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Abolish the Minority Woman Tax!

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In this issue of the *Journal of Women's Health*, Rodrigues Armijo et al.[1] are to be commended on their excellent article on citizenship tasks for women physicians in academic medicine and the extra burden they shoulder for the sole privilege of being academic physicians. They have elucidated how citizenship tasks are unfairly distributed and coined a new addition to the literature—a ''citizenship tax.'' It is appalling, but it is the very tip of the iceberg.

Many authors have written about the unique burdens faced by women in academic medicine. First and foremost is the pay disparity, which virtually guarantees that women with the same experience, productivity, and clinical expertise are paid less than men.[2,3] It is an injustice that is pervasive in our system, and calls have been made to end this sexist practice.[4] Women in academic medicine also face a motherhood penalty, which costs career progress, lost wages, and stigma,[5] whereas men are rewarded for fatherhood.[6] Women of color in academic medicine face additional challenges. Often in academic medicine the term ''women'' refers to ''White women,'' as the layered experiences of under-represented minority (URM) and other women of color are frequently omitted from the discussions and data.[7–9]

Rodrigues Armijo et al., however, *did* include the experiences of women of color in their discussion of the additional woman tax.[1] Their subanalysis of data found that women of color experienced more of a burden from additional citizenship tasks than their White women colleagues. Women of color felt that race played a role in their feelings of obligation to take on additional uncompensated citizenship tasks. However, the analyses do not separate out those data for URM women in medicine, defined as Black, American Indian/Alaska Native, Latina, and Pacific Islander women.

The specific obstacles faced by URM faculty in academic medicine are best described as a system of disparities or taxes.[10,11] URM faculty take on additional work, including diversity efforts and clinical responsibilities, while experiencing the challenges of racism, isolation, disparate compensation, and a lack of mentorship. These taxes diminish time for scholarship, placing URM faculty at a disadvantage for promotion. Owing to their intersectional identities, URM women in academic medicine endure a ''minority woman tax,'' the summation of the minority tax, *and* the woman tax. URM women are rarely represented in studies on women and academic medicine, even those that acknowledge women of color. As a result, they are consistently excluded from the conversation and their experiences go invalidated.

We have asked four Black women physicians, and authors of this editorial, to collect stories of the manifestations of the minority woman tax. We recognize that we are not highlighting other URM women's specific experiences and hope to highlight them in subsequent publications. These stories are very personal, and to protect those who trusted us with them, we have anonymized the stories. One physician shares that as a Black woman physician, she is continuously tokenized: ''I am asked to interview minority candidates for both residency and faculty positions, be featured in multiple promotional videos for the hospital's marketing team, mentor minority residents (even outside of my department), and sit on various committees throughout the university and hospital because they are diversity adjacent or they needed more diversity on the committee, even when they are completely outside my career interests. Although I do believe that being a good departmental citizen is an important component of my job, the amount of time spent away from both clinical and scholarly activities is a direct tax to the productivity and quality of my work as an academic physician. Additionally, I have been told that as a faculty member, I am not paid to advance my career, so 100% of my scholarly activity must be done on my own time—nights and weekends. I cannot imagine a more sexist and racist declaration.''

Another physician shared, ''I typically choose to describe myself as a Black Woman Physician Mom. Given the lack of Black women in academic medicine, I often take it upon myself to coach or mentor Black women pre-med students, medical students, and residents. I try to give my time as others did for me, knowing the relative lack of opportunities to find those that look like us to fill that role. I often volunteer to be the woman

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and/or minority voice on numerous committees and initiatives. Each time I volunteer to help (almost always uncompensated for additional time beyond standard work hours), I am faced with having to decide how much I am willing to take away from my husband and children.'' She continues, ''During many interactions with White patients, it becomes apparent the patient's lack of trust in my medical knowledge and ability stems from my race, gender, and youth. This places an added burden (tax) on me to prove my competence. During encounters with patients of color, there is often a sense of pride shared between us, but also a hidden expectation that I will be more giving, lenient, self-sacrificing of my time, or an expectation that I will provide free care to demonstrate my dedication to my people.''

A third physician shares, ''as a Black woman physician, my gender identity is often eclipsed by my racial identity. On committees and in meetings, I am rarely the only woman, but frequently I am the only Black person at the table. In formal and informal discussions of sexism and gender inequities in medicine, the repeated failure to acknowledge Black women's experiences makes it difficult to find a genuine coalition with the White women who are centered in these conversations. I am in effect, paying an 'invisibility tax.' When my White women colleagues complain about being called 'nurse' by a patient, I understandingly shake my head in agreement while also thinking to myself that as a Black woman physician, 'nurse' is not the n-word I worry about being called by my patients.''

Speaking with one senior Black woman physician leader, she shared, ''I can only echo the sentiments shared here. The invisibility tax stifles career advancement at multiple levels and prevents movement into leadership positions within institutions. Because of the invisibility tax, we too often must hear our ideas presented by others as their own, never giving us acknowledgment for our hard work. This can lead to anger, resentment, and burnout. Being shut out of promotion into leadership positions that could end these 'taxes' leads to further pay disparity and opportunities to influence decisions that directly impact Black women.''

These accounts from Black women physicians illustrate how the minority taxes intersect with the woman taxes to adversely affect URM women in academic medicine. This minority woman tax is an additional injustice that must be named, acknowledged, and eliminated.

So, what can academic medicine do to remove the minority women tax as we seek equity? First, we must acknowledge this tax, recognizing that the labor of URM women subsidizes the work of non-URM faculty further perpetuating the inequities that exist. Second, we must elevate the voices of URM women in academic medicine and intentionally make space for their expertise in areas of influence. Third, we need more scholarship exploring and validating the experiences of URM women in academic medicine. Once we have identified and named the ''taxes,'' academic medicine can then build the ''tax shelter'' to eliminate them. This tax shelter will make academic medicine a more just environment for URM women, and by so doing, promote equity for all faculty in academic medicine.

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