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Improved Infectious Diseases Physician Compensation but Continued Disparities for Women and Underrepresented Minorities

To the Editor—We appreciated seeing a recent report on physician compensation in *Open Forum Infectious Diseases*. Trotman et al [1] found, in the largest survey of infectious diseases (ID) physician compensation to date, that ID physicians are generally paid more than the amounts previously published in Medscape and Doximity reports [2, 3]. The authors made initial efforts to examine differences in physicians' salary by gender and noted that further analyses of the gender disparity in physician salaries are underway in conjunction with the Gender Disparity Task Force established by the Infectious Diseases Society of America (IDSA) in September 2016 [4].

Evaluating compensation disparities by race/ethnicity is equally important and complementary to evaluating disparities by gender. Although African Americans and Hispanics account for 13% and 18% of the US population [5], respectively, they account for only 7% and 12% of ID trainees [4] and only 4% and 8% of IDSA member physicians [1]. Moreover, underrepresented minority (URM) physicians earn less than white physicians [6] but are more likely to care for URM patients [7], who are, in turn, disproportionately affected by infectious diseases [8].

Unfortunately, the Medscape, Doximity, nor IDSA publications on compensation have not included comparisons by race or ethnicity. Some data on physician compensation by race are presented in the full ID compensation report available to IDSA members online (www.idsociety.org/clinical-practice/compensation/compensation/), in the "Clinical Practice: Compensation" section [9]. According to these data, African American ID physicians were paid 7%–13% less than almost all other racial/ethnic groups as private practice owners, hospital employees, academic medical center employees, and research/teaching physicians (Table 1).

Although these data are based on unadjusted salaries with few responders in the URM categories for each practice type, they illustrate several points. First, given that disparities in pay do seem to exist in this small sample, a more robust attempt to gather income data on URM members, adjusting for other potential confounders, is warranted. Second, it will be important to identify reasons for these compensation disparities, support URM ID fellows and junior faculty through leadership development, and develop strategies to create more equitable compensation. Finally, although the survey collected binary information about gender, it did not collect information about gender identity and sexual orientation; further work should be done to define and report on these factors.

We are heartened to see increasing awareness of the inequities in physician compensation and career advancement. In their 2017 report, Aberg et al [4] urged IDSA "to establish a diversity and inclusion committee to generate the data

Table 1. Median Compensation for Full-Time Infectious Disease Physicians by Race/Ethnicity[a]

Practice Type	White		African American		Asian American		Hispanic		Other	
Private practice	Respondents, No.	Median Income, $	Respondents, No.	Median Income, $	Respondents, No.	Median Income, $	Respondents, No.	Median Income, $	Respondents, No.	Median Income, $
Sole owner, partner, or solo practice	150	298 500	10	262 700	32	293 800	20	300 000	15	390 000
Associate or employee	37	220 000	6	…[b]	29	210 000	12	191 500	4	…
Hospital or clinic employee	245	236 000	17	220 000	81	250 000	44	242 800	25	220 000
Academic medical center employee	372	190 000	14	175 000	98	170 000	49	180 000	19	150 000
Pediatric practice	84	175 000	1	…	19	160 000	14	167 500	4	…
Research/ teaching	317	200 000	14	172 500	46	158 600	26	173 500	8	…
Public health	58	194 000	6	…	9	…	3	…	3	…
Other	138	287 000	7	…	19	262 000	13	212 000	7	…

Abbreviations: AMC, academic medical center

[a]Data taken from the full infectious diseases compensation report available to Infectious Diseases Society of America members online (www.idsociety.org/clinical-practice/compensation/compensation/), in the "Clinical Practice: Compensation" section [9]. Numbers represent the number of full-time physician respondents answering each question.

[b]Income results in groups with <10 respondents were suppressed to maintain confidentiality.

necessary for developing a strategic plan to improve the diversity of our workforce and eliminate disparities". In September 2018, IDSA appointed members to the new Inclusion, Diversity, Access & Equity (IDA&E) Task Force, and the group has already released a set of guiding principles whereby IDSA commits to reflect the diversity of its membership [10]. Future tasks should include the creation of a road map for the IDA&E Task Force that includes definitions, metrics, and actionable plans to address gender and racial/ethnic disparities in ID and ensure that the full potential of women and URM ID physicians is realized. Meanwhile, individual ID physicians can themselves be more intentional about reaching out to mentor, sponsor, and support women and URM to join and remain in the field of ID.

In conclusion, we are encouraged by the ID physician compensation data published by Trotman et al [4] and look forward to additional analyses focused on gender and racial/ethnic income disparities. Creation of the Gender Disparity and IDA&E task forces with their commitment to examining disparities are positive steps toward ensuring equity for all IDSA members. We look forward to seeing the work of these 2 groups and are optimistic about the future of women and URM physicians in ID.

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Jasmine R. Marcelin, Sara H. Bares, and Nada Fadul

Division of Infectious Diseases, University of Nebraska Medical Center, Omaha

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Correspondence: Jasmine R. Marcelin, MD, Division of Infectious Diseases, University of Nebraska Medical Center, 985400 Nebraska Medical Center, Omaha, NE 68198-5400 (jasmine.marcelin@unmc.edu).

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