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Ethical Legal Feature

Micro-inequities in Medicine

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Guest Discussants: Mary Rowe, PhD, Michael S. Sinha, MD, JD, MPH, Diana M. Molinares, MD, Nancy D. Spector, MD
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Introduction

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In this ethical legal column, the guest editor, Julie Silver, MD, focuses on the concept of micro-inequities, a term coined by Mary Rowe, PhD (one of the invited columnists) more than 40 years ago. For the *PM&R* reader, this concept has broad and important implications. The unintentional and systematic biases experienced by women, ethnic and racial minorities, people with disabilities, sexual and gender minorities, among other groups, raise ethical implications about social justice in multiple interdependent contexts—the workplace, clinical care, educational programs, academic societies, and policy initiatives. Although there is increased awareness of the concept of micro-inequities, their continued perpetuation is unsettling and requires thoughtful attention and strategies.

Dr Silver is a leader in rehabilitation medicine, well known for her scholarship in cancer rehabilitation, workforce diversity, and inclusion. She is an Associate Professor and Associate Chair in the Department of Physical Medicine and Rehabilitation (PM&R) at Harvard Medical School. Dr Silver is an educator, innovator, master clinician, startup company founder, and an award-winning author who has authored or edited nearly 100 books. Her expertise in inequities and inclusion is exemplified by her innovative research on the under-representation of women physicians in medical societies, including physiatry [1,2]. Dr Silver and the invited contributors highlight the nature and layers of micro-inequities in PM&R and in medicine more generally and suggest ways to address the problem. As always, I welcome responses to the ethical legal column at dmukherjee@sralab.org.

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Guest Editor: Julie K. Silver, MD
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There is a robust body of literature documenting disparities for the health care workforce, and in this column, we focus on 1 aspect—micro-inequities. In 1970, Dr Chester Pierce (an eminent Harvard professor and psychiatrist) wrote about micro-aggressions—snubs, slights, and insults—that might seem small but can do great damage. His work was primarily focused on race and ethnicity. A few years later, Mary Rowe, PhD, came to the Massachusetts Institute of Technology (MIT) as its first ombudsperson. In her new position, she heard about many small inequities that did not quite fit the definition of micro-aggressions but appeared to undermine workers who identified with at least 1 under-represented group. These seemingly minor inequities or micro-messages

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often seemed unintended—presumably arising from implicit (unconscious) bias and perhaps owing to ignorance or negligence. Rowe coined the term *micro-inequities* to define this wider set of harmful events.

Today, we know that micro-aggressions and micro-inequities contribute to workplace cultures that undermine ethical codes of conduct, and this can be particularly true in medicine, where there are decades of literature that demonstrate marked workforce disparities combined with inexplicably slow progress in closing gaps [1]. In contrast, our expectation is that every physician and health care professional will be treated with respect, will be compensated fairly, and will have equal opportunities for career advancement. Why does our own evidence base demonstrate this disconnect?

For this column, I invited 4 commentators to offer their perspectives on micro-inequities as they relate to the medical workforce. The first is Dr Rowe, who coined the term and continues her seminal work on this topic as an Adjunct Professor of Negotiation and Conflict Management at the MIT Sloan School of Management. The second is Michael Sinha, MD, JD, MPH, an early career physician and an attorney who has been a strong advocate for gender equity. Dr Sinha is currently a Research Fellow at Harvard Medical School. The third commentator is a newly minted physiatrist, Diana Molinares, MD, who is a Cancer Rehabilitation Fellow at the University of Texas MD Anderson Cancer Center. Dr Molinares shares her valuable insights as a physiatrist with intersectionality—she is a woman and a Hispanic and therefore identifies with more than one under-represented group. Nancy Spector, MD, is a Professor of Pediatrics and Associate Dean of Faculty Development at the Drexel University College of Medicine. Dr Spector also is the Executive Director of the renowned Executive Leadership in Academic Medicine (ELAM) program that has trained many women deans and department chairs and other leaders.

As the commentators share their perspectives, it is important to consider whether current medical training and continuing education efforts are doing enough to actively dispel stereotypes and other learned behaviors that can undermine ethical codes of conduct. Indeed, looking at workforce disparities through an ethical lens might help us to view ways in which our current training and work environments might inadvertently reinforce and even build on pre-existing beliefs that, consciously or not, influence who we value. After all, disparities tend to arise from unethical behaviors, and we might not be doing enough to intentionally change the status quo. Perhaps counterintuitively, in training and beyond, there is an unintentional and culturally ingrained overlay of subtle inequities and indignities. I call this "promoting a micro-inequity mindset" and define it as an established set of attitudes that someone holds, consciously or unconsciously, that leads them to normalize micro-inequities and micro-aggressions that support systemic discrimination.

Moreover, I suggest that common errors in critical thinking strengthen a micro-inequity mindset:

1. Perpetuating myths (eg, there aren't enough qualified women or women aren't as skilled, dedicated, or ambitious as men)
2. Holding the affected group responsible for deficiencies (eg, women need to find better mentors or fix problems instead of leaders fixing them)
3. Preserving willful ignorance about the problem (eg, leaders who are not familiar with the evidence base regarding health care workforce disparities)

There is a growing body of research on micro-inequities for women in medicine. For example, one study found that women speakers were more frequently introduced by their first names or not called "doctor" during recorded grand rounds [2]. My work with colleagues has found that the important work that women physiatrists are doing is often left out of medical society newsletters [3] and that high-impact pediatric journals under-represent women physicians as first authors of perspective-type articles [4].

Health care professionals, including physicians, demonstrate unconscious bias that can affect our work; furthermore, there appears to be a gap regarding our stated commitment to impartiality and the extent to which it is truly embraced [5]. Bias, in any form, can negatively affect physician productivity, retention, burnout symptoms, and delivery of patient care. How seemingly small, but pervasive, disparities or injustices can undermine the medical workforce is the subject of this ethical legal column.

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Helping Individuals and Organizations to Prevent Micro-inequities

Mary Rowe, PhD
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In 1973, I took my 6-year-old son to the MIT Medical Department for a checkup. We got there a bit early and looked through the windows. We could see a woman at a desk near the front and saw empty offices beyond. I said to my son, "The doctor isn't here yet; we may need to wait." "But, mum," he said, pointing to the woman. "How do you know that *she* isn't a doctor?" This incident hit me hard. For a year I had been trying to understand how to deal with micro-discrimination that appeared to be unintentional—and, every day, how to deal with my own biases.

In that first year working for the MIT president, my title was "Special Assistant to the President and Chancellor for Women and Work." I received men and women on any work-related issue and served as an ombudsperson for the MIT community. I had expected to deal with big issues—unequal pension plans, family leave and child care, programs on rape and self-defense—and I did.

I had not expected the flood of apparently "little" issues that were legally not actionable and often even hard to recognize—but they were sand in the gears for hundreds of women and men. I consulted with Dr Chester Pierce of Harvard who taught about "micro-aggressions" based on race—micro-hostilities that are hard to handle. This helped. I did hear many concerns about micro-aggressions based on race—and numerous others based on gender and some based on race and gender. In addition, many complaints were just about micro-bullying—"small" acts of cruelty.

However, in addition to reports of aggressive behaviors (in which perpetrators should have known what they were doing), I received daily complaints of "small" actions that appeared discriminatory and even seriously injurious—but likely were unintentional. Numerous people appeared unaware or were negligent. And many—including me—seemed unconsciously biased and did things or said things that could do damage. In my work and in articles, I labeled this much larger set of behaviors *micro-inequities*. In a dozen micro-inequities papers published in 1973-1990 [1], I included all "small" acts that are unfair whether they are aggressive and hostile or not. I defined micro-inequities broadly as apparently small events that are often ephemeral and hard to prove and events that are covert, often unintentional, and frequently unrecognized by the perpetrator that occur wherever people are perceived to be "different."

Furthermore, what was I to do about my own transgressions—my own unconscious bias—if I could not consciously stop it? In 1973 I read the available literature about changing behavior. I learned that it helps, a bit, to study common modes of bias—to try to bring them to consciousness. However, the most powerful mode for change was not to scold myself, but rather, to substitute better behaviors—ones that I wanted anyway—that would block the discriminatory behaviors I intended to prevent.

My goal became to try to "deliver authentic respect" to everyone—not an easy task. I had to consider whether my words and behavior, with each person I met, would be interpreted as respect. I tried, whenever possible, to look for and then affirm the accomplishments of others, rather than starting with gaps in performance or faults. Thus, in my first year at MIT, I began to think and write not only about micro-inequities but also about "micro-affirmations." I defined micro-affirmations as "apparently small events which are often ephemeral and hard to see, events that are public and private, often unconscious but very effective—which occur wherever people wish to help others to succeed" [2].

Hundreds of individuals have written to me, since 1973, that practicing (truthful) micro-affirmations is a powerful and useful way to think and act. System-wide programs to teach micro-affirmations could well be found useful by organizations.

Although research does not show that our current training about unconscious bias, by itself, changes biases or behavior, I believe that individuals *can* change their behavior to some degree, in a different way. We can learn behaviors that tend to *block* our biases. Also, I have seen that micro-affirmations not only provide leverage against biases but also might help to address ignorance and negligence. Here are some ideas as to why a systematic approach to affirming behavior can work (there is scholarly research on each of these points).

Blocking and Perhaps Modifying Unconscious Bias

We can try to practice—with *everyone*—affirming genuine achievements of others and acts of kindness. If we look for (at least some) excellence in the work of everyone and are determinedly respectful, then we might be able to block some micro-inequities and remediate our lack of knowledge about others and even negligence. Research suggests that behavior follows attitudes. Behavior also can change attitudes; this is the basic principle underlying diversity programs. If we consciously focus on genuine excellence in each person, then we can modify our biases.

Ameliorating Damage

Micro-affirmations (eg, from supervisors, mentors, and affinity groups) can help to counteract or

compensate for some of the emotional or reputational damage caused to individuals when they are hurt by unfair acts.

Meeting Core Emotional Concerns

Appreciation and affirmation are "core concerns" for all humans; institutional programming on micro-affirmations can help in making the workplace happier and more productive (micro-affirmations, in some circumstances, matter as much to recipients as tangible rewards such as money).

Evoking Reciprocal Affirmation and Role Modeling

Research suggests an innate impulse toward "reciprocity"; affirming behavior can spread as recipients respond to genuine recognition of excellence from affirmers. We also know that people are sensitive to the morale and happiness of those around them and especially attuned to the behavior of local managers. If managers become role models for affirming behavior, then *bystanders* and recipients might follow suit.

Teaching Specific Goals and Skills and Meeting Specific Interests of Recipients

Specific affirmations can confirm particular skills that are needed in settings such as a hospital. In addition, it is important to recipients that their own *specific* interests be affirmed with words and actions.

Readers will note that all these ideas need discussion and research. What is "micro-affirmation" and what is a "macro-affirmation" and how are they related? How are they to be observed and assessed? Who decides? Can micro-affirmations help change a climate of bullying, racism, misogyny, and other forms of discrimination? Can micro-affirmations help to change the behavior of a person who is ubiquitously disrespectful? We need to understand the concomitant role in an organization of its having tough rules and consistent application of consequences for injurious behavior. It takes a "systems approach"—with consistent values and support—for individuals to build an affirming climate.

Some organizations are working to understand the effect of "affirming" the accomplishments of members. They collect the memories of minorities and women about significant affirmations. They look for cross-cultural, cross-generational, and cross-cohort differences—and tally practical effects—such as improvements in recruiting and decreases in complaints. They search for ways to communicate these ideas in ways that do not just remind women (or men for that matter) of being told to be "nice." The goal is to exemplify the ideals of fairness and respect in genuine and authentic affirmations of the achievements of others.

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Micro-inequities in Medicine: Legal and Ethical Implications

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Picture this scenario: a female attending physician enters a patient's room on the inpatient unit of an academic medical center accompanied by a male medical student. The patient addresses the medical student as "doctor" and largely ignores the physician. The medical student doesn't correct the patient, but when the physician attempts to clarify her leadership role on the medical team, the patient replies, "You look too young to be a doctor." Later in the day, the patient asks to speak with "the nurse that came by this morning."

Each aspect of this scenario represents a micro-inequity, a term first described by Mary Rowe, PhD, in 1973 [1]. Samantha Brennan, PhD, expanded on Rowe's definition, noting that micro-inequities are "small, unjust inequalities often pointed to as a part of the larger story about larger scale inequalities, such as women's unequal place in the workforce" [2]. What are the legal and ethical implications of such micro-inequities in the health care workplace?

From Micro- to Macro-inequity

Rowe identified a "cumulative, corrosive effect" of micro-inequities [1]. For women in health care, including physicians, physicians-in-training, and medical students, micro-inequities can have a number of cumulative effects that can take a mental and physical toll over time. This can include—but is not limited to—stress, anxiety, and depression that can lead to job dissatisfaction and burnout. The source of the micro-inequity can vary but can come from colleagues, staff, administrators, and, as the example notes, even patients. Although it might be easier for some to brush off individual micro-inequities, their cumulative effect can wear down even the most resilient of individuals. The impact of micro-inequities can be amplified for women in medicine, particularly those who also identify as

members of other under-represented groups, such as ethnic minorities or lesbian, gay, bisexual, and transgender.

Micro-inequities and a Hostile Workplace Environment

Micro-inequities, on their own, generally do not rise to the level of actionable discrimination or harassment. Yet, taken together, they can have the effect of creating a hostile work environment claim that a court might allow to proceed to trial. Rather than discrete overt acts of harassment, such claims would be focused on the cumulative effect of a series of actions over time.

To be successful under Title VII of the Civil Rights Act, the U.S. Supreme Court held that harassment based on gender "must be sufficiently severe or pervasive 'to alter the conditions of [the victim's] employment and create an abusive working environment'" [3]. Whether that substantial threshold has been met will depend on the facts of the case, but courts can consider sexual or racial harassment directed at the affected individual and harassment directed at others in the workplace. A second U.S. Supreme Court case clarified that, for purposes of Title VII, discrimination based on gender could be construed to include same-sex discrimination [4]. As such, hostile workplace environment claims are to be evaluated in a gender-neutral fashion.

Absent an overt or egregious act, it's unlikely that the cumulative effects of micro-inequities alone would meet the requirements of a successful hostile workplace environment claim. The facts of the case would be reviewed from the perspective of an objective "reasonable person," although if the plaintiff were to win the case, then a court could take his or her subjective emotional distress into consideration when calculating damages. In a separate case, the U.S. Supreme Court distinguished discriminatory behavior from "those petty slights or minor annoyances that often take place at work and that all employees experience" [5]. Further, even a hostile workplace environment, if it affects all employees equally, cannot be the basis for a Title VII claim. Courts also are unlikely to extend liability to employers for micro-inequities arising from patients, unless evidence shows the employer failed to respond to specific complaints.

Legal and Ethical Imperative to Correct Micro-inequities

Micro-inequities against women physicians in the workplace should be taken as seriously as micro-inequities against patients in clinical care settings. In medicine, colleagues should be attentive to the concerns and needs of others in the workplace. Tactfully and nonjudgmentally calling out micro-inequities when they occur can limit stress and anxiety and educate those who might have inadvertently caused them. However, the onus need not fall on the aggrieved individual to object to micro-inequities: bystanders (nonparties to the micro-inequity) also can be engaged.

Male colleagues have a responsibility to respond when they identify micro-inequities affecting women in the workplace. Consider what the male medical student in the hypothetical scenario could have done. When addressed as "doctor," he could have told the patient, "I'm not a doctor yet, but this is my attending physician, Dr K. She's in charge of your care in the hospital." Perhaps the medical student was oblivious to the patient's remark, too focused on systematically presenting the details of the patient's history and physical examination. Presenting on the wards can be a stressful experience for a medical student. However, a simple debrief after leaving the bedside can be instructive; it can be integrated into constructive feedback of the student's case presentation. Although it might often seem easier for trainees to avoid correcting patients or colleagues, they should learn to identify micro-inequities in the workplace, even those that do not affect them directly.

Health care organizations and administrators also must be more proactive in addressing micro-inequities. Electives or modules focused on resilience, efficiency, and physician well-being often focus on the individual, rather than on the systemic issues contributing to and perpetuating a culture of micro-inequity. When employers address micro-inequities, they might minimize the incidence of overt discrimination or harassment and prevent escalation of micro-inequities into more egregious misconduct. An environment where micro-inequities are tolerated might evolve into an environment where macro-inequities or sexual harassment become a legal issue.

The #MeToo, #MeTooMedicine, and #TimesUp movements have the potential to broaden the scope of employment law over time to address the cumulative impact of micro-inequities. Some states, such as California, require employers to take "all reasonable steps necessary to prevent discrimination and harassment from occurring" in the workplace [6]; an element of this response could include adequate and timely response to micro-inequities. Rather than acting purely to limit legal exposure, health care organizations ought to focus on creating a culture of health not only for patients but also for providers. This extends to maintaining a workplace environment in which micro-inequities are taken seriously; the well-being of women in medicine might depend on it.

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Micro-inequities: You Can't Fight What You Don't See

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I live by the maxim, "You can't fight what you don't see," and macro- and micro-inequities are no exception to this rule. Growing up in an environment where inequities occur frequently and are considered normal limits your ability to realize they are constantly happening to you. This was precisely my case. I was born and raised in Colombia, a country where I went to medical school and lived until I was 24 years old. In Colombia, men are often considered superior and therefore are given significant advantages. Although I started questioning this view at a young age, I learned to accept these situations as part of my life, making it very hard for me to identify macro-inequities and even harder to realize subtler yet more frequent micro-inequities. Fortunately, this environment was counteracted by the education I received during my 11 years at an all-girls school. The students and most teachers were female, so gender disparities were not an issue. I soon learned that recognition should be based on merit, not personal, unchangeable factors.

My Experience During Medical Training

In retrospect, during my medical training, I found I was the target of a macro-inequity during my first month of medical school as an enthusiastic 18-year-old young woman from a small town near the northern coast of Colombia who had recently moved to Bogotá (the capital) to attend medical school. My anatomy professor, an older man, made me the target of his jokes in front of more than 100 of my classmates. His jokes made fun of my accent and he invoked stereotypes of the people of my region. At the time, I laughed at the jokes without realizing how it was going to influence my demeanor and actions for the rest of my time in medical school. However, what happened is that, because of this professor's bias, from then on, many of my classmates recognized me as the stereotypical girl from the northern coast of Colombia. In consequence, they assumed I was not very intelligent, and it was not until they realized that I had one of the highest grade point averages among my classmates that they started to see me differently. Over the years, I gained my professors' and peers' respect and graduated in the top 3 of my class. However, instead of starting on the same playing field, I had to prove my value first. Those inequities drove me to prove that I am not only an excellent physician but also do not fit any stereotypical label. In the end, I have to say that this experience has made me not only self-conscious but also stronger and resilient.

By the time I finished medical school, I expected to be treated unfairly; however, during residency in the United States, my expectations started to change. I sought out mentors who helped me achieve my goals and discover my value as a physician. Matching to my top program and positive feedback from my peers and attendings were some micro-affirmations that made me realize I was up to the challenge. I learned a new way of thinking that helped me understand that there should be no tolerance for actions that singled out, overlooked, ignored, or discounted an individual based on innate characteristics, such as race or gender. Nonetheless, I continued to experience these kinds of situations, although in subtler ways. In the United States, blatant actions that condone obvious discrimination, such as that involving my anatomy professor, are taken seriously by medical professionals. However, micro-inequities, because of unconscious bias, flourish. The fact that they are considered micro doesn't make them less reprehensible but does make them harder to be identified and penalized.

Although the leaders and faculty in my residency program were very supportive, I had to deal with micro-inequities that came from a variety of other sources. As a minority woman and an international medical graduate, I have what is termed *intersectionality*. This means that because I am associated with more than one under-represented group, people might consciously or unconsciously be more biased against me. Therefore, every day I face the challenge of proving to others that I am not in my position by chance, but rather by a combination of intelligence and hard work. For example, I recall when an interviewer said that I should join his residency program because it was likely that other programs would not appreciate "somebody like you." I immediately asked what he meant by this statement, and he responded that because I was an international female applicant, other programs might not see my full potential. He essentially complimented his own intelligence (by recognizing my value) while simultaneously devaluing me. He might have thought that he was giving

me a compliment; however, highlighting my potential "weaknesses" was a way of undermining my candidacy based on unchangeable characteristics.

Micro-inequities can come from our colleagues or superiors, but patients also feed into this cycle. It is very common, especially in Miami, where I completed my residency, to encounter patients who do not address female physicians in the same respectful way as our male colleagues. Often, they refer to us by our first name or, what is more reproachable, they use expressions, such as sweetie, honey, or *mami* (a Latin expression) to address us. These expressions discount our position as physicians and force us try to compensate for that.

Impact on My Career Moving Forward

Experiencing inequities throughout my life has allowed me to see them more as challenges than as obstacles. However, it also has conditioned me to think I am constantly being scrutinized, and feeling this need to prove myself can be emotionally and physically exhausting. At this point in my life, now that the field is more level, I am not sure how much of the need to prove myself is coming from what other people expect from me versus my own sense of responsibility.

My experiences will continue to influence the way I interact with people and conduct myself, especially at work. Understanding the impact that inequities can have on someone's career and knowing how macro- and micro-inequities take form will help me to identify and counter them. Having gone through this process also will be valuable in helping me to educate the younger generation of physicians to not only stand up against any type of inequity but also to not become one of those who consciously or unconsciously create a negative culture.

I believe that people are increasingly realizing that there is no room for any type of discrimination. Women have stood up and our voices are stronger than ever. We have the momentum in our favor to take the ball across the goal line and ensure that inequities become just an unfortunate chapter of our history.

Micro-affirmations

I believe micro-affirmations are our human responses to counteract the negative impact caused by micro-inequities. In my case, micro-affirmations have been fundamental in developing the self-confidence that has allowed me to get to the point in my career where I am today. However, they should be used only to highlight someone's genuine achievements and excellent work. Affirmations should never be confused with helping somebody based only on personal preferences or gender, race, or religious affinity.

That being said, it is difficult to put our personal affinities to the side. I often find myself wanting to help Hispanic international graduates trying to get into a residency. I remember when I was one of them. However, I make sure to provide the same opportunities for all students without considering their place of origin. If affirmations are used in an erroneous way, then we are at risk of transforming them into inequities. Ideally, micro-affirmations should be unbiased acknowledgments of a person's accomplishments.

Strategies to Mitigate Micro-inequities That Exclude Women: A Call to Arms

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In "Advancing Women and Closing the Leadership Gap: The Executive Leadership in Academic Medicine (ELAM) Program Experience," Richman et al [1] noted the "myriad of microinequities that exclude women and undermine their self-confidence and productivity." These micro-inequities include salary inequities and pervasive gender insensitivity that lead to disadvantages, such as the availability of fewer mentors and institutionalized, unconscious bias.

In 2018, salary inequities remain glaringly real. Male primary care doctors earn almost 18% more than female doctors and male specialists earn 36% more than their female counterparts [2]. In 2016, researchers found that 30% of female medical school faculty reported sexual harassment over the course of their careers [3]. Therefore, although women have made notable advances in numbers in positions of leadership, inequities in salary and prevalent bias remain as bulwarks that need to be dismantled. Effective sponsorship, with its benefits of advocacy and feedback, has great potential to combat these micro-inequities and other forms of bias and can have a significant, positive impact on a woman's career trajectory. Sponsorship of talented women in academic medicine has been recognized in recent years as a critical piece in the puzzle of how to help advance their careers. In an article in *Academic Medicine*, Amy S. Gottlieb, MD, and Elizabeth L. Travis, PhD, stated, "Formal sponsorship programs that match women with senior leaders facilitate access to beneficial relationships and institutionalize the value of equal opportunity" [4].

In reflecting on sponsorship and its potential to affect not only the advancement of individual women but also the overarching community of women in academic medicine, I recognized even more clearly the influence that one ELAM cofounder had in helping to move women forward and upward, making headway against the systemic inequity in the upper chambers of academic medicine. The ELAM program recently lost one of its brightest lights. D. Walter Cohen, DDS, who cofounded the program with

Patricia Cormier, EdD, and Page Morahan, PhD, in 1995, passed away on June 29, 2018. Dr Cohen clearly represented how powerful the work of a sponsor can be and made it clear to me that the journey toward gender equity in academic medicine needs to be a partnership between women and men. Dr Cohen was a visionary leader who helped blaze the trail for women leaders in academic medicine and a sponsor for women at a time when sponsorship was the exclusionary "old boy network."

When the ELAM program was conceived, there were just 3 women deans of medical schools. Currently, there are 23 women deans of medical schools (13 of whom are ELAM alumnae), which deserves real celebration. At the same time, micro-inequities that were present in the early years of ELAM remain true and ingrained in the culture of academic medicine. We have made inroads in some ways but have stalled at progressing in other ways. How do we frame our tactics for our next steps?

In 1993, Drs Cohen, Cormier, and Morahan conducted a needs assessment of medical school deans. After reviewing the findings, they designed a program that would address the challenges of advancing women leaders in academic health centers, would help sustain the success of women who achieved these leadership positions, and would work to change the culture of academic health centers to value the contributions of women. The program has had remarkable success with a measurable impact on the number of women in academic leadership positions. More than 1,000 ELAM graduates are leaders around the world, helping to narrow the gender gap in academic medicine. Other leadership development programs such as those offered by the Association of American Medical Colleges, early and mid-career Women Faculty Leadership Seminars, and the Harvard T.H. Chan School of Public Health's Emerging Women Executives in Health Care also have had a major impact in moving women into the upper ranks of academic leadership positions.

However, as ELAM approaches its 25th anniversary, Dr Morahan recently noted that although she was excited about this milestone, she also was saddened that, a quarter of a century later, women had still not reached parity in academic medicine.

For change to occur, conversations about micro-inequities need to be ongoing and be present in the highest forms of leadership. Robert Alpern, MD, Dean of the Yale School of Medicine, "speaks to all 29 departments at Yale School of Medicine each year about the 'climate of caring.' People have to believe that the people at the top really care, so I talk about it and the department chairs talk about it, not HR'" [5].

And now, in the age of the internet and Twitter and other forms of social media, another, more immediate platform, is available. The doors have flung wide open for women and allies to call out egregious behavior, to nimbly react to transgressions, and to create cohesive communities of supporters. Here, we have a public space where women can galvanize their colleagues to create online communities, disseminate research without needing an invitation, and report when they experience or see bias.

Other tactics include intentional efforts to increase the number of female voices by nominating women for awards, offering speaking opportunities, particularly as keynote speakers, interviewing women for stories, and using their quotes. Additional efforts should include leadership training for women; policies to ensure pay equity, leave flexibility, and no harassment or discrimination; implicit bias training for all; intentional inclusion of women on search committees; instituting policies that mandate women to be finalists for positions at every level in an organization; and facilitating women to serve on boards.

Transforming the culture of academic medicine by opening up sponsorship from the "old boy network" to include and promote women will go a long way in the battle against micro-inequities. Although this is not the only piece of the puzzle, it is a significant one, and one women and men can work on together.

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Concluding Remarks

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These excellent commentaries provide insights into how a thriving micro-inequity environment can be harmful by itself and can actively support macro-inequities, including in compensation and promotion. Although most first-year American medical students are female, only 15% of deans are women [1]. Other high-ranking positions show similar gaps for women that

cannot be explained by a lack of qualified or interested candidates. Nevertheless, many U.S. medical schools have no programs in place to address gender equity [2]. Importantly, there also are documented disparities for men and people across the gender spectrum who identify with at least 1 under-represented group.

There is no doubt that we have an ethical imperative to intentionally address workforce disparities and to ensure that medical training and practice provides a supportive and equitably inclusive environment for everyone. There is broad agreement that explicit (conscious) bias has no place in medicine. Although implicit (unconscious) bias is harder to identify, it places physicians, patients, and many others in harm's way. Implicit bias has been implicated as a major contributing factor in health care workforce disparities—large and small. For women, PM&R is similar to other specialties in that there are documented historical and current disparities.

The good news is that there is increasing awareness about and decreasing tolerance for health care workforce disparities. I believe some of this is due to robust online forums that provide women and our allies an opportunity to connect and share information [3]. For example, the Women in PM&R Facebook group has more than 1,200 members.

For women physiatrists, there are some notable markers of progress including steps being taken to identify gender disparities. For example, several PM&R departments have conducted internal faculty compensation analyses and transparently shared the results with stakeholders. The incoming Editor-in-Chief of *PM&R* is a woman physiatrist, and this journal and the *American Journal of Physical Medicine and Rehabilitation* have taken active steps to address disparities for women on the editorial board. The Association of Academic Physiatrists (AAP) has developed a Women in Academic Physiatry task force that I co-chair with Sara Cuccurullo, MD, and includes male and female physiatrists working together. We just released a report that identifies gaps at the AAP and proposes solutions to address them [4]. The AAPM&R Board of Governors is in the process of finalizing a diversity and inclusion strategic plan and creating a new standing committee to inform board members' decisions and actions as individual leaders and to evolve a more inclusive organizational culture.

Solving micro- and macro-inequities must begin with education about these issues and then proceed to informed discussions regarding next steps. These are core principles of medical professionalism. In the journal *Academic Medicine*, the authors of a perspective on medical professionalism suggested that it "should serve to ensure that practitioners are worthy of the trust bestowed on them by patients and the public. Most fundamentally, therefore, professionalism requires that health professionals, as a group, be ready, willing, and able to come together to define, debate, declare, distribute, and enforce the shared competency standards and ethical values that must govern medical work" [5, p. 713]. There is no doubt that our shared ethical values include treating all trainees and colleagues fairly, and to do this we must confront bias in all its forms and rid medicine of the resultant micro- and macro-inequities.

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