzzi B. Comparison of National Institutes of Health Grant Amounts to first-time male and female principal investigators. *JAMA*. 2019;321:898–900. <https://doi.org/10.1001/jama.2018.21944>.
4. Saltzman Amanda, Hebert Kristi, Prats Samantha, et al. Women urologists: trends in mentoring and career choices. *Urol Pract*. 2016;3:302–308. <https://doi.org/10.1016/j.urpr.2016.01.005>.
5. Torres MB, Salles A, Cochran A. Recognizing and reacting to microaggressions in medicine and surgery. *JAMA Surg*. July. doi:10.1001/jamasurg.2019.1648.
6. Sue DW, Capodilupo CM, Torino GC, et al. Racial microaggressions in everyday life: implications for clinical practice. *Am Psychol*. 2007;62:271–286. <https://doi.org/10.1037/0003-066X.62.4.271>.

<https://doi.org/10.1016/j.urology.2019.05.061>
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