

Status of Women Faculty in the UCSF DOM

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Introduction: Why we wrote this report

In 2018, the Department of Medicine (DOM) at the University of California, San Francisco (UCSF) undertook the first department-wide work experience survey of our faculty. Nearly 700 faculty responded to the Culture Change (C-Change) survey, a survey developed and validated by the National Initiative on Gender, Culture and Leadership in Medicine at Brandeis University. Forty-six percent of respondents identified as women, 11% as Underrepresented in Medicine (UIM), and 8% as LGBTQ. Respondents represented faculty across a range of divisions, career stages, and clinical sites. The survey was the first in which DOM has formally explored the vitality and engagement of our faculty.

Through the survey, we learned that women in DOM are overall younger than men, more likely than men to have been at UCSF for fewer than 10 years, more likely to hold the rank of assistant rather than associate or full professor, and more likely to work part time and have children under the age of 18 at home or responsibilities for caregiving of elderly or disabled adults. Women across the UCSF DOM are also slightly more likely to work primarily as clinicians, and women research faculty are more likely to do clinical, translational or health services/health policy research – and less likely to do basic research – than men.

While overall our faculty reported high levels of engagement and work satisfaction, we also learned that women are less likely than men to look forward to coming to work, more likely to feel burned out, and less likely to feel advancement is as open to them as anyone else. Even more concerning, more women faculty often feel that they are ignored, isolated or invisible, that they need to hide what they feel and think, that their input doesn't make a difference in decisions that affect them, and that it is difficult to succeed without sacrificing personal and family commitments. Taken together, responses to the C-Change survey indicate that women have higher levels of concern that gender bias adversely affects female faculty and that UCSF treats men and women differently with respect to promotion.

Though each of our three main clinical sites/organizations – UCSF Health (comprised of Parnassus, Mission Bay, and Mt. Zion sites), Zuckerberg San Francisco General Hospital (ZSFG), SF Veterans Health Care System (VA) – had unique themes and struggles in the C-Change survey, the experiences and concerns of women faculty in DOM were consistent across sites. Women faculty across the United States and Europe have reported similar concerns on this survey, drawing attention to issues of gender and UIM equity and the need for institutions to bolster women's feelings of self-efficacy in career advancement.¹

As we shared these results across the DOM, the survey responses and informal conversations raised many questions. Are women in fact paid less than men for the same work in UCSF DOM? Are women faculty promoted and accelerated at different rates than men? If disparities exist, what changes should we make to address them? How can we tease apart the interrelated factors that negatively influence women's experience as faculty members in DOM, and address as many of them as possible?

We acknowledge the changing environment outside and within academic medicine since these data were collected and this report was conceived. These changes are myriad and include the COVID-19 pandemic and increased recognition of racism, specifically acknowledgement of violence against African-Americans and a growing awareness of the prevalence of Asian-American/ Pacific Islander hate.

Much has been written about the impacts of racism and gender bias in academic medicine, and we would not expect our department to remain unaffected by this wider climate.

Since the COVID-19 pandemic began, closures of in-person school, the need to shift to working at home while also caring for and supporting the learning of young children, the pressure to shut down research programs and/or adapt them in new, pandemic-focused directions, and managing fears of illness and infecting loved ones while caring for patients all placed unique demands on women faculty throughout the U.S. and here at UCSF.

While this survey does not provide specific data about intersectional considerations of race, ethnicity, and gender, it is crucial to better understand and address the experiences of women of color in academic medicine. As we grapple with changes to the workplace catalyzed by the pandemic, DOM has an opportunity to change our culture to make it more supportive and equitable, for the benefit of all.

Focus and format of this report

Below we present brief descriptive statistics regarding women faculty in the UCSF DOM, including information on rank and series. Following these data, the report is organized as a series of questions we had about women's status in DOM. For each question we provide a brief background, data if available, an analysis, and suggestions for next steps. We include information about race and ethnicity when available, acknowledging the limitations of data presented by gender alone. Please note the dates for data collection throughout the report; the pandemic and a subsequent leadership transition led to a delay between the administration of the C-Change survey and the current report. We have used the most up-to-date information possible. Therefore, the report includes 2021 Net Promoter Score Data and 2018 C-Change data. (We plan to re-administer the C-Change survey in late 2022.) We conclude this report with information about exemplary programs already in place and several suggestions regarding what the DOM can do to strengthen the experience, voices, and engagement of women faculty.

While we chose to focus this report on women faculty in DOM, we recognize that most of the women employed by the DOM are staff, rather than faculty or trainees. Efforts to better understand staff experience and address gender and racial inequity will likely have a positive impact on our entire workplace culture and deserve their own focus and attention.

A survey of the landscape

The broader context: evidence for gender inequity in academic medicine

The disparity between men's and women's salaries for equal work is a well-known national phenomenon: across all industries, white women make 79 cents for every dollar a man makes, African-American women 62 cents, Latinas 54 cents, Asian-American women 90 cents, and Native American women 57 cents.² Academic medicine is not immune to these disparities – a 2013 study demonstrated an average pay gap of over \$51,000/year between men and women at U.S. public medical schools.³ Women physicians' career progress often falls victim to a "motherhood penalty," in which time lost from childbearing/childrearing leave and a higher probability of part-time work can negatively impact career progression, promotion timelines, and salary.⁴ This pay gap even extends to leadership roles, such that after adjustment for term length, specialty, inflation, title, regional cost of living, and academic productivity, male leaders in academic medicine have higher salaries than women leaders.⁵

In the domains of clinical care, research, and education, peer-reviewed literature demonstrates marked inequities between men and women in academic medicine. In the delivery of clinical care, women physicians have been demonstrated to have modestly better patient outcomes in inpatient⁶ and outpatient⁷ settings. Women are also more prompt in responding to patient messages, reviewing results, and spend more time documenting care in the electronic health record.^{8,9} Compared to male physicians, women are also less likely to face malpractice litigation. Unfortunately, women subspecialists are less likely to receive referrals than their male colleagues, especially from male referring physicians.¹⁰

As educators, women also face significant implicit bias. Randomized, experimental data demonstrates that lecture transcripts¹¹ and online instruction¹² are rated as worse if attributed to women compared to men. In the field of research, data demonstrate lower salaries¹³ and smaller lab start-up packages¹⁴ for women scientists. Women scientists also take longer to receive independent R01 grant funding than their male colleagues.¹⁵ Even when women do receive grants, the funding amount is less – first-time female NIH grant awardees receive, on average, \$40,000 less than men.¹⁶ Women full professors are less likely to hold endowed chairs that provide financial support, even after adjustment for scholarly performance.¹⁷ Women scientists are also disadvantaged because male scientists systematically undercite the work of their female colleagues,¹⁸ and citation indices influence advancement. A randomized study demonstrated that identical research faculty CVs were rated as worse if they were labeled as a female compared to a male scientist.¹⁹ Women scientists perform more uncompensated service in the form of peer reviews than their male colleagues.²⁰ Similarly, in the increasingly important realm of social media, data from a national scientific meeting demonstrated that men did not "like" or retweet women's Twitter posts as often, so that women scientists at the meeting tweeted as much as men but did not garner as much influence.²¹

Nationally, there are known advancement disparities in academic medicine. While graduating medical school classes have been at least 50% female since 2003,^{22,23} today only 20% of full professors of medicine in the U.S. are women. In a 2020 cohort study published in the *New England Journal of Medicine*, women who graduated from medical school after 1997 were 38% less likely to be promoted to full professor than men²⁴ graduating in the same cohort.

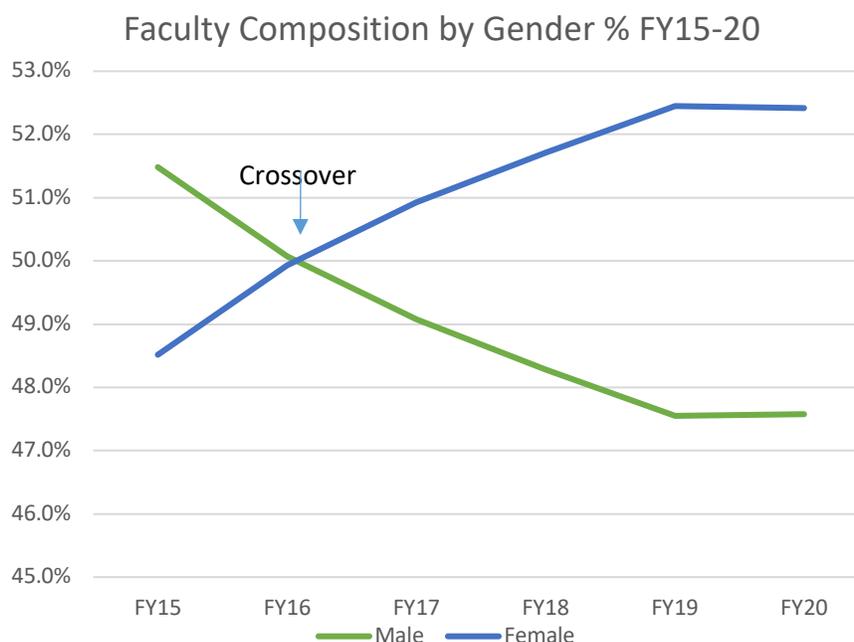
The local landscape

UCSF has come a long way as an institution since admitting the first women to study medicine in the 1870s (Appendix 1). Women now make up 53% of our faculty (UCSF-DOM, 2020);²⁵ they became the majority in 2016. Women also account for 56% of all enrolled medical students (UCSF-OIR, 2020).²⁶ It is important to note that gender/gender identity reporting in the PRISM system (the DOM faculty database that served as the source of the faculty data below) is limited by a binary designation and therefore does not explicitly include those who may identify using non-binary gender language.

Table 1. Total Faculty by Gender, 2019

Female	Male	Total
465	409	874
53.2%	46.8%	100%

Figure 1. Faculty Composition Trend, Five Years



To better understand the status of our women faculty in other dimensions, we conducted additional descriptive analyses, shown below. These graphs highlight the preponderance of women faculty at the assistant and associate professor levels and in the Health Sciences (HS) Clinical Series (with similar numbers of women and men in the academic senate series, Clinical X and In Residence).

Figure 2: Rank by Gender

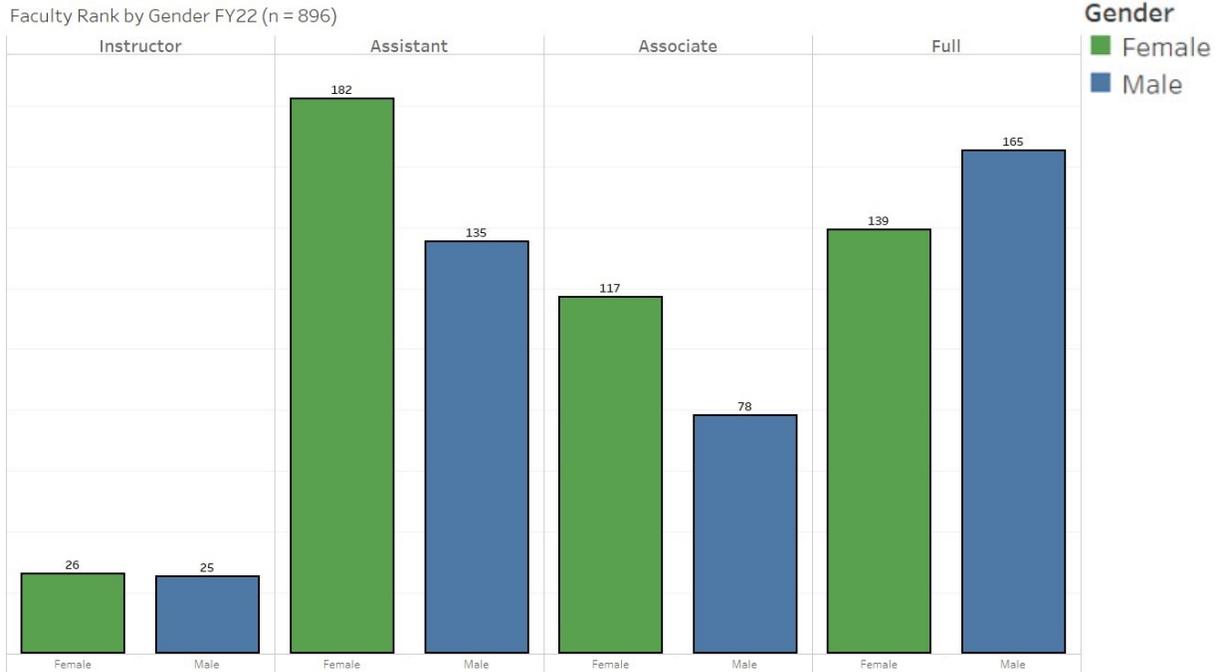
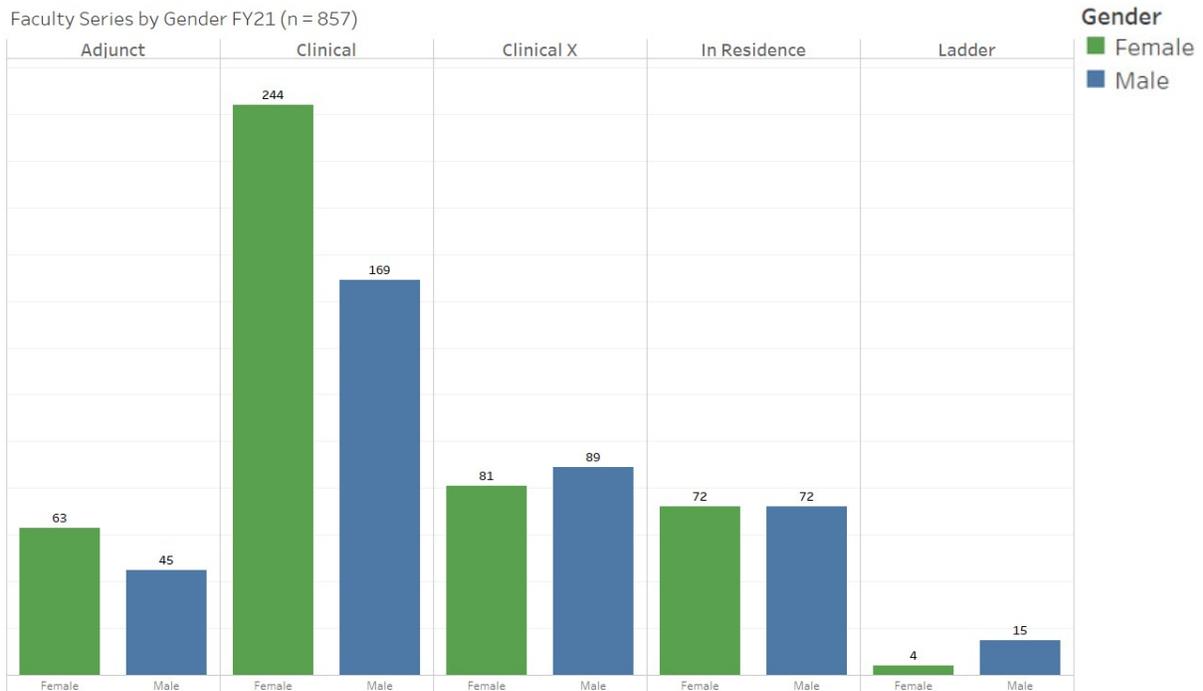


Figure 3: Series by Gender



Q: Is there salary parity between men and women in UCSF DOM? How did the COVID pandemic temporary salary freeze affect women and men in DOM?

Although the peer-reviewed literature has demonstrated multiple factors underlying inequities in academic medicine, this report examines pay equity specifically. The analysis below is cross-sectional, which gives us a snapshot of pay equity at a given time. We do not have the data to permit a longitudinal analysis that examines faculty pay over time. Moreover, the analysis below does not address the extent to which UCSF DOM experiences the same structural inequities as the broader landscape of academic medicine.

In 2014, UCSF created the Faculty Salary Equity Review (FSER) Committee to conduct regular equity analyses of faculty salaries and address any inequities identified.^{27,28} Beginning in FY15, DOM prepared its own analysis of compensation to complement the salary analysis done by the UCSF School of Medicine. This analysis accounted for VA pay differences, as well as for an unequal distribution of women across higher and lower paying internal medicine subspecialties. DOM's analysis focused on the X component (base salary per UC faculty salary scales) and the Y component (negotiated compensation) but did not take into account Z compensation (incentive and moonlighting pay). The initial analysis in FY15 found that the compensation of women was 3.9% lower than that of men, a difference that reached statistical significance. In contrast, there was no statistically significant differences in the salaries of women PhDs or the salaries of URM faculty in either the MD or PhD cohort.

DOM repeated its regression analysis of X+Y compensation in FY16. It identified several imbalances that could not be explained or justified. As a result of this analysis, 43 women faculty received equity adjustments (totaling \$213K) in their FY16 X+Y compensation. A repeat regression analysis for FY16 that included these equity adjustments no longer found any statistically significant differences in the compensation of women faculty.

Subsequent regression analyses of FY17, FY18, and FY19 data continued to include multiple variables, including rank/step, subspecialty, K awardee status, and major leadership roles. After accounting for all of these variables, across all of the years, there was no statistically significant difference in the compensation of either women faculty or URM faculty:

Table 2:

FY Data	Faculty Cohort	Female		URM	
		Coefficient	p-value	Coefficient	p-value
FY17 X+Y+VA , FY16 Z	MD only	-0.0190	0.0760	0.0040	0.8320
FY18 X+Y+VA, FY17 Z	MD + Phd	-0.0287	0.0562	0.0031	0.9033
FY19 X+Y+VA, FY18 Z	MD + Phd	-0.0250	0.0930	-0.0080	0.7430

For the two years that Z compensation was included in DOM's analysis, there was a statistically significant negative gender coefficient for Z compensation—but not for X+Y compensation or for total compensation:

Table 3:

FY Data	Faculty Cohort	X+Y		Z	
		Coefficient	p-value	Coefficient	p-value
FY17 Z	MD + PhD	-0.0178	0.1860	-0.7685	0.0000
FY18 Z	MD + PhD	-0.0190	0.1270	-0.8130	0.0010

For purposes of the Equity Review analysis, Z payments include incentive payments (66%) and moonlighting payments (34%) but exclude leadership stipends and outside income. Incentive and moonlighting payments in DOM account for only ~5% of faculty compensation. While it seems likely that these additional Z payments represent choices by men and women regarding their desire to perform additional clinical work, there may be biases in working conditions or opportunities for such work that should be further explored. In the FY19 FSER analysis, there was no statistically significant gender coefficient for either XYZ compensation or XY compensation.

In FY21, as a measure to mitigate the economic fallout from COVID, the School of Medicine mandated that faculty salaries be frozen, with no merits, promotions, or COLAs. Some raised the concern that women, who make up a larger percentage of early-career faculty than men, and who are up for merit increases more often as a result (eligibility for merit advancement occurs every two years for assistant and associate professors and every three years for professors), might feel the effects of the freeze more than men. However, our analysis of faculty salaries in **DOM found that the salary freeze affected men and women equally** (see Appendix 2 for further analysis).

Most recently, in its FY22 FSER analysis, DOM identified a negative gender imbalance of 2.9% in XYZ compensation that reached statistical significance. But once again DOM found no statistically significant negative gender imbalance with respect to XY MD compensation.

The primary change driving the gender imbalance in XYZ compensation in FY22 are the Z payments: DOM's analysis pointed to a statistically significant negative gender imbalance of 35.9% in MD Z payment. Specifically, MD Z payments have grown disproportionately since the FY19 FSER analysis due to an increase in internal moonlighting. More so than clinical incentives, moonlighting payments have gone disproportionately to men (59% to men compared to 41% to women). To test the hypothesis that moonlighting payments were driving the XYZ and Z gender imbalance, DOM conducted a supplemental analysis, including only clinical incentives in its Z payments while excluding internal moonlighting payments. In this supplemental analysis, there was no statistically significant gender imbalance in either XYZ, XY, or Z compensation for MDs – again indicating that moonlighting payments are driving the small gender imbalance in faculty Z payments.

By policy, moonlighting opportunities are available to all faculty on a gender-neutral basis. However, there are a few factors that likely tilt moonlighting payments towards men. In at least one sub-specialty with substantial moonlighting compensation, seven of the eight faculty physicians are men. In two other divisions with significant moonlighting opportunities, women outnumber men, but male physicians volunteer for moonlighting disproportionate to their headcount.

Implications

When we compare the average salary for women DOM faculty to men DOM faculty, women have lower salaries. This difference is possibly explained by five factors: the distribution of women by faculty rank and step (with women more junior on average), subspecialty (with women more highly represented in lower paid specialties, on average), holding a K award (K awardees tend to be paid less than their clinical counterparts because of salary support limits set by K awards, and women are more highly represented in the current cohort of K awardees), moonlighting (men are more likely to volunteer for moonlighting and/or are over-represented in specialties with lucrative and frequent moonlighting) and holding a leadership role (despite progress in this regard – see below – men are still more likely than women to hold such positions). To achieve true gender salary parity, each of these factors needs to be examined for bias, and for potential department-level strategies to address any biases.

Taking each in turn, rank/ step is determined by seniority and ongoing career progression. We hope that the increasing number of women joining the faculty as assistant professors will rectify any disparities due to career rank/step over time. To make this goal a reality, however, the promotions process must be fair and women faculty must be retained. Steps to enhance equity in the promotions process are discussed below.

Second, gender distribution varies widely across subspecialties, inside and outside of UCSF. Women are more likely to go into lower paying subspecialties, both locally and nationally. As a leader in medical education, UCSF DOM can explore and address cultural or other biases that stand in the way of a more equitable distribution of women across the specialties of internal medicine.

Third, the proportion of female K awardees is steadily increasing: in 2020, 55% of NIH mentored career awards went to women.²⁹ Our goal is that many of these K awardees will ultimately progress to senior faculty positions in the department, with higher pay.

Finally, leadership roles – which may be associated with significant salary support and/or stipends – are determined at the institutional and often at the departmental level. Future analyses will specifically examine to what extent leadership roles lead to salary disparities and accordingly inform an action plan. Evidence-based actions such as advertising and searching leadership positions and applying UCSF Office of Diversity's recommendations for equitable searches (discussed below) are now being implemented for leadership searches in the department.

The gender imbalance in Z payments also invites further efforts to promote equity. Potential equity strategies include achieving greater gender diversity in clinical subspecialties that currently offer more incentive pay and/or moonlighting opportunities; revising incentive programs in the other clinical subspecialties to provide more incentive opportunities; and providing more moonlighting opportunities in other divisions. Another approach might be to develop mechanisms to distribute the essential, unpaid labor of academia – like teaching, mentoring, and committee work – more equitably, thereby freeing up more of women's time to improve wRVU productivity or take on additional clinical shifts for pay if desired.

Other relevant equity strategies include UCSF's commitment to 12 weeks of paid childbearing *and* childrearing leave. The opportunity for both men and women (in an opposite sex couple) to take 12 weeks of paid leave may help establish years of more equal sharing of parental labor in the home, thereby providing flexibility to women to take on additional clinical work if desired or develop areas of clinical expertise.

Lastly, the innovative practice of time-banking (not currently in place at UCSF),³⁰ whereby faculty are provided with professional or personal support in kind, in exchange for unpaid academic labor, is a step worth exploring.

Conclusions and next steps

Building on its FY22 FSER analysis, the department will perform an unadjusted analysis of the association of gender with salary, and sequentially adjust, adding in one variable at a time to the model, starting with (1) rank-step, and adding in order (2) subspecialty, (3) K awardee status, and (4) major leadership roles. This will allow the department to determine the extent to which each of these salary-determining factors is driving the observed gender differences in salary. We will add the additional category of non-URM Asian race to the model as well, in line with evidence from the American Association of Medical Colleges that point to potential disparities in this group.³¹

As demonstrated by the analyses described above, to truly achieve and maintain salary equity for men and women, DOM must continue to be vigilant regarding changes in our work and economic environments, appreciate the unique value that women physicians add to academic medicine, periodically repeat salary equity analyses to avoid backsliding, and commit to addressing more insidious processes that shape women's and men's career choices.

Q: Are men and women promoted and accelerated equitably?

Promotion is the universal measure of success in academia. At UCSF, one's salary and retirement benefits are tied to rank and step (but not series) in the promotions process. If we are to achieve equality and equity in academic medicine, it is essential that we perform a close examination of our promotions practices, standards, and outcomes. Just as important as reflecting on our outcomes is the need to provide transparency about the promotions process, commit to supporting our faculty to successfully achieve promotions, and chart a strategic course for the future of the promotions process.

The vast majority of faculty in DOM are successful in receiving merit advancements and being promoted to the next rank. For the purposes of this report, we chose to examine accelerations, which represent progression in the promotions process by one, two, or three years beyond the expected rate. We focused on accelerations because at the time of this analysis, accelerations had the least uniformity and transparency of any part of the promotions process and thus may have been more subject to bias. Examining accelerations was more feasible given the availability of relevant data and ***given that the vast majority of our faculty in DOM are successfully promoted***, we felt we would find more variability and opportunities for learning in examining accelerations rather than promotions. We did not examine on-time promotions for this analysis. We asked the question: **Are women and men, and UIM and non-UIM faculty, accelerated at the same rates?**

To answer this question, we examined all faculty in the DOM eligible for a career advancement and active as of November 10, 2020. We identified 138 approved accelerations for those faculty with an effective date of July 1, 2016 to July 1, 2020. We examined potential factors (sex, UIM status, UCSF site, rank, series, and division) associated with acceleration and conducted statistical analyses (Appendix 3).

While women comprised 54% of the faculty, they only comprised 46% of the accelerations (in crude analysis without attention to other factors, men had a 47% higher chance of being accelerated than

women). UCSF site, rank, and series were associated with acceleration. When the analysis was adjusted for these factors, **gender and UIM status were not associated with acceleration** (odds ratio of acceleration for women vs. men, 1.01, 95% CI 0.66-1.56; OR for UIM v. non-UIM, 1.23, 95% CI 0.59-2.55). However, site, rank, and series *were* predictors of acceleration: faculty at ZSFG (OR 1.66 compared to reference group of Parnassus, 95% CI 1.02-2.68), faculty in the Clinical X (OR 4.02, 95% CI 2.10-7.71), In Residence (OR 7.54, 95% CI 4.03-14.10), and Ladder series (OR 9.64, 95% CI 3.52-26.40) all compared to the reference group of HS Clinical series, and increasing faculty rank (OR 1.81, 95% CI 1.30-2.51 considering rank as a continuous variable ranging from 1 for assistant to 3 for Full Professor) were more likely to be accelerated than faculty at UCSF Health or the SFVA, faculty in the HS Clinical and Adjunct series, and assistant professor faculty. Thus, **the observed difference in acceleration, in which more men received accelerations than women, is explained by a higher proportion of men at the associate and full professor level and in the Clin X, In Residence, and Ladder Rank series, rather than by gender-related factors acting independently.**

It is also essential to understand *where* our women and UIM faculty are in the DOM and how that has changed over time. There are more women than men in the HS Clinical and Adjunct series and more women currently at the assistant and associate ranks. We also have more UIM faculty in the assistant professor rank, though there is no statistical difference in the proportion of UIM faculty across series. **Most changes from non-Academic Senate (ie, HS Clinical and Adjunct) to Academic Senate series (ie, Ladder, In Residence and Clinical X) occur at higher ranks (usually at the time of promotion to associate professor), regardless of gender. Therefore, women and UIM faculty may be less likely to be accelerated because they are concentrated in the early career, non-Academic Senate series, a circumstance that we aim (and expect) to change over time.**

We learned several lessons from the process of analyzing accelerations. First, we recognized our obligation to keep close records of promotions and accelerations decisions and review those decisions periodically for equity. Secondly, we appreciated the need to develop clear, consistent guidelines for acceleration at the level of the DOM and disseminate those to our department, so that all division chiefs, and all faculty, are aware of the option to request an acceleration. In part driven by this analysis, in 2018-19, the DOM created a multi-stakeholder process to develop guidelines for acceleration, largely to decrease any potential arbitrariness and bias. **These new DOM acceleration guidelines can be found, along with numerous other helpful resources on the promotions process, on the [DOM website](#).** Additional SOM-level information on the promotions and acceleration can be found [here](#).

Beyond this important departmental work of making the promotions and accelerations process more consistent and transparent, to achieve true gender equity in academic medicine we must wrestle with larger questions, such as: Do faculty of all genders move from their initial series of Adjunct or HS Clinical to Academic Senate series (when desired) at the same rate and over similar time frames? How can we update our criteria for promotion in the research series, such that they reflect current realities of the time needed to achieve independent funding as an investigator and our departmental values of supporting collaboration and creativity? At what point in their careers are we most at risk of losing women and UIM faculty to other positions either within or outside of academia, and how can we more successfully retain them? **Our analysis provides some reassurance about acceleration at the current moment. We are committed to monitoring women faculty careers over time to ensure parity in career trajectory, and, given the known additional disparities for women of color compared to white women**

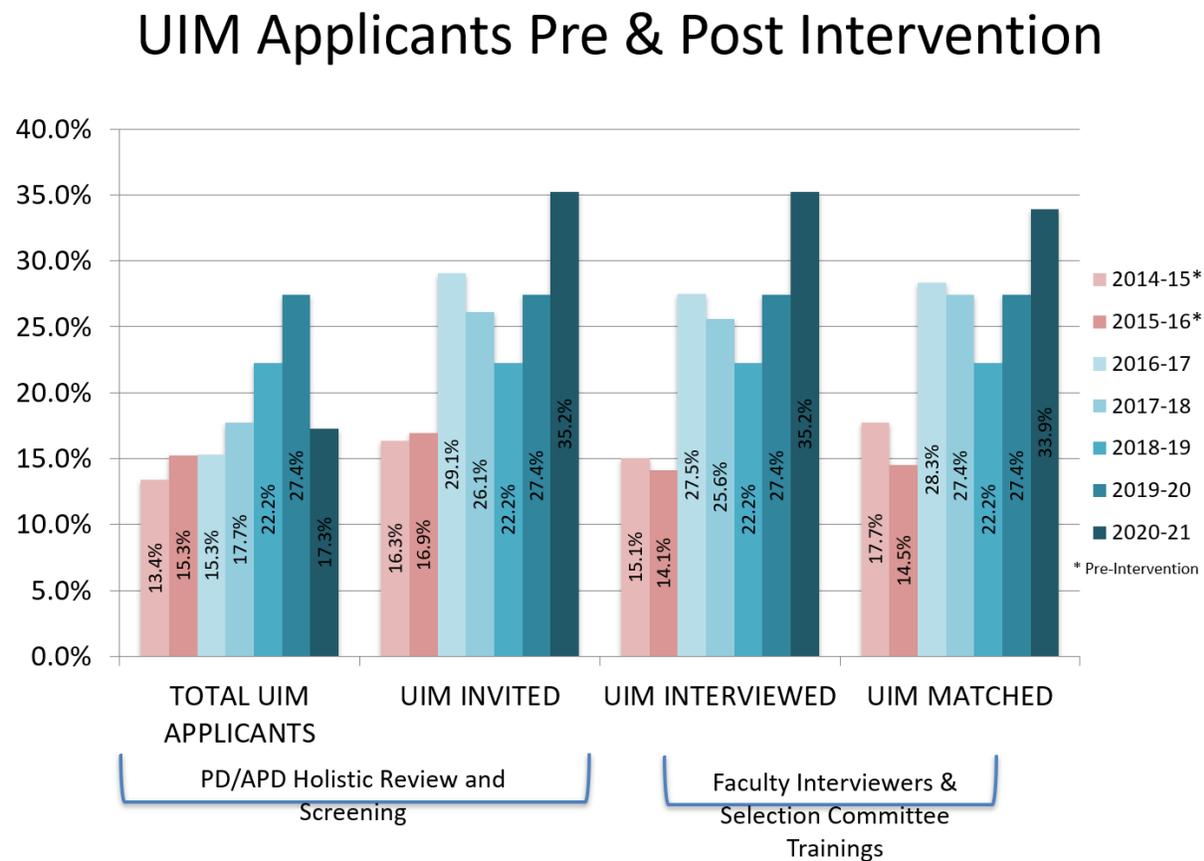
as well as white men in U.S. academic medicine broadly,³¹ we plan track career progression by gender and race/ethnicity.

Q: What processes are in place to support equity in hiring in DOM? Are they working?
How can we do better?

As stated above, while this report primarily focuses on women faculty in the DOM, there are equally important issues that relate to race and ethnicity – and many of these impact women faculty and trainees as well. Many of the strategies to improve gender equity will impact race/ethnic equity as well, and vice versa.

DOM participates in several important equity programs and strategies designed to support the development of diverse applicant pools and minimize the role of implicit bias in hiring and selection. Our residency program and many of our fellowship programs utilize a process of holistic review³² to screen applicants for interview and to create final rank lists. This program has been successful at increasing diversity of UIM resident trainees from 15% to 34% over a four-year period and has served as a national model for other programs. See graph below for details.

Figure 4: UIM Applicants Pre & Post Intervention



Another DOM intervention designed to increase diversity is the Diversity in Bench Sciences (DiBS) Program. This innovative program provides three years of guaranteed salary support plus \$20,000/year of research support to individuals pursuing laboratory-based careers as physician-scientists who share

and enhance the DOM's commitment to diversity. Given that a large percentage of DOM faculty hires are candidates who trained at UCSF, strengthening the pipeline is an essential step toward a diverse faculty.

Searched faculty positions in DOM must follow certain equity strategy requirements. These include the mandatory Statement of Contributions to Diversity from all applicants, search committees that have at least 50% women and/or UIM members, and interaction with the assigned equity advisor for the search. [Equity advisors](#) are senior faculty members who educate and assist search committees in developing a diverse applicant pool and recognizing and addressing implicit bias. Suggestions to maximize the impact of these equity strategies include: agreeing on and ranking desired qualities for the search *prior* to reviewing any applications; active assessment of each applicant's Statement of Contributions to Diversity and discussion in the search committee; the use of standardized interview questions; attention paid by the search committee chair to assuring confidentiality and that all voices are heard; and a commitment from the division and department to track participation of faculty on search committees to avoid over-burdening certain faculty who may already be contributing broadly to the diversity mission.

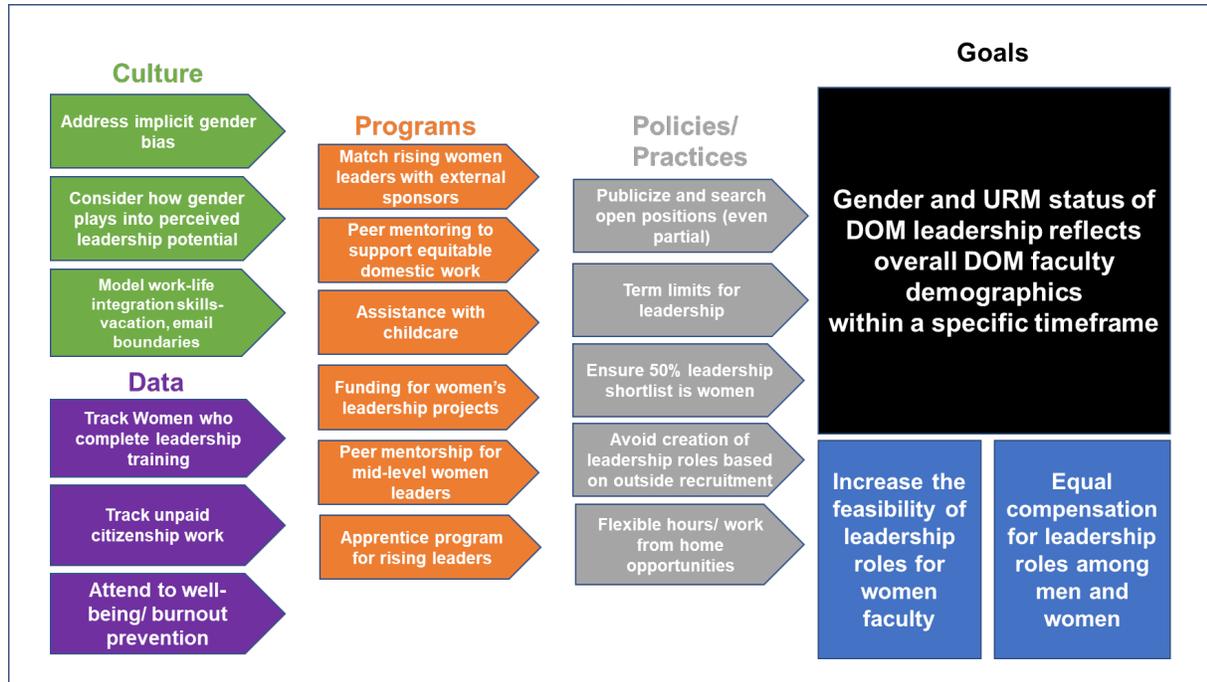
Over the last five years, DOM has hired 523 faculty: 52% women and 7% UIM (Native American, Black/African American, Latinx). The percentages of women and UIM faculty do not include those who declined to disclose information on race and gender at the time of hire. Of 193 externally searched positions over a three-year period prior to April 2020, 80% of shortlists (candidates recommended for interview) contained at least one woman and/or UIM candidate (defined by the University of California as Native American, Black/African American, Latinx, or Asian). The majority of new hires in DOM have been in the HS Clinical Series, highlighting the importance of addressing issues of clinical workload, burnout and career mentorship to promote retention of these faculty. There continues to be a need to achieve equity in the recruitment and retention of physician-researchers in DOM.

[Q: Are women and men equally likely to hold leadership roles in DOM? How can we better support emerging women leaders?](#)

DOM has a unique organizational model with three distinct clinical sites, each with its own divisions and leadership structures. In total, DOM has 38 separate divisions. The leadership of these divisions, including interim leadership, includes 21 (55%) men, 17 (45%) women, and 7 (21%) UIM faculty. Of the 24 division chiefs recruited over the past five years, 46% are women and 25% UIM. The DOM Chair's Council, composed of vice and associate chairs responsible for both site-based operations and cross-cutting mission areas, is composed of 12 members, eight of whom are women and two UIM.

In 2019 as part of DOM's Women's Professional Development Series, we held an open session on strategies to increase women in leadership at UCSF. To prepare for that session, we asked successful women leaders to share their ideas about how to promote women in leadership. We then added suggestions that arose during the discussion session. These ideas ranged from those about the process and outcomes evaluations for leaders to mentorship and sponsorship to creating working conditions that support women moving into leadership positions. These suggestions are synthesized below:

Figure 5: Strategies to Increase Women in Leadership



Q: How many men and women hold endowed chairs in DOM? Do we have an endowed chair or other leadership role in Women's Health, Gender Equity, or UIM Equity?

Endowed chairs are defined as positions "supported by payout from an endowed fund, a fund functioning as an endowment, a gift, or an annual allocation . . . made available to the chair holder in support of his/her teaching, research and/or service activities".³³ Endowed chairs vary in amount and are relatively scarce resources, with only 60 in our department of nearly 1,000 faculty. Currently, 15 (25%) of DOM's endowed chairs are held by women, and 6 (10%) held by UIM faculty.

The process for naming faculty to endowed chair positions varies from chair to chair. It is not uncommon for a faculty member to hold an endowed chair position from the time they are named until retirement or separation from UCSF. The UCSF DOM currently has no endowed chair positions related to gender or UIM equity or to women's or minority health.

One innovative way to distribute the benefit of an endowed chair equitably is encapsulated by the Kroc Endowed Chair in the Pulmonary division and the Russell Engleman Endowed Chair in Rheumatology. When these chairs were due to be passed on, they had matured financially to a state where multiple smaller endowed chairs were created. These chairs specifically went to mid-career faculty and were awarded through an open competitive process and limited to six years, ultimately benefiting the careers of several women faculty in DOM.

Faculty perspectives

In this section, we present the findings from two large efforts to better understand the experience of women physicians as faculty in the DOM: the yearly Net Promoter Score (NPS) survey, and the C-Change survey administered in 2018.

NPS data have been collected annually at UCSF Health and, since 2016, demonstrate a positive trend in the perceptions of women regarding their feelings about the workplace environment, though a stark gap persists between men and women. In 2020, ZSFG also began collecting NPS data, but we do not have this data for VA faculty. In contrast, the C-Change was conducted in 2018 at all three sites and will be repeated at all three sites in late 2022.

The most recent NPS data from UCSF stratified by gender are from FY19, and some high-level results are presented below. More recent 2021 NPS data were shared by division, gender, and UIM status in late 2021. For 2021, looking specifically at burnout in the Department of Medicine (using the Maslach-2 burnout inventory, which has a range of 0-7, with 0 representing symptoms of burnout a few times a year or less and 7 representing daily burnout), women's scores are on average six points higher than male faculty scores, representing markedly higher burnout frequency. For the other burnout measure, Mini-Z burnout, women's scores are on average 10 points higher than men's scores, again representing significantly higher intensity of burnout, with the response of "I am at the point where I may need some changes or may need to seek some sort of help" much more common among women.

As shown below (Figures 6 and 7), women faculty are less likely than male faculty to recommend UCSF as a place to work and more likely to report burnout.

Figure 6: Net Promoter Scores

Net Promoter Scores

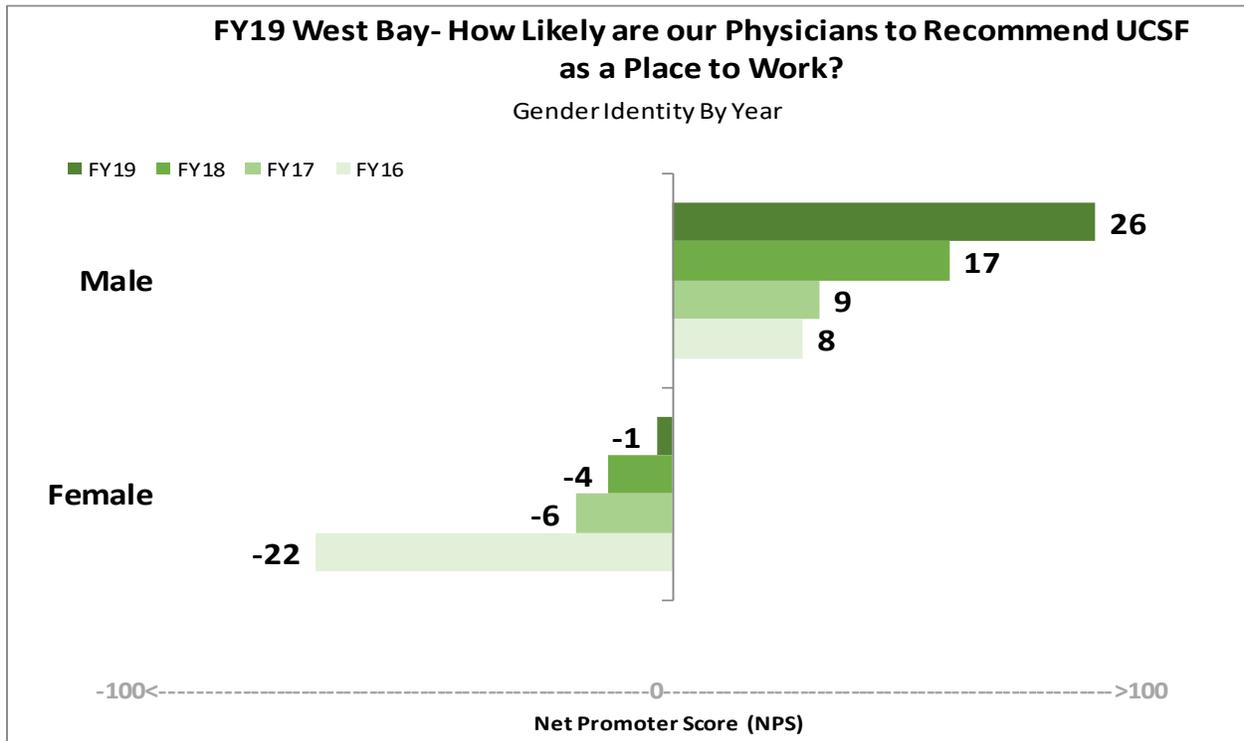
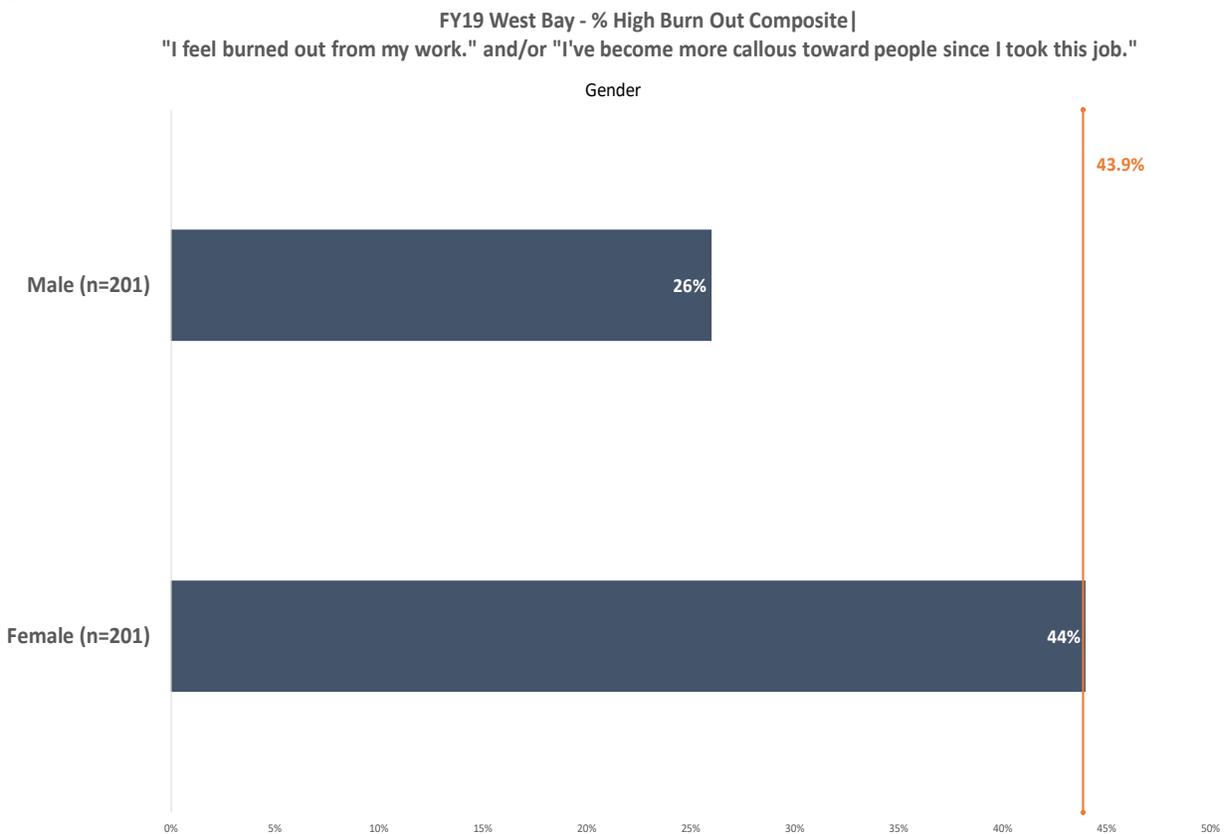


Figure 7: High Burn Out Composite



Burnout is more common among women physicians than male physicians nationally, and multiple factors have been implicated in burnout for women, including lower pay,¹³ workplace discrimination,³⁴ and highly prevalent sexual harassment.³⁵ Interestingly, evidence is emerging that women practice medicine differently, with more time spent on documentation, more prompt replies to patient messages and review of patient results,⁸ and, for hospitalists, shorter lengths of stay and fewer readmissions than male physicians.⁶

C-Change survey

In an effort to better understand these NPS differences about lived work experiences and perceptions among women, men, and underrepresented minorities within the entire DOM, the department leadership supported a 12-dimension survey designed, administered, and analyzed by investigators at the National Initiative for Gender, Culture and Medicine (located at Brandeis University) in 2018. The Culture Change or C-Change survey is described by the authors as “a tool measuring dimensions of the existing culture in order to address the professional and personal development of faculty in academic medical centers.”³⁶ This effort marked the first time data were gathered on multiple dimensions of the culture of our department, with a focus on gender, culture, and leadership in medicine. The survey has been utilized by more than 30 academic medical centers in the US, and as such provides population-specific comparator data that is nationally normed.

“The C - Change Faculty Survey assesses medical faculty perceptions of their organizational culture and professional experiences. It consists of 74 questions that assess levels of vitality, trust, competition,

*professionalism, feelings of being valued and belonging, gender and diversity inclusion and equity, and other constructs related to the organizational culture for faculty. It also collects data on faculty roles (e.g., percent time spent in research, education, administration, clinical time) and faculty perception of their school's support for career development, mentoring and work-life management. It assesses burnout and faculty commitment to their institution, as well as intention to leave academic medicine.*³⁶

Results of the survey were received and disseminated across the entire DOM, at each of the major medical center facilities (UCSF Health, Zuckerberg San Francisco General Hospital, SF Veterans Administration Medical Center) and by invitation through numerous division meetings in the fall of 2019.

The faculty were enthusiastic and supportive of the C-Change initiative, with an 80% response rate (n=765). This broad participation allowed for wide dissemination of responses while preserving anonymity. For the purposes of this report, we present the data on work experience stratified by gender and race/ethnicity below by each major medical center site. For each graph, higher scores (further toward the periphery of the spider plot) indicate a more positive culture, except for the domain of ethical/moral distress, where lower (less distress) is better. Additional summary data from the C-Change survey is available in the appendices.

Figure 8. C-Change Responses by Gender, UCSF Health

Dimensions of the Culture Male and Female Faculty Responses

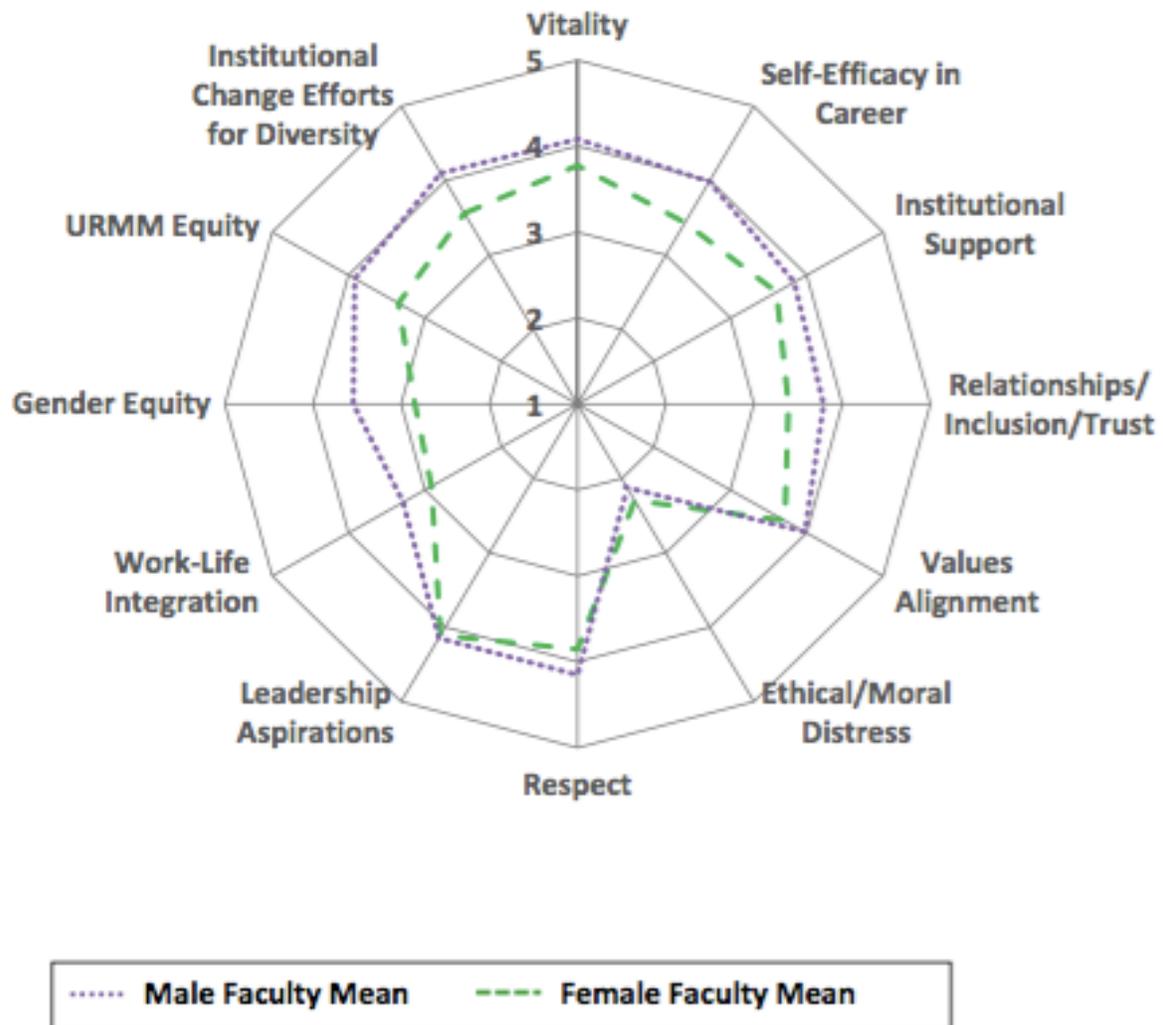


Figure 9. C-Change Responses by Gender, ZSFG

Dimensions of the Culture Male and Female Faculty Responses

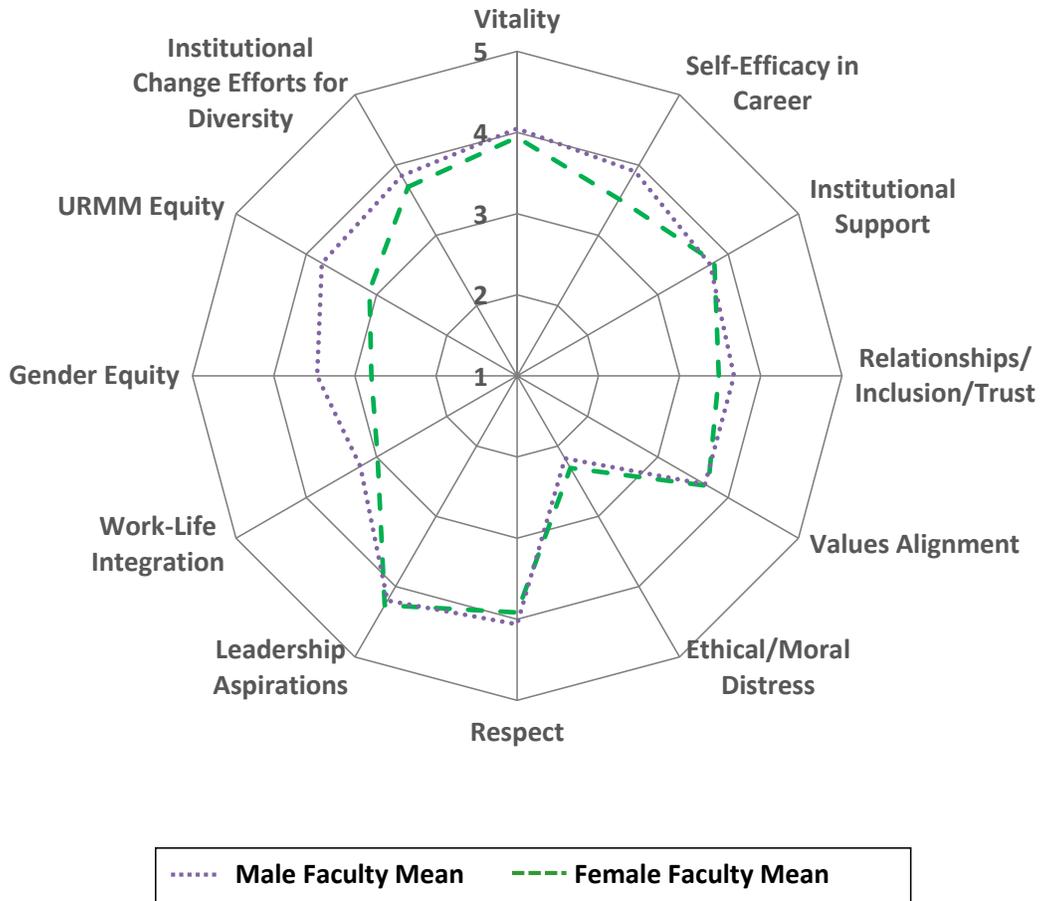
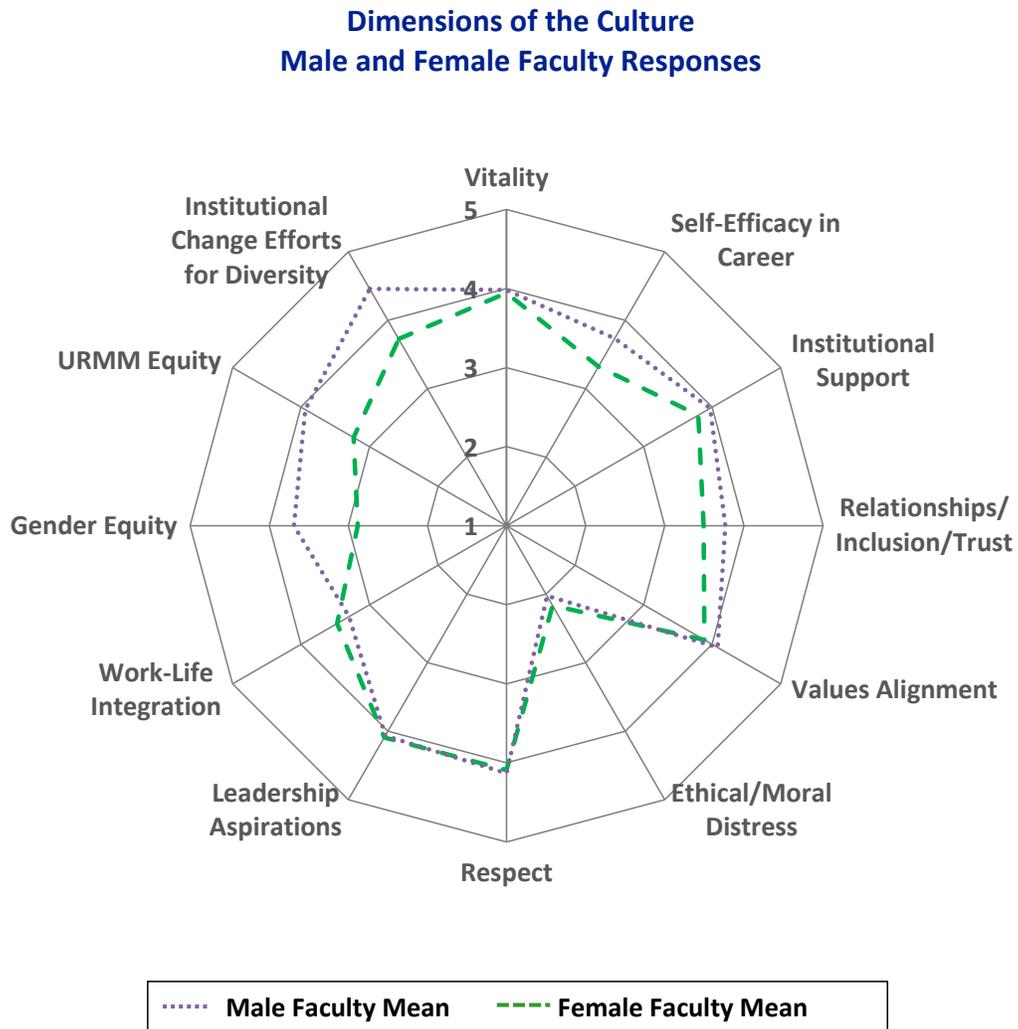


Figure 10. C-Change Responses by Gender, VAMC



Through the C-Change survey, we learned that women across the DOM have more negative perceptions of gender equity, UIM equity, self-efficacy in career, and relationships/inclusion/trust than their male faculty counterparts. When examined by clinical site, additional differences in women and men faculty experiences are appreciated.

From the C-Change data and departmental town halls discussing the results, we developed a Toolkit for Leaders to support the vitality of women faculty (Appendix 5).

Conclusion

Creating this report revealed numerous strengths of the UCSF Department of Medicine regarding gender equity. We are a department in which women comprise more than 50% of our faculty. These diverse

women faculty provide exemplary clinical care, develop and implement successful research programs, educate our learners, and lead in many areas of our department, clinical sites, and school.

In this detailed analysis, we found that data regarding salary equity, as well as accelerations and promotions, was largely reassuring – with observed differences in salary mostly explained by differential amounts of internal moonlighting, and differences in accelerations attributable to factors other than gender. The proportion of women faculty who are successfully promoted is quite high, with no observed differences noted by gender. While DOM leadership roles (associate chairs, vice chairs, and division chiefs) are more likely to be held by men than women, the proportion held by women has risen from 30% (14/46) to 49% (24/49) over the past five years.

Yet there are important concerns regarding the status of women faculty in the UCSF DOM. Women tend to experience their work more negatively, including the perception of gender and racial equity, self-efficacy in career, and relationships/belonging/inclusion at work. Women faculty in our department, like women in the workforce everywhere, have been disproportionately impacted by the COVID-19 pandemic, which has created significant additional demands and made work/life balance even more elusive. Despite recent positive changes in the climate for women in our department, residual structures embedded in the fabric of academic medicine still promote a culture of individualism and single-minded devotion to work that can make the environment less fulfilling and supportive for *everyone*.³⁷

To enhance gender equity in the UCSF DOM, we must continue to listen to our faculty, examine our assumptions about the way things work, and look for the story beneath the surface of the inequities we uncover. Through both supporting our women and UIM faculty through community building, mentorship, and a commitment from all of us to change the way we structure our department, we can make the UCSF DOM a more equitable place to work.

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Appendix 1: Historical Overview

Aaron Tabacco, PhD, RN

May 8, 1873

“The question of the propriety of admitting ladies to the regular course of instruction was introduced and discussed at some length which resulted in the appointment of a committee composed of Profs. Stout, Brigham, & Bates who requested to report on this subject at the next meeting.”

Shortly after the original Toland Medical College became the University of California Department of Medicine, the institution’s faculty were presented with what was considered a bold question at the time: Should women become physicians? The faculty of 1873, unsure how to respond to the applications of women to the course of study, appointed a committee to consider the requests. After being referred to the Regents of the University, it was determined that women were to be allowed access to all courses of study, including that of medicine. Given no option, the faculty complied, though they were generally suspicious and unhappy with the decision.

Two years after that declaration and the matriculation of women into the course of study, Dr. R. Beverly Cole, Professor in the Department, offered the following thoughts in his Valedictory Address:

“Some two years ago application was made by several ladies of attainment and refinement for admission to the medical department, but as the Faculty had not yet been educated up to the point of conceding there was any propriety in allowing them to enter, last year these ladies applied to the Board of Regents...”

As is well known, I have always been opposed to the admission of ladies to the profession of medicine (as general practitioners), and, certainly, to mixed classes in our Universities; and, without discussing the merits of this question – the why and the wherefore – I am still in doubts as to its propriety. Yet I must confess that my experience during the past session has in nowise confirmed my reasons heretofore advanced...

...it remains for me to say to the gentleman of the junior class that they must look out for their laurels, lest their lady associates, in another two years, through their superior attainments, cause a blush to mantle their cheeks.”

- R. Beverly Cole, Commencement, November 3, 1875

In contrast to the harsh and resistant mindset that had characterized the arguments of the department’s recent changes, Dr. Cole saw firsthand that women were fully capable of not only maintaining the rigors of medical education and practice, but in fact, excelling at their work. This change of tune must be credited largely to the aptitude and tenacity of Lucy Wanzer who had deeply impressed Dr. Cole with her abilities as a medical student. The following year (1876), Lucy was endorsed by the faculty for graduation, having completed her studies and attained final examination results solidly in line with her male counterparts. With that, Dr. Wanzer secured her place in UCSF history as the first woman to graduate with a medical degree from the institution and in the State of California.

Nearly twenty-five years later, the Department of Medicine (not yet classified a “School”) would take further steps toward gender equity and equality when recent women graduates were listed among the faculty for the first time as “assistants” or “clerks” in health clinics affiliated with the department. Doctors (and sisters) Grace and Adelina Feder, for example, were the first women to be listed in the annual proceedings of the University of California Department of Medicine as clinic assistants in 1898.

The limitations of women in faculty roles, however, would begin to more fully diminish with Dr. Rachel Ash. Dr. Ash was listed as eligible for graduation and granted the degree of MD by the University of California, Department of Medicine, May 8, 1899. By the accounting of final exam scores which determined the right of graduation and the ranking of graduates for honors, Dr. Ash earned the highest marks of her graduating class of 32 people, which was calculated at a score of 1389. The graduating class consisted of 28 men and four women. Notably, of the top five scores of the class, three were women and held the 1st, 2nd, and 5th positions in the rankings. Dr. Ash not only went on to become a highly published author of scientific papers on the practice of medicine, but she was also the first woman on record to be granted the official faculty title of “instructor” at the department, gaining entrance to all faculty meetings which she attended faithfully for many years in the early 1900s.

These early years of the 20th century foreshadowed not only the hard-won successes of early women physicians, but also foreshadowed many of their continuing struggles. Dr. Una Yone Yanagisawa, for example, was the first Japanese-American woman to earn a baccalaureate degree in the United States from the University of California in 1898, and then with her exceptional abilities went on to graduate from the Department of Medicine as a member of the class of 1901. While Dr. Yanagisawa faced much of the same discrimination as her white female colleagues, her status as a woman of color and first female Japanese physician added to the barriers she faced. Unable to practice medicine in her adopted city of San Francisco, she would eventually apply her skills as a capable practitioner by providing what may have been some of the only qualified health care granted to Japanese-American prisoners during the tragic U.S. internment camp era of WWII.

Drs. Wanzer, Feder, Ash, Yanagasawa, and many others served as important pioneers in the field of medicine, helping to define a uniquely University of California, San Francisco way of opening doors and blazing new trails for women. Shortly after Dr. Wanzer offered the petition for women to enroll in the study of medicine, women composed approximately 10% of each graduating class for many decades, more than twice the number in the Schools of Medicine on the East Coast. Additionally, as these early women physicians established their excellence in practice, research, and service, they have continued a steady march of progress, including those whose ethnicities are underrepresented in medicine (UIM).

The inaugural medical institution of the 19th century has grown into a School of Medicine large enough to have many departments. And among those is ours, the current Department of Medicine (DOM). Our inherited namesake continues to be a place of advancement for women, where they now compose 53% of our faculty (UCSF-DOM, 2020). Women now also account for 56% of all enrolled medical students (UCSF-OIR, 2020) in the School of Medicine. In this report, we will present the current state of the status of women within our department, cataloging their achievements and contributions, and evaluating the

progress we have made. We hope with this effort to continue making the UCSF Department of Medicine into the most equitable, inclusive, diverse, and supportive place for women in medicine.

* Special thanks to Polina Ilieva, CA, Head of Archives and Special Collections, UCSF Library, as well as her colleague Edith Martinez for their invaluable assistance with this historical research and access to the original source documents.

Appendix 2: Implications of the FY21 Salary Freeze by Gender

The department examined the effects of the salary freeze on men versus women faculty. The representation of women is disproportionately high at the assistant and associate rank, which suggests a salary freeze in any one year might disproportionately impact them, as a disproportionately larger share of women are up for advancement every two years (as assistant and associate professors) instead of every three years (as full professors.) This difference in distribution by rank would only lead to salary disparities resulting from the freeze if the proportion of women up for advancement was evenly spread in every year. By chance, for the class of faculty getting advanced in FY21, a greater proportion of men happened to be up for advancement at the assistant and full rank in FY21. Therefore, the FY21 salary freeze affected men and women equally.

Appendix Table

	Women		Women Total	Men		Men Total	Grand Total
	No Merit/ Promo	Yes Merit/ Promo		No Merit/ Promo	Yes Merit/ Promo		
ASSISTANT	87	58	145	44	35	79	224
ASSOCIATE	47	63	110	34	41	75	185
FULL	95	36	131	118	50	168	299
INSTRUCTOR	7		7	3		3	10
Grand Total	236	157	393	199	126	325	718
		40%			39%		

Table legend: “Yes” and “No” refer to the number of women up for advancement in FY21

Appendix 3: Selected list of internal programs to support women in the UCSF DOM

Community building, networking, and peer support:

[ZSFG Warm Hearts](#): A multi-specialty organization whose vision is to support the diverse women faculty at ZSFG through community and skill building.

[WILD: Women in Leadership Development](#) program for residents and fellows. Began with a DOM-specific initiative and has now expanded to all of UCSF GME. Yearlong leadership series has reached hundreds of trainees on topics such as negotiation, building a mentorship team, personal finances, and responding to microaggressions.

DOM Women's Development Series: Multi-site events pre-pandemic included the following topics: Speaking with Credibility and Confidence (Collaboration with WILD-GME), Responding to Gender Microaggressions in the Workplace (Collaboration with UCSF Committee on Status of Women for International Women's Day), Increasing Women in Leadership at UCSF, Update on Family Friendly Policies at UCSF, and One Calendar: Strategies for Cultivating Work-Life Balance.

Dinners with Luminaries (pre-pandemic): led by Dr. Meshell Johnson, Associate Chair for Diversity, Equity and Inclusion with the goal of bringing small groups of UIM faculty together with notable UCSF leaders for food, mentorship, and conversation.

Developing DOM leaders to support equity:

Leadership development program for new division chiefs and senior leaders in DOM: goal to orient, develop and build community amongst new faculty leaders. Course includes discussion of equity and strategies to promote inclusion.

Supporting career advancement of women and UIM faculty:

Improved guidance for advancement and promotion, available here: <https://dom.ucsf.edu/dom-faculty-advancement-guidelines>

Individual mentorship for all UIM early and mid-career faculty conducted by Dr. Meshell Johnson to develop career plans, build mentorship teams, and connect with resources.

UCSF guidance on documenting the impact of the COVID-19 pandemic in your promotions packet: <https://facultyacademicaffairs.ucsf.edu/academic-personnel/academic-review-and-advancement/COVID-Personal-Statement-and-CV-Guidance.pdf>

Improving working conditions for research and clinical faculty:

Support program for late Assistant Professor research faculty in the time of COVID: The DOM granted 9 CoBrA grants for a total of \$344,700 to support faculty whose research was disrupted by the pandemic.

Lactation RVU program at UCSF Health: Michelle Mourad, Vice Chair of the Department of Medicine for Clinical Affairs advocated for a new program at UCSF Health which provides protected time during clinical work for nursing mothers for up to one year following the return to work from childbearing leave. This program was recently replicated at ZSFG under the leadership of Delphine Tuot, Associate CMO of Specialty Care and Diagnostics at ZSFG.

Appendix 4: Analysis of Accelerated Promotion in DOM

Faculty Accelerations Analysis

Table 1. Department of Medicine faculty demographic and appointment characteristics. The table also provides predictors of acceleration based on unadjusted and adjusted analyses. Odds ratios calculated using logistic regression, incidence rate ratios calculated using Poisson regression.

Characteristic	Total Eligible Faculty (n=816)	No Acceleration (n=689)	Acceleration (n=127)	p-value	Unadjusted OR (95% CI)	Adjusted OR (95% CI)	Adjusted IRR (95% CI)
Under-represented in medicine				0.963	0.98 (0.52-1.88)	1.23 (0.59-2.55)	1.16 (0.71-1.90)
Not under-represented in medicine	738 (90.4%)	623 (90.4%)	115 (90.5%)				
Under-represented in medicine	78 (9.6%)	66 (9.6%)	12 (9.5%)				
Gender				0.046	1.47 (1.01-2.15)	1.01 (0.66-1.56)	1.01 (0.74-1.37)
Female	439 (53.8%)	381 (55.3%)	58 (45.7%)				
Male	377 (46.2%)	308 (44.7%)	69 (54.3%)				
Campus				0.001			
Parnassus	522 (64.0%)	447 (64.9%)	75 (59.1%)		Reference	Reference	Reference
VAMC	121 (14.8%)	110 (16.0%)	11 (8.7%)		0.60 (0.31-1.16)	0.59 (0.29-1.21)	0.66 (0.38-1.16)
ZSFG	173 (21.2%)	132 (19.2%)	41 (32.3%)		1.85 (1.21-2.84)	1.66 (1.02-2.68)	1.40 (1.01-1.93)
Series in FY2021				<0.0001			
HS Clinical	372 (45.6%)	355 (51.5%)	17 (13.4%)		Reference	Reference	Reference
Adjunct	109 (13.4%)	102 (14.8%)	7 (5.5%)		1.43 (0.58-3.55)	1.44 (0.58-3.61)	1.41 (0.60-3.32)
Clinical X	164 (20.1%)	126 (18.3%)	38 (29.9%)		6.30 (3.43-11.55)	4.02 (2.10-7.71)	3.45 (1.98-6.00)
In Residence	147 (18.0%)	94 (13.6%)	53 (41.7%)		11.77 (6.52-21.27)	7.54 (4.03-14.10)	5.30 (3.13-8.96)
Ladder Rank	24 (2.9%)	12 (1.7%)	12 (9.5%)		20.88 (8.19-53.27)	9.64 (3.52-26.40)	5.79 (2.97-11.28)

Rank in FY2021 (modeled as continuous, nptrend p<0.0001)				<0.0001	2.68 (2.05-3.51)	1.77 (1.29-2.43)	1.56 (1.22-2.01)
Assistant	302 (37.0%)	289 (41.9%)	13 (10.2%)				
Associate	198 (24.3%)	169 (24.5%)	29 (22.8%)				
Full	316 (38.7%)	231 (33.5%)	85 (66.9%)				
Time in years at UCSF (mean, std dev)	8.4 (5.8)	7.9 (5.6)	11.2 (5.7)	<0.0001	1.09 (1.06-1.12)	Not included due to collinearity with FY21 Rank	Not included due to collinearity with FY21 Rank

Table 2. Department of Medicine faculty demographic and appointment characteristics including division. The table also provides predictors of acceleration based on unadjusted and adjusted analyses. Odds ratios calculated using logistic regression, incidence rate ratios calculated using Poisson regression.

Characteristic	Total Eligible Faculty (n=816)	No Acceleration (n=689)	Acceleration (n=127)	p-value	Unadjusted OR (95% CI)	Adjusted OR (95% CI)	Adjusted IRR (95% CI)
Underrepresented in medicine				0.963	0.98 (0.52-1.88)	1.24 (0.60-2.60)	1.17 (0.71-1.94)
Not underrepresented in medicine	738 (90.4%)	623 (90.4%)	115 (90.5%)				
Underrepresented in medicine	78 (9.6%)	66 (9.6%)	12 (9.5%)				
Gender				0.046	1.47 (1.01-2.15)	1.02 (0.66-1.58)	1.01 (0.74-1.38)
Female	439 (53.8%)	381 (55.3%)	58 (45.7%)				
Male	377 (46.2%)	308 (44.7%)	69 (54.3%)				
Campus				0.001			
Parnassus	522 (64.0%)	447 (64.9%)	75 (59.1%)		Reference	Reference	Reference
VAMC	121 (14.8%)	110 (16.0%)	11 (8.7%)		0.60 (0.31-1.16)	0.58 (0.28-1.19)	0.65 (0.37-1.15)
ZSFG	173 (21.2%)	132 (19.2%)	41 (32.3%)		1.85 (1.21-2.84)	1.65 (1.01-2.69)	1.39 (1.00-1.93)
Division				0.172			
General Internal Medicine/ Geriatrics/Occupational Health & Environmental Medicine	194 (23.8%)	164 (23.8%)	30 (23.6%)		Reference	Reference	Reference
Cardiology/Gastroenterology	120 (14.7%)	99 (14.4%)	21 (16.5%)		1.16 (0.63-2.14)	0.92 (0.47-1.82)	0.94 (0.58-1.52)
Hospital Medicine/Palliative Care	166 (20.3%)	150 (21.8%)	16 (12.6%)		0.58 (0.31-1.11)	1.22 (0.57-2.57)	1.15 (0.66-2.00)
Hematology Oncology/Nephrology/ Pulmonology	187 (22.9%)	156 (22.6%)	31 (24.4%)		1.09 (0.63-1.88)	1.02 (0.55-1.90)	1.02 (0.66-1.58)
Experimental Medicine/Prevention Science	30 (3.7%)	26 (3.8%)	4 (3.2%)		0.84 (0.27-2.58)	0.44 (0.13-1.52)	0.57 (0.22-1.42)
Endocrinology/HIV, ID & Global Medicine/Infectious Disease/ Rheumatology	119 (14.6%)	94 (13.6%)	25 (19.7%)		1.45 (0.81-2.62)	1.02 (0.52-1.99)	1.03 (0.66-1.59)
Series in FY2021				<0.0001			
HS Clinical	372 (45.6%)	355 (51.5%)	17 (13.4%)		Reference	Reference	Reference
Adjunct	109 (13.4%)	102 (14.8%)	7 (5.5%)		1.43 (0.58-3.55)	1.67 (0.65-4.33)	1.56 (0.64-3.80)
Clinical X	164 (20.1%)	126 (18.3%)	38 (29.9%)		6.30 (3.43-11.55)	4.11 (2.13-7.97)	3.50 (1.99-6.16)
In Residence	147 (18.0%)	94 (13.6%)	53 (41.7%)		11.77 (6.52-21.27)	8.43 (4.37-16.24)	5.70 (3.28-9.92)
Ladder Rank	24 (2.9%)	12 (1.7%)	12 (9.5%)		20.88 (8.19-53.27)	10.09 (3.60-28.25)	5.95 (3.04-11.63)
Rank in FY2021 (modeled as continuous, nptrend p<0.0001)				<0.0001	2.68 (2.05-3.51)	1.81 (1.30-2.51)	1.59 (1.23-2.04)

Assistant	302 (37.0%)	289 (41.9%)	13 (10.2%)				
Associate	198 (24.3%)	169 (24.5%)	29 (22.8%)				
Full	316 (38.7%)	231 (33.5%)	85 (66.9%)				
Time in years at UCSF (mean, std dev)	8.4 (5.8)	7.9 (5.6)	11.2 (5.7)	<0.0001	1.09 (1.06-1.12)	Not included due to collinearity with FY21 Rank	Not included due to collinearity with FY21 Rank

Additional Analyses

Table 3. Relationship between division and acceleration.

	No acceleration (n=689) Column %	Acceleration (n=127) Column %	p-value	Unadjusted OR (95% CI)
Division			0.249	
Hospital Medicine	137 (19.9%)	14 (11.0%)		Reference
Cardiology	61 (8.9%)	13 (10.2%)		2.09 (0.93-4.70)
Endocrinology	23 (3.3%)	8 (6.3%)		3.40 (1.28-9.02)
Experimental Medicine	7 (1.0%)	2 (1.6%)		2.80 (0.53-14.78)
Gastroenterology	38 (5.5%)	8 (6.3%)		2.06 (0.80-5.27)
General Internal Medicine	121 (17.6%)	23 (18.1%)		1.86 (0.92-3.78)
Geriatrics	35 (5.1%)	7 (5.5%)		1.96 (0.73-5.22)
HIV, ID, Global Medicine	22 (3.2%)	10 (7.9%)		4.45 (1.76-11.25)
Hematology/Oncology	61 (8.9%)	13 (10.2%)		2.09 (0.93-4.70)
Infectious Diseases	25 (3.6%)	5 (3.9%)		1.96 (0.65-5.92)
Nephrology	32 (4.6%)	4 (3.2%)		1.22 (0.38-3.96)
Occupational Health	8 (1.2%)	0 (0%)		Unable to compute
Palliative Care	13 (1.9%)	2 (1.6%)		1.51 (0.31-7.36)
Prevention Science	19 (2.8%)	2 (1.6%)		1.03 (0.17-3.82)
Pulmonology	63 (9.1%)	14 (11.0%)		2.17 (0.98-4.83)
Rheumatology	24 (3.5%)	2 (1.6%)		0.82 (0.17-3.82)

Table 4. Department of Medicine faculty demographic and appointment characteristics. The table also provides predictors of acceleration based on unadjusted and adjusted analyses. Odds ratios calculated using logistic regression, incidence rate ratios calculated using Poisson regression.

Characteristic	Total Eligible Faculty (n=816)	No Acceleration (n=689)	Acceleration (n=127)	p-value	Unadjusted OR (95% CI)	Adjusted OR (95% CI)	Adjusted IRR (95% CI)
Underrepresented in medicine				0.963	0.98 (0.52- 1.88)	0.88 (0.45- 1.70)	0.90 (0.52-1.57)
Not underrepresented in medicine	738 (90.4%)	623 (90.4%)	115 (90.5%)				

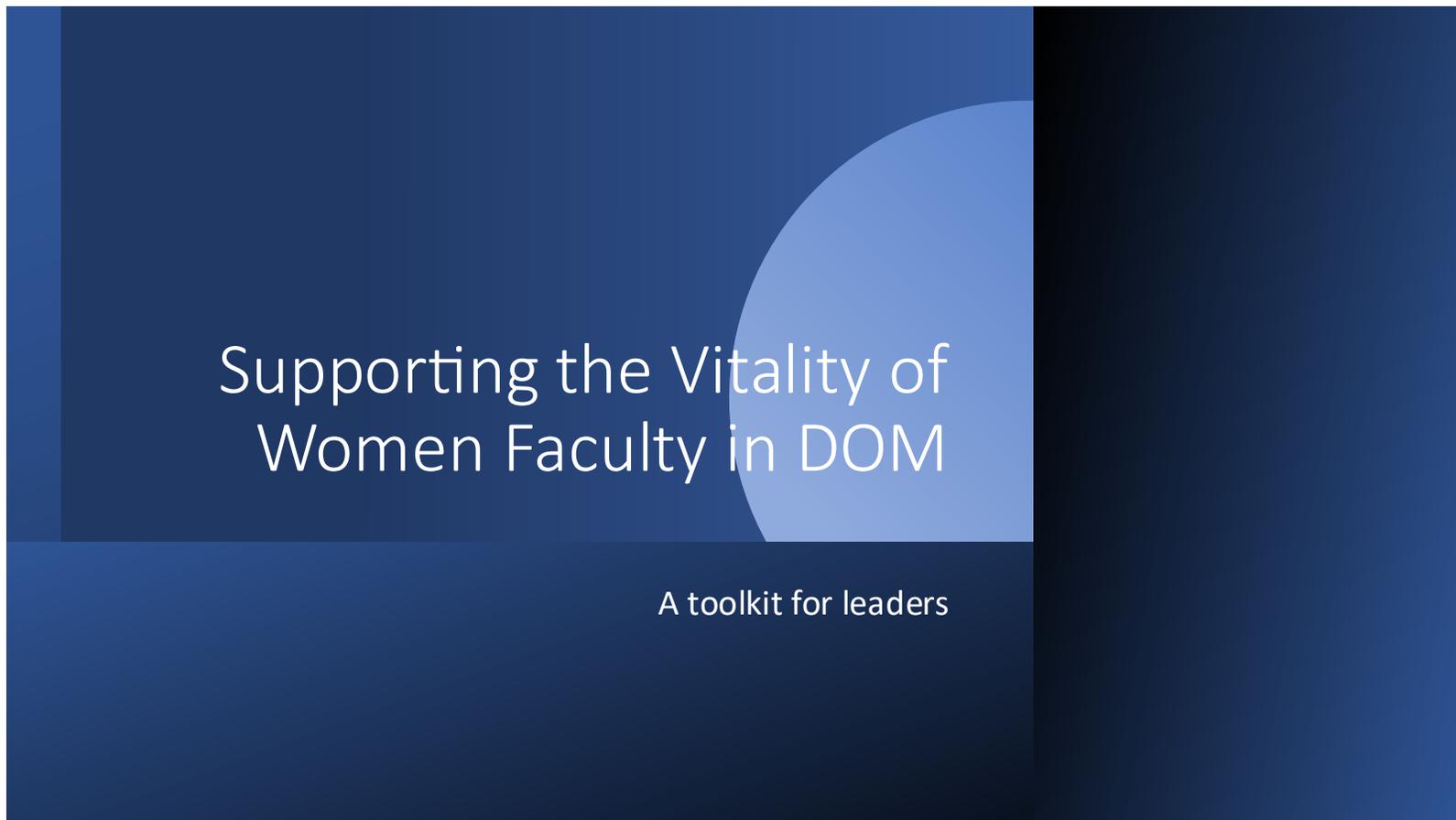
Underrepresented in medicine	78 (9.6%)	66 (9.6%)	12 (9.5%)				
Gender				0.046	1.47 (1.01-2.15)	1.57 (1.07-2.31)	1.45 (1.05-2.00)
Female	439 (53.8%)	381 (55.3%)	58 (45.7%)				
Male	377 (46.2%)	308 (44.7%)	69 (54.3%)				
Campus				0.001			
Parnassus	522 (64.0%)	447 (64.9%)	75 (59.1%)		Reference	Reference	
VAMC	121 (14.8%)	110 (16.0%)	11 (8.7%)		0.60 (0.31-1.16)	0.58 (0.30-1.14)	0.62 (0.34-1.14)
ZSFG	173 (21.2%)	132 (19.2%)	41 (32.3%)		1.85 (1.21-2.84)	1.94 (1.26-2.99)	1.71 (1.21-2.40)

Table 5. Department of Medicine faculty demographic and appointment characteristics including division. The table also provides predictors of acceleration based on unadjusted and adjusted analyses. Odds ratios calculated using logistic regression, incidence rate ratios calculated using Poisson regression.

Characteristic	Total Eligible Faculty (n=816)	No Acceleration (n=689)	Acceleration (n=127)	p-value	Unadjusted OR (95% CI)	Adjusted OR (95% CI)	Adjusted IRR (95% CI)
Underrepresented in medicine				0.963	0.98 (0.52-1.88)	0.93 (0.48-1.81)	0.94 (0.54-1.65)
Not underrepresented in medicine	738 (90.4%)	623 (90.4%)	115 (90.5%)				
Underrepresented in medicine	78 (9.6%)	66 (9.6%)	12 (9.5%)				
Gender				0.046	1.47 (1.01-2.15)	1.59 (1.07-2.36)	1.46 (1.05-2.03)
Female	439 (53.8%)	381 (55.3%)	58 (45.7%)				
Male	377 (46.2%)	308 (44.7%)	69 (54.3%)				
Campus				0.001			
Parnassus	522 (64.0%)	447 (64.9%)	75 (59.1%)		Reference	Reference	Reference
VAMC	121 (14.8%)	110 (16.0%)	11 (8.7%)		0.60 (0.31-1.16)	0.54 (0.28-1.07)	0.59 (0.32-1.09)
ZSFG	173 (21.2%)	132 (19.2%)	41 (32.3%)		1.85 (1.21-2.84)	1.86 (1.19-2.90)	1.64 (1.16-2.32)
Division				0.172			
General Internal Medicine/ Geriatrics/Occupational Health & Environmental Medicine	194 (23.8%)	164 (23.8%)	30 (23.6%)		Reference	Reference	Reference
Cardiology/Gastroenterology	120 (14.7%)	99 (14.4%)	21 (16.5%)		1.16 (0.63-2.14)	0.98 (0.52-1.84)	0.98 (0.58-1.66)
Hospital Medicine/Palliative Care	166 (20.3%)	150 (21.8%)	16 (12.6%)		0.58 (0.31-1.11)	0.51 (0.26-0.98)	0.56 (0.32-0.99)
Hematology Oncology/Nephrology/ Pulmonology	187 (22.9%)	156 (22.6%)	31 (24.4%)		1.09 (0.63-1.88)	0.94 (0.53-1.66)	0.95 (0.60-1.51)
Experimental Medicine/Prevention Science	30 (3.7%)	26 (3.8%)	4 (3.2%)		0.84 (0.27-2.58)	0.63 (0.20-1.97)	0.68 (0.26-1.76)

Endocrinology/HIV, ID & Global Medicine/Infectious Disease/ Rheumatology	119 (14.6%)	94 (13.6%)	25 (19.7%)		1.45 (0.81-2.62)	1.15 (0.63-2.11)	1.11 (0.68-1.80)
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Appendix 5: Toolkit for Supporting the Vitality of Women Faculty in DOM



Supporting the Vitality of Women Faculty in DOM

A toolkit for leaders

What can
division chiefs
and managers
do to: Improve
gender and
UIM equity?

- **“It is harder for women to get ahead here than men”:**
 - Commit to equity in start up and retention packages
 - Be proactive about suggesting women and UIM faculty for accelerations
 - Create an equitable distribution of unpaid, essential labor in academia
 - Teaching, mentoring, committee service
 - Appreciate the connection between doing the unpaid labor and having less bandwidth for leadership roles, clinical bonuses and other Z related activities

What can
division chiefs
and managers
do to:
Improve
gender and
UIM equity?

- **“It is harder for women and UIM faculty to get ahead here”:**
 - Support the creation of divisional women’s groups and events to promote gender and UIM equity
 - Recognize and appreciate sponsors of women and UIM faculty in your division
 - Support women in mid-level leadership roles by creating community, assistance with branding oneself as a leader, and opportunities to advance



What can
division chiefs
and managers
do to: Improve
gender and
UIM equity?

- **“Unconscious bias adversely affects female and UIM faculty here”:**
 - Commit to and facilitate 100% participation in UCSF SOM Diversity Champions Training
 - Notice microaggressions when they occur and practice allyship
 - Recognize that patients and clinical staff are an unseen source of microaggressions against women and UIM physicians, and work within the institutional culture to address this

What can DOM do to: Improve gender and UIM equity?



Elevate women and UIM faculty in positions of departmental leadership



Better understand the issues:

Focus groups
State of Women in the DOM report



Support and mentor those interested in improving climate



Participate in campus and site-wide initiatives



Create brave spaces for all to feel heard and welcomed

What can division chiefs and managers do to: support work-life balance?

- **“My workplace isn’t family friendly”:**
 - Educate yourself and your faculty on 3FI initiatives:
 - 12 weeks paid childbearing and childrearing leave (Comp plan members)
 - Stop the clock
 - Modified duties
 - Proactively assist faculty who are returning from leave in their re-entry
 - Lactation time, place, RVU adjustment
 - Consider relieving faculty returning from leave from service commitments for a defined time period
 - Identify a re-entry faculty mentor who can help with adjusting to logistics of parenting and working

What can division chiefs and managers do to: support work-life balance?

- **“It is difficult to succeed here without sacrificing personal and family commitments”:**
 - Frame the issue as a moral imperative
 - Carefully consider how you communicate
 - Avoid after hours/weekend emails if possible
 - Ask your division members how they want to communicate (but be cautious about pressure to appear singularly dedicated to work)
 - Consider adding a line in your signature block:
 - *“Please note: I strive to be email free nights and weekends and do not expect a response during those times.”*

What can division chiefs and managers do to: support work-life balance?

- **“It is difficult to succeed here without sacrificing personal and family commitments”:**
 - Consider the impact and cost of the “culture of overwork, superperformance and rampant individualism” in medicine
 - Value your faculty and staff’s personal lives
 - Vacation out-of-office
 - Visibility of personal priorities

What can DOM do to: support worklife balance?



Recognize the direct connection between **clinical productivity demands** and work life balance. Creatively, collaboratively and relentlessly advocate for improvements



Address the tensions for research faculty centrally by providing funding and grant support



Develop an attention management mentorship program to support faculty in achieving high levels of focus and efficiency