ORIGINAL RESEARCH

How Early Career Family Medicine Women Physicians Negotiate Their First Job After Residency

Annie Koempel, PhD, RD, Melissa K. Filippi, PhD, MPH, Madeline Byrd, MEd, Emma Bazemore, Anam Siddiqi, MPH, and Yalda Jabbarpour, MD

Background: **Nested within a growing body of evidence of a gender pay gap in medicine are more alarming recent findings from family medicine: a gender pay gap of 16% can be detected at a very early career stage. This article explores qualitative evidence of women's experiences negotiating for their first job out of residency to ascertain women's engagement with and approach to the negotiation process.**

Methods: **We recruited family physicians who graduated residency in 2019 and responded to the American Board of Family Medicine 2022 graduate survey. We developed a semistructured interview guide following a modified life history approach to uncover women's experiences through the transitory stages from residency to workforce. A qualitative researcher used Zoom to interview 19 geographically and racially diverse early career women physicians. Interviews were transcribed verbatim and analyzed using NVivo software following an Inductive Content Analysis approach.**

Results: **Three main themes emerged from the data. First, salary was found to be nonnegotiable, exemplified by participants' inability to change initial salary offers. Second, the role of peer support throughout residency and early career was crucial to uncovering and rectifying salary inequity. Third, a pay expectation gap was identified among women from minority and low-income households.**

Conclusion: **To rectify the gender pay gap in medicine, a systems-level approach is required. This can be achieved through various levels of interventions: societally expanding the use of and removing the stigma around parental leave, recognizing the importance of contributions not currently valued by productivity-based payment models, examining assumptions about leadership; and institutionally moving away from fee-for-service systems, encouraging flexible schedules, increasing salary transparency, and improving advancement transparency. (J Am Board Fam Med 2024;00:000–000.)**

Keywords: **Family Medicine, Negotiating, Pay Equity, Primary Care Physicians, Primary Health Care, Qualitative Research, Salaries and Fringe Benefits, Women Physicians, Workforce**

Introduction

The gender pay gap in medicine is well-documented, with research demonstrating that women physicians earn significantly less than their male counterparts.[1–6] When controlling for hours worked, early career female family medicine physicians were found to make approximately 16% less than men.[7] When matched by payment models, female physicians earned less than males, with a 21% gap under productivity-based models.[8] Several factors contribute to these disparities, including differences in billing practices, use of parental or family leave, inbox management, time spent with patients, and negotiation tactics.[8,9] Research suggests that male physicians often exhibit a greater willingness to negotiate for higher salaries and are more frequently selected for leadership positions, further exacerbating the earnings gap.[10]

Previous research identified significant variations in the negotiation skills of family medicine graduates.[11]

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Corresponding author: Annie Koempel, PhD, RD, American Board of Family Medicine, 1648 McGrathiana Parkway, Suite 550, Lexington, KY 40511-1247. (E-mail: AKoempel@theabfm.org).

Notably, women often expect lower salaries than their male counterparts, contributing to or exacerbating the gender pay gap. Furthermore, residents self-report a lack of tools for successful negotiation, and women residents displayed lower confidence in their negotiation abilities compared with their male counterparts.[12] Additional studies have highlighted the propensity of female job applicants to be penalized for negotiating, especially when interacting with male interviewers.[3,13] Importantly, even when they do negotiate, women are less likely to receive what they ask for when compared with men[14] and may even be penalized for initiating negotiation.[15] Such findings highlight the need for change on an institutional level, such as pay transparency and hiring practices developed through diversity, equity, and inclusion frameworks.

To date, research on the gender pay gap within medicine – and specifically within primary care – has been quantitative in nature, defining the scope and extent of the issue. Many of these articles offer more training on negotiation as one potential solution to the gender wage gap, but none focus on the actual experiences of women in primary care as they negotiate their first job out of residency. This article explores participants' experiences negotiating for their first jobs out of residency to understand contract negotiation barriers.

Methods

This article is part of a larger qualitative study concerning the gender pay gap within family medicine, of which negotiating is one piece. A purposeful sample of American Board of Family Medicine (ABFM) diplomates who self-identified as women were recruited via e-mail over a 1-month period. All participants were early career physicians (3 to 5 years out of residency) and reported making less than the average income of $250,000 for a family physician in the United States.

All interviews were conducted via Zoom by a trained qualitative researcher (AK) using a semistructured interview script between February 9, 2023, and March 22, 2023. The interview guide was informed by a life history approach, in which questions progressed chronologically from the decision to pursue medicine to the present day. This larger study, of which the present results are a part, was composed of questions focused on mentorship opportunities, interviewing for a first job out of residency, negotiating for a first job, and gendered differences in work and compensation. Interviewees received $150 in remuneration for their time and effort.

Interviews were recorded and transcribed verbatim and lasted approximately 1 hour. Data were iteratively analyzed by 2 qualitative researchers (AK, MF) via inductive content analysis (ICA), with the assistance of secondary coders (EB, MB, AS). ICA follows standard stages of reading and familiarizing oneself with the data, organizing data into larger units through the development of an initial codebook based on the data, then "breaking open" and refining the data into subcodes before the final step of synthesis and interpretation.[16] The initial codebook was created by AK and MF using an initial set of interviews. All coding disagreements were reconciled via discussion. A coding comparison query, which calculates percentage agreement between 2 coders, found that all codes achieved greater than 90% agreement. Representative quotations have been edited for readability and to maintain the anonymity of the speaker.

This study was Institutional Review Board approved by the American Academy of Family Physicians (AAFP) Institutional Review Board.

Results

Efforts were made to recruit a diverse sample of early career women family physicians; 118 e-mails were sent to eligible physicians inviting them to participate with a final sample of 19 participants.

Interviews continued until thematic saturation was achieved. Just over half the sample (53%) self-identified as white and a third (32%) as Asian (Table 1). All Black women (n = 21) in our sample frame were invited, but no Black women chose to participate. Approximately one-third of participants (36%) worked in the Western census region of the United States, primarily in an urban location (79%). The average age of participants was 35 years old, and 42% worked in a hospital or hospital-owned practice. Demographic information of study participants may be compared to the demographic information of their cohort (Table 2).

While the language in this study and current article reflects a gendered binary, it is important to note that nonbinary and trans individuals face their own challenges navigating the same systems. Furthermore, we acknowledge the fluidity of gendered perspectives rather than strict, binary rules.

Table 1. Race and Practice Information of Study Participants from 2022 American Board of Family Medicine National Graduate Survey (Early Career) (n = 19)

Variable	Category	Percent (n)
Race	White	52.6% (10)
	Asian	31.5% (6)
	Pacific Islander or Native Hawaiian	10.5% (2)
	Black	0% (0)
	Other	5% (1)
Practice type	Hospital or hospital owned practice	42.1% (8)
	FQHC	21% (4)
	Managed care or HMO	10.5% (2)
	Academic health center	10.5% (2)
	Federal	5% (1)
	Government clinic, nonfederal	5% (1)
	Independently owned medical clinic	5% (1)
Rurality	Urban	79% (15)
	Rural	21% (4)
Census Region	West	36.8% (7)
	South	26.3% (5)
	Northeast	26.3% (5)
	Midwest	10.5% (2)

Abbreviations: FQHC, federally qualified health center; HMO, health maintenance organization.

Three main themes emerged from the data about negotiating. First, women overwhelmingly reported that salaries were nonnegotiable. Second, peer support played a crucial role in navigating institutions and uncovering injustices. Third, what we are calling a *pay expectation gap* was common, particularly among mothers and those from minority and/or low-income households.

Salary as Nonnegotiable

Women were overwhelmingly told by various members of administration that contracts were standard and nonnegotiable. Even when they hired a lawyer to review their contract, which most programs reportedly encouraged residents to do but only a handful of women did, this messaging of nonnegotiable contracts prevented many women from even attempting to engage in the negotiation process:

> "I didn't negotiate at all. Because the HR people told me upfront, oh, our contract is nonnegotiable. And they sent me like a document that laid out like, oh, for your number of years of experience, this is the pay level you fall into. And it's the same for everybody. And these are the benefits and it's the same for everybody. And so I was like, okay, I guess I can't negotiate."

Institutional standards for what was negotiable varied across practices. No preliminary patterns related to practice type and negotiability emerged from the data. Rather, regardless of practice type, some women were able to engage in negotiations and others were not. Within practice discrepancies also occurred. For example, one physician initially felt empowered to ask for a higher salary, but later discovered that was not possible:

> "When I talked with [the hospital recruiter and HR], [salary] seemed more negotiable and when I got to the boss [it wasn't]."

Women also encountered resistance to attempts at transparency as administrators maintained the obliqueness of how salaries were calculated:

> "I was asking. . .was there going to be any sort of recognition of the degree of how difficult the panel was. . .they were trying to explain to me. . .- they have this whole system of how [compensation by acuity] works. . .but they were like oh you don't have to worry about that."

In general, women expressed frustration with the mixed messages they received and found the negotiation process to be "weird" and trigger insecurities; it forced them to be "accommodating and pretend family was not significant," and confront how "it is so much easier to be perceived as mean and argumentative as a woman." In short, regardless of the process or outcome, negotiating was perceived as a negative experience by all participants.

Importance of Peer Support

Informal networks, such as co-residents, colleagues, family, and friends, were more consistent sources of support during negotiations than formal advisors or mentors. Women who had family members in or adjacent to the medical field tended to feel the most confident discussing negotiating and engaging in the process:

> "I have family members that are doctors. One of them, she's a family doctor too. And yeah, I really felt comfortable like talking to her about the different options I had. And another uncle too. And in the residency, there was also one of my

Table 2. Race and Practice Information of Respondents to the 2022 American Board of Family Medicine National Graduate Survey (Early Career) (n = 923) Study Participants Are a Sub Sample of this Cohort

	Categorical Income		
	<$250,000	>=$250,00	All Incomes
Total	696	227	923
Race			
American Indian or Alaska Native	4 (0.6%)	4 (1.8%)	8 (0.9%)
Asian	137 (19.7%)	51 (22.5%)	188 (20.4%)
Black or African American	59 (8.5%)	19 (8.4%)	78 (8.5%)
Native Hawaiian or Other Pacific Islander	2 (0.3%)		2 (0.2%)
Other	52 (7.5%)	17 (7.5%)	69 (7.5%)
White	442 (63.5%)	136 (59.9%)	578 (62.6%)
Rurality (RUCC)			
Urban	591 (88.1%)	174 (77.3%)	765 (85.4%)
Rural	80 (11.9%)	51 (22.7%)	131 (14.6%)
Principal practice site			
Academic health center/faculty practice	106 (16.6%)	8 (4.7%)	114 (14.1%)
Federal	32 (5.0%)	1 (0.6%)	33 (4.1%)
Federally qualified health center or lookalike	106 (16.6%)	13 (7.6%)	119 (14.7%)
Government clinic, nonfederal	8 (1.3%)	4 (2.4%)	12 (1.5%)
Hospital/health system owned medical practice	237 (37.0%)	81 (47.6%)	318 (39.3%)
Independently owned medical practice	78 (12.2%)	14 (8.2%)	92 (11.4%)
Indian health service	1 (0.2%)	3 (1.8%)	4 (0.5%)
Managed care/HMO practice	23 (3.6%)	16 (9.4%)	39 (4.8%)
Other	21 (3.3%)	7 (4.1%)	28 (3.5%)
Rural health clinic (federally qualified)	18 (2.8%)	22 (12.9%)	40 (4.9%)
Work site clinic	10 (1.6%)	1 (0.6%)	11 (1.4%)
Practice Region			
Midwest	156 (22.8%)	59 (26.0%)	215 (23.6%)
Northeast	113 (16.5%)	18 (7.9%)	131 (14.4%)
South	237 (34.6%)	72 (31.7%)	309 (33.9%)
West	178 (26.0%)	78 (34.4%)	256 (28.1%)

Abbreviation: HMO, health maintenance organization.

attendings which I felt very comfortable talking to him too about the different options that I had."

Co-residents – particularly those a year or two ahead of job candidates – were important sources of information about salary offers and what nonsalary benefits were negotiable. Nonsalary benefits that were discussed by participants included paid time off, flexible schedules, signing bonuses, moving expenses, and certification reimbursement:

"I had classmates…who were interviewing at other [places]. They would tell me this is what they offered me…. And I had friends who received other stuff than just salary increases – signing bonuses, relocation expenses, or reimbursement for licensing fees."

As participants entered their practices and developed networks of colleagues, these became important to overcoming institutional barriers to salary transparency:

"As doctors we frequently just shared our contracts around. We'll print up extra copies and so we are [transparent] with each other, but admin is not."

The importance of peer support to uncovering and overcoming injustices was also discussed:

"My second year as an attending, [my colleagues and I] discussed the salaries that we had been given amongst ourselves…And it turns out the five of us as new hires, the salaries that were given…was all in order of gender and color, like it was the white cisgender man [who] had the highest salary, even though he had the least amount of training and the least amount of educational

roles. Then next was the white man who identified as LGBTQ. Then next was the white cisgender woman, and then next was me as a light-skinned Asian female. And then last was one of my colleagues who's a Black woman."

These discussions resulted in the attendings collectively approaching management, who had recently turned over, and resolving the issue. In addition, the new leadership of the hospital undertook efforts to review salary data within and across departments.

While some participants had positive experiences with mentors and advisors from residency, most participants had more open and honest conversations about salary and negotiations within their informal networks.

Pay Expectation Gap

Many of the physicians interviewed struggled with confidence in their knowledge and worth as they transitioned out of residency:

> "I was … impressed by the number [I was offered], right? Cause I'm getting out of residency…. I'm like, oh wow, this is a good number and I feel stupid to ask for more."

This tendency to not feel deserving of a higher salary was exacerbated among women who were pregnant or had young children at home:

> "As freshly out of residency I don't have that experience…I'm pregnant, I felt they were almost doing me a service by hiring me instead of the opposite way around."

In addition, women from minority and/or low-income households tended to have reduced expectations for how much their time and expertise was worth:

> "I'm already as a…fellow at that time, making more money than my parents ever made in life. So no matter what the number is, it's going to be more than I'm accustomed to."

These same women reported not realizing that they could negotiate for nonsalary benefits. One participant in particular, a minority woman from a low-income household, shared that she "did not even know what [my] salary was until well after signing my contract." Her previous (and ongoing) precarity as the daughter of low-income immigrants contributed to her unwillingness to negotiate, even for nonsalary benefits.

Participants described how they tended to under appreciate their expertise as they exited residency. Some stated they recognized or felt that institutions played on their insecurities, fueling a system of pay inequity.

Discussion

This study explored early career women physician's experiences negotiating for their first job out of residency to ascertain their engagement with and approach to the negotiation process. During contract negotiations, women overwhelmingly reported that salaries were nonnegotiable. Peer support played a crucial role in negotiating nonsalary benefits for physicians' first job out of residency, as well as uncovering unjust salaries and renegotiating contracts 3 to 5 years into their career. A pay expectation gap was identified, where women who were pregnant, had children, or were from low income or minority households, had lower expectations for what they deserved to be paid.

Negotiation bans across a range of industries, including healthcare, have recently been instituted to attempt to minimize the gender pay gap.[17] These bans, however, tend to backfire. Many health systems compensate based on productivity, and women spend more time with patients when compared with men. Women should be able to negotiate for salaries that fit their work style. In other words, women should be offered the opportunity to be compensated on quality patient care rather than mere productivity.[18] Furthermore, some leadership positions, particularly those with administrative duties, offer higher salaries[19–21], but women face barriers to entering such positions[22], despite taking on more unpaid responsibilities, such as teaching. It is unclear which women were entering institutions with negotiation bans, but it is noteworthy that all women understood "no" to mean "no," which is unsurprising given the gendered nature of consent culture.[23–25]

Despite feeling insecure or not having the tools to negotiate for salary, many women described advocating for increased nonsalary benefits, such as paid time off, flexible schedules, signing bonuses, moving expenses, and certification reimbursement. Physicians with friends and family in or adjacent to the medical field were more confident in discussing and navigating

negotiations. Peer networks – of coresidents and colleagues – also played a crucial role in advocating for increased pay either during initial negotiations or contract renewals. Informal networks of peers are crucial to uncovering injustices, particularly when institutions actively work against payment transparency.

Even with the support of peers, however, systemic changes are necessary, especially to support women from low-income and minority backgrounds. The gender pay gap – the difference between what men and women in similar positions earn – and the pay offer gap – the difference between what men and women are offered during negotiations for similar positions – are well established within the literature.[2,3,7,9,26,27] Data from this project suggest a third gap – what we call the *pay expectation gap* – the difference between what men and women expect to be offered for the same position. While we did not interview men for this project, other research suggests that men are more confident about their skills in negotiation.[12,14,28] The pay expectation gap identified in this study suggests that women expect to be offered less salary and benefits when they are pregnant, have children, or come from low income or minority households. Previous research suggests that men are more willing to negotiate and expect higher salaries.[10,12,15] Men were not interviewed for this study, but more work should be conducted among early career men to better understand how their approach to negotiation differs from women's and how the pay expectation gap is gendered, as previous research suggests, among early career family physicians. Based on these data, however, women did not expect to earn more than they were initially offered and often this belief extended to nonsalary benefit negotiations. While some women did negotiate for nonsalary benefits, women from low-income and minority households, in general, did not know this was an option.

Strengths and Limitations

The narrowly defined sampling frame of this study (early career women physicians who are diplomates of the ABFM and earn less than average) is a strength in that it increases the transferability (but not generalization) of results across similar groups in the United States. A major limitation is the lack of Black women participants. Efforts were undertaken to recruit Black women (see methods), and current research is continuing this work through the development of an expansion of this project that focuses exclusively on barriers faced by Black family medicine women physicians.

Data collection methods were designed to gather in-depth, nuanced data concerning women's experiences navigating the process of obtaining and negotiating their first job out of residency. A strength of this method is in the range of human experience revealed and that is often lost in the process of quantification. This method elucidates the successes and barriers women encountered along with their reflections, but future research might explore the micro- psychological and emotional aspects of engaging in negotiating through phenomenological approaches such as autoethnography or participant observation. It was both a limitation and a strength that participants were 3 to 5 years post negotiating their first job. It was a limitation given the natural limits of human memory, but this is outweighed – or at least balanced – by the strength of hindsight and improved understanding of institutional policies as well as participants' own confidence and self-worth. Furthermore, institutional policies concerning contracts and negotiations were not probed, limiting our understanding of whether negotiation bans were the product of institutional policy or mere tactic. Future research should explore the perspectives of health systems' administrators and health care workforce policy.

Conclusions

In this study, women overwhelmingly reported that salaries for their first job out of residency were nonnegotiable. While it is unknown if this was due to institutional policy, there is a need for increased transparency and payment reform, including a move away from productivity-based models toward those that reward quality patient care. While some states have instituted transparency laws[29], these are limited to job postings – a step in the right direction, but not enough to uncover entrenched compensation differences. Informal peer support played a more consistent role than formal mentorship during initial negotiations and later renegotiations. Mentors and residency programs can play a larger role in preparing residents for salary and nonsalary negotiations while facilitating the development of strong, multi-year peer networks. In addition, and importantly, more work needs to explore and

understand how nonbinary and trans individuals navigate these same systems.

Finally, more work needs to focus on the pay expectation gap. Our current system, rooted in white, male privilege, emphasizes competition and individualism over caregiving and community.[30] Previous research found that "women who get to the highest levels got there by being men."[31] The goal should not be in teaching women how to be men, but in transforming the system itself to reflect equality and equity. This can be achieved through institutional changes such as moving away from fee-for-service systems, encouraging flexible schedules, increasing salary transparency, and improving advancement transparency as well as societal changes, including expanding the use of and removing the stigma around parental leave, recognizing the importance of contributions not currently valued by productivity-based payment models, examining assumptions about leadership.

This study was made possible by the participation of women family physicians who volunteered their time and stories to advance the understanding of the personal impacts of the gender pay gap and other gendered issues within medicine. This work would also not be possible without the guidance and support of Andrew Bazemore.

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