Chapter 4
Leadership in Pediatrics

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Introduction

"You can't be what you can't see." This sentence, attributed to the American activist Marian Wright Edelman, is commonly used to describe the barrier of not being able to see someone like yourself achieve success or attain a leadership position. Many girls can see women as pediatricians, as this generation likely has a woman for a primary care physician. In 2019, 64.3% of active physicians in pediatrics were women [10]. Can they see a woman in leadership, though?

In its "Blueprint for Action: Visioning Summit on the Future of the Workforce in Pediatrics" [39], the Federation of Pediatric Organizations noted that "Changes have occurred in education and training, clinical practice, research, and leadership that have resulted in the transformation of the profession of pediatrics, resulting in increasing workforce and leadership diversity and gender equity." One of the priorities focused on in this blueprint was "Acknowledge the impact that the increasing proportion of women has on the field of pediatrics." This resulted in a vision statement that the profession be strengthened by optimizing "expertise, leadership, and diversity in a changing pediatric workforce." Fair pay, representation, and promotion based on meritocracy make sense to us; however, they are not practiced in the vast majority of medicine as of 2021. We delve into the scope of the leadership gap and how to resolve it in this chapter.

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The Importance of Women in Leadership

Women report less control than men on the daily demands of a physician's life: managing clinic and office schedules and patient volume and controlling workplace issues [32]. Women have also been shown to be at risk for burnout when they lack power in the workplace and control over their work schedule [32]. From a practical standpoint, having women in leadership could help women who are not in positions of power improve their lives. The effect of having someone in leadership who can understand the cultural norms, pressures, and experiences of women cannot be overestimated. Of course, this is most likely to be a woman, but a man certainly can play the same role. Indeed, we are counting on men to play this role.

In the business world, having women in leadership has been associated with improved financial performance, with an average 15% profitability increase for those firms going to 30% women in corporate leadership [35]. There is also improved equity for female executives and improved practices for the entire workforce, such as paternity leave [36]. McKinsey & Company found that companies highest in "gender diversity on their executive teams are 21% more likely than other firms to report above-average profitability" [31]. Theories for this effect include "increased skill diversity within top management, which increases effectiveness in monitoring staff performance, and less gender discrimination through the management ranks, which helps to recruit, promote, and retain talent" [35].

Medical and professional outcomes may also be better with a woman's influence [9]. For hospitalists, readmission and in-hospital mortality rates are lower for patients who have female physicians [9, 42]. Particularly interesting is a 2018 study of mortality in heart attack patients, shown to be higher in female patients treated by a male physician. Mortality rates decreased "when male physicians practice(d) with more female colleagues" [24].

Fairness

Gender equality in pediatric leadership is a "matter of fairness and social justice" [40]. In 2019, 64.3% of active pediatricians in the USA were women [10], and 72.4% of pediatric residents and fellows were women [2]. Despite the majority of pediatricians being women, women held only 26.2% (41 of 149) of Pediatric Department Chair positions in 2018 [41].

The Her Time is Now Campaign [26] emphasizes focusing on and discussing gatekeeping in career advancement in academic medicine "through the combined lens of how ethical conduct and financial support intersect." This is an important document with candid assessments of gender bias and suggestions for fairness/gender equity. The effect of intersectionality is also addressed in the report and should be acknowledged as a barrier particularly for women from minoritized backgrounds attaining leadership positions. The authors note that for their 2020 report, "many of the same issues apply to women working in all healthcare settings and in fields

beyond medicine." Highlighted in the report is the combination of structural and institutional gender bias that impairs career advancement at every level. This impairment makes the timeline for promotion so lengthy that women are at risk for not being promoted, even by the time they retire.

As a mother with a 9-year-old daughter, I (Logan) am concerned about her likelihood for success in the medical or corporate world, should the current environment not change. I wonder if she will carry the same anxiety I have into rooms full of men making decisions, with me being the only woman. I wonder if she will be interrupted when she has the courage to voice an idea, or if she will be encouraged and supported by a woman leader to speak up.

I too (Chatterjee) am a mother, and my daughter is currently a medical student. Unfortunately, I see her face some of the same sexism, discrimination, and misogyny that I did a generation ago. I do believe that she is empowered through her education and life experiences thus far to be able to speak up and bring about needed change, but it is still an uphill task. There is much work to be done to reduce (and ideally, eliminate) the biases against women in medicine that persist despite efforts to remove them.

Scope of the Issue

The gaps between income, promotion, and leadership positions between men and women discussed in this chapter have persisted even though the "pipeline" of women is more than sufficient for gender parity, especially in pediatrics [41]. When discussing the status of women in pediatric leadership, the significance of cultural bias against women cannot be ignored. The leadership status of women in pediatrics follows what we understand about the status of women overall in our male-dominated leadership culture.

There is extensive research illustrating the bias against women in medicine and science. For example, a 2012 study of 127 academic science faculty showed the faculty (men and women) rated a male applicant for a manager position as "significantly more competent and hirable than the (identical) female applicant" [33]. In this same study, faculty offered less career mentoring and smaller salaries to women, even as they reported liking the female applicants more than the male applicants. The authors concluded that this inequity could shape the self-efficacy, goal-setting, and ultimate career trajectory of women in scientific fields.

The Pay Gap

In 2021, the income gap between men and women physicians is well documented, with studies reporting 16–37% difference, with men making more money than women [1]. The gender pay gap for physicians is one of the largest in the USA, with

women physicians earning "75 cents on the dollar compared with their male counterparts" [34]. This mirrors the income gap in society as a whole, in which women are paid 82 cents for every dollar paid to men, for the same work [7]. In their discussion of gender income gaps in all medical specialties, the authors of a manuscript detailing results of the Physician Work Life Study noted that "slower promotion to positions of leadership" may contribute to this income gap. They theorized that the study's results, showing that differences exist between men and women in "patient mix, time pressure in patient visits, income, control of daily work life, and burnout" contribute to leadership and income gaps [32]. Women typically do more work-related citizenship tasks (and feel less in control of their obligation to these tasks), such as acting as a required representative, serving on committees, and working in recruitment efforts. This work, which has been proposed as a "tax" that disproportionately effects women, may impair their compensation and promotion to leadership [8].

Inequity in wages is theorized to occur in part due to occupational segregation, with work done by women systemically undervalued [7]. Professions dominated by women have lower incomes, and women are overrepresented in low-wage fields [23]. Pelley and Carnes have written about the pattern known as "tipping" – once a certain number of women enter a profession that was previously dominated by men, that profession experiences a rapid decline of men entering the profession (e.g., bank tellers, secretaries, and teachers). In medicine, this is particularly felt in pediatrics and obstetrics-gynecology, the two most women-predominant specialties, where salary relative to the average physician has declined ~20% in four decades [37].

"The Motherhood Penalty" also contributes to the pay gap, in which lower salaries and fewer promotions are offered to women who have children than to women without children. Coupled with the fact that "fathers make 119% of what men without children earn," the so-called "Fatherhood Bonus," these effects "result in women with children earning only 73% of what fathers earn" [7].

The Promotion and Leadership Gaps

In academic medicine, the Association of American Medical Colleges (AAMC) published 2014 statistics on female leadership, with women comprising 21% of full professors, 15% of department chairs, and 16% of deans [29]. Data from the 2018 to 2019 AAMC survey showed that "the number of women deans increased by about one each year, on average" from 2013 to 2018, with 18% of medical school deans being women in 2018 [5]. The promotion gap persists but is slowly improving, with women comprising 25% of full professors per the 2018–2019 AAMC data; still, the majority of women faculty remain at the lowermost rank of instructor (58%) [5]. Interestingly, 26.2% of pediatric chairs being women in 2018 [41] and 2019 data showing that less than 20% of academic medicine department chairs are women are very similar to the proportion of women who are deans [5, 12]. For

women of color, this "leaky pipeline" is worse; 2018–2019 AAMC data show that underrepresented in medicine women "made up 15% of women chairs in basic science and clinical science departments" [5]. To address this issue, the AAMC Group on Women in Medicine and Science has developed toolkits for education and intervention in their "Strategies for Advancing the Careers of Women of Color in Academic Medicine" [3].

Leadership in medical societies has been deemed one of the crucial areas to address, as this leadership is influential in setting policy and changing pediatric practice. Medical societies have been identified as a "gatekeeper" to career advancement in academic medicine by the Her Time is Now Campaign ("Her Time is Now Report. Version 2"). The specialty of pediatrics struggles to equitably represent women in senior leadership, with only 37.5% (three of eight) of president-equivalent positions being held by women. However, there are signs that this could change, as women comprised 54.5% of pediatric society board positions in 2019 [27, 41].

Outside medicine, a 2014 sample of 21,980 firms in 91 countries was studied to quantify female leadership. Less than 5% of organizations had a female CEO and over half had no female "C-suite" members [36]. In 2021, the European Union (EU) reported that women held 7.8% of Board Chair and 8.2% of CEO positions in the largest publicly listed companies in the EU. Less than 29% of board members in those companies are women [20].

The Queen Bee Phenomenon

One argument for women's leadership assumes that women leaders support and grow other women leaders, eventually resulting in a gender-equitable leadership structure. However, when women are in organizations where leadership is male-dominated, evidence shows that the same hierarchical structure is more likely reinforced than changed. Even more discouraging is that "queen bees" in organizational structures hold other women back, instead of supporting them in advancement opportunities. Derks et al. discussed the "queen bee" as a woman "who pursue(s) individual success in male dominated-work settings by adjusting to the masculine culture and by distancing (herself) from other women" [17]. Because of the cultural bias against them and their lower perceived gender role, women who adopt a "queen bee"-type practice are likely doing so in an attempt to resolve their personal leadership disadvantage. Particularly in emphasizing the typically male-associated characteristics of leadership, women may feel the need to simulate their male colleagues in order to succeed. Further research has shown that women in leadership tend to support each other (and quotas) at the same organizational hierarchical level but see themselves as different, having sacrificed more, than junior women in the organization [21]. This attitude of perceiving great sacrifice to rise in leadership may make it less likely for a senior woman to support a junior woman who she does not see as having the same drive to succeed.

Promising Practices: Changing the Status Quo

If nothing changes, it has been estimated that it may take 50 years to reach gender parity in medical leadership [12]! The COVID-19 pandemic in 2020, with the associated job losses and inequities disproportionately affecting women, is seen as further threatening even that shocking forecast [4]. The importance of career development for women has become magnified: men and women leaders, as the change-makers of organizations, must elevate gender equity issues for fair treatment, pay, and promotion to leadership. These topics include the range of issues discussed in this and other chapters of this book. Additionally, there are practical solutions that the pandemic has illuminated and leaders can implement, such as normalizing conversations around life-work integration, developing and supporting peer professional networks, providing flexible work and teaching options, and alleviating child and family care stresses [28, 34].

Changing the status quo involves tactics complementary to those presented below and are included in other chapters of this book. As an example, suggested topics/questions to address are listed in Table 4.1.

What Men in Leadership in Pediatrics Can Do

Notice that this section comes before the "What Women in Leadership in Pediatrics Can Do" and the "What Women Can Do" sections. This is purposeful, as we must not demand that women make/lead the changes needed to combat the bias and unfair practices against them alone or primarily. It is neither practical nor fair to ask this.

Intentional change is needed among male leaders in pediatric healthcare organizations, medical societies, medical journals, and funding organizations [13]. The evidence behind gender inequity across the breadth of pediatrics is clear; ignorance about the problem or disregarding it is not acceptable. Men in positions of power can and should change the status quo by educating themselves and their peers, measuring the problem in their organization, and using metrics to resolve it. Use of the

Table 4.1 Questions for leaders in academic medicine

What else can be done in academic medicine to ensure fair pay for women?
What can academic institutions (i.e., employers) do to ensure that women faculty are promoted fairly to assistant, associate, and full professor?
What can academic institutions do to ensure that women's time and effort in diversity, equity, and inclusion work is financially supported and given high priority for academic promotion?
What can academic institutions do to ensure that all of their faculty have equitable opportunities at medical societies?

This text was adapted with permission from Her Time is Now Report. Version 2. Published September 1, 2020. Available at https://sheleadshealthcare.com/.

Her Time is Now Report ("Her Time is Now Report. Version 2") to highlight gender inequity issues and pose questions leaders can ask themselves and their institution can be a good starting place. On an individual level, sponsoring women, in addition to mentoring them, results in purposeful, mindful promotion.

Some men will lead by example and encourage their fellow leaders to do the same. These voices are crucial and result in positive peer pressure that can be very influential. For example, at the 2021 AAMC Spring Council of Deans meeting, Dr. Francis Collins, Director of the National Institutes of Health, spoke about his practice with panels he is asked to participate in. He asks about other participants on the panel, and if no women are included, refuses the invitation. He said he does not want to be part of a "Manel" (a panel of experts that consists of men only) and that when organizers look for participants with gender diversity in mind, they usually find highly qualified people (F. Collins, personal communication, May 7, 2021).

What Women in Pediatrics Leadership Can Do

Alongside men in leadership positions, women leaders must be intentional about promoting leadership skill development among women in the pediatric workforce. Leadership training for women physicians must be part of institutional planning and metrics, and leaders must be held accountable for it. Some examples of highly effective leadership training programs are listed in Table 4.2.

Budgetary support of women for these types of programs, and others, is necessary, as is the time needed to participate. Leaders can and should provide this.

We know that sponsorship is crucial for junior employee and faculty success; women leaders are essential in this role, and the tenets of sponsorship are noted in the preceding paragraph. However, combating the "queen bee" phenomenon is challenging when women remain in male-dominated organizations, especially if they

Table 4.2 Examples of leadership training programs (many focused specifically on developing women leaders)

The Executive Leadership in Academic Medicine (ELAM) program [19] (longitudinal program)
Association of American Medical Colleges (AAMC) mid-career women faculty leadership development seminar [6]
AAMC early career women faculty leadership development seminar
AAMC minority faculty leadership development seminar
Women's Wellness through Equity and Leadership [43] collaborative [38]
Association of Medical School Pediatric Department Chairs (AMSPDC) Pediatric leadership development program [11]
Harvard Medical School career advancement and leadership skills for women in healthcare program
ADVANCE gender equity symposium
Women in Medicine summit
FemInPEM conference

see themselves as having sacrificed significantly for leadership opportunities. Research shows that "the tendency of successful women to resist affirmative action programs stems from their own career experiences" [21]. The intersection of work and family stress, lack of promotion and salary fairness, and the existing cultural and organizational gender bias make rising to positions of leadership seem daunting. Making the climb to leadership less stressful for women who are earlier in their careers can mitigate this and is part of this book's focus.

The impact of having women leaders for the authors has been immense. For one author (Chatterjee), having the support of a woman Provost and President/CEO helped her transition to her role as the first woman Dean and person of color to lead her medical school. Faced with the triple challenges of the pandemic, racial justice issues, and a looming accreditation visit, Dr. Chatterjee stated: "I had shattered a glass ceiling. I should have expected some of the shards to fall on me. If I backed out in this time of crisis, it would perhaps jeopardize the chance for other women who might follow in my footsteps. It was a heavy burden to bear, but one of my own choosing. It was also a great privilege that I did not feel I could relinquish lightly" [16]. For one author (Logan), having a woman Chair of Pediatrics "helped normalize work-life balance stress and provided a sounding board for how to navigate the pressures of being a Division Director while mothering three young children." Equally valuable was the Chair's intentionality in discussing promotion and how to achieve it. In addition, the sponsorship of women leaders in the Office of Academic Affairs and Career Development led to leadership training opportunities invaluable to career progression.

As a Department Chair, Dr. Chatterjee encouraged many women faculty members to aspire to leadership positions. One such faculty member was hesitant to take on leadership roles due to her family responsibilities. Dr. Chatterjee encouraged her to attend the AAMC Mid-Career Women Faculty Leadership Development Seminar [6]. Upon her return from the seminar, the faculty member took on the role of Division Chief. When a subsequent decanal position opened up, she asked Dr. Chatterjee if she should apply for it. With Dr. Chatterjee's encouragement and support, she was appointed as an Assistant Dean. This is an example of the value of sponsorship and the empowerment of women pediatricians as self-advocates.

What Institutions Can Do

It is established that gender bias is pervasive and present as "woven into the organization's culture" [30]. The result is that leadership decisions are based on bias and not on merit. As noted in the introduction to this chapter, this can lead to the promotion of women occurring at a slow rate or not at all.

The programs mentioned above are very selective. To achieve gender leadership equity in pediatrics, more women than can be served by high-level programming

must have training that enables them to negotiate their work life and income, advocate for themselves for promotion and leadership training, and influence decision-making. Mid-career support for women, in particular, can get women to the leadership positions shown to improve organizational performance [35]. Institutions that are offering career training sessions or programming for women physicians, whether it be for early-, mid-, or late-career physicians, must keep metrics on participant career trajectory and promotion to leadership positions. By publishing results of those programs, "Best Practices" can be developed, evolved, and spread to other institutions. These metrics can be used to develop scorecards for institutional success on gender equity, further enhancing Best Practices.

Transparency of these metrics, and how institutions compare on gender equity success, is important in attracting and sustaining a workforce of women across all specialties. The BeEthical Campaign [13] supports this approach, calling on leaders to "document and correct workforce disparities in an efficient and effective manner" by using longitudinal data analysis and transparency of "process, analysis, and results." BeEthical has published proposed metrics for leaders and a process for leaders to use those metrics in evaluating gender equity [13]. These metrics include research funding and salary support, administrative time, and committee work that partially account for promotion inequity and often go underrecognized [12]. The promotion gap can be addressed in part by "adopting flexible promotion and advancement criteria, including promotion tracks that reflect the wide range of responsibilities and unique contributions of female physicians" [1].

Male dominance in medical leadership has become the default position; this must be challenged by a combination of culture change, reduction in and eventually, elimination of implicit biases toward women, and policies that support gender equity. "Subtle sexism" is a complicated problem that extends from our cultural beliefs and existing workplace systems; "subtle bias may make it challenging for women to ascend organizational hierarchies even in the absence of overt discrimination" [18]. There is some evidence that intentional work, even if brief, in addressing gender bias may improve outcomes and actions to promote gender equity. Carnes et al. conducted intervention over a 2.5-hour workshop for faculty at an academic medical center, focused on "gender bias-habit changing," that significantly improved survey scores on gender bias topics that support women in their career advancement [15].

Suggested policy changes include term limits for leaders [12] and mandated representation on corporate boards and political leadership roles [20, 36]. As the presence of women on boards may improve the "pipeline" for leadership roles in the organization, quotas have been proposed and used in some cases to support gender diversity [35]. Research shows that women who announce a pregnancy or are returning from maternity leave "described being passed over for leadership roles in favor of colleagues perceived as less qualified"; possible mitigating measures are to change "policies that exclude part time physicians from leadership roles" [25].

What Women Pediatricians Can Do

Awareness of gender-based leadership barriers is important for all women to have. For example, being able to recognize that "women leaders being mistaken for support staff" is a sign that the organizational culture associates leadership with masculinity or that "women having to learn how to lead on their own without a mentor" is an organizational lack of mentoring problem. Diehl et al. [18] provide more examples of gender-based leadership barriers and a Gender Bias Scale that are helpful to raise awareness of potential bias and that can be used to help organizations understand where issues lie, from the perspective of the women in the organization.

Women preparing for leadership will need the support of mentors and sponsors, both men and women. Gaining that support, for most, requires intentional skill development. While some women may naturally advocate for themselves, others find this difficult. Whether formally, such as in a course, or informally by individual learning/networking, skill development is needed. Table 4.3 lists topics that have been helpful to the authors but is not necessarily comprehensive:

One author (Logan) has found that a combination of individual learning to address some topics in depth (e.g., learning to say no and fighting imposter syndrome) and proactively asking about opportunities available for formal education is helpful. Engaging men as allies to help in challenging situations, and finding a peer group of women for support, has also been valuable. For Dr. Logan: "Advocating for myself and my leadership goals means (1) saying 'no' to anything that is not aligned with my goals, (2) discontinuing work that does not contribute to the institutional or professional mission, (3) it's ok to push back, and (4) it's ok to seek and accept help." For Dr. Chatterjee, being open to opportunities, selecting those aligned with her values and goals, and seeking the advice of mentors and sponsors were all helpful in her career development.

Table 4.3 Topics for skill development

"Graceful self-promotion" – Speaking about oneself and one's accomplishments with style and confidence
Improving professional visibility
Building a professional network
Sponsorship
Transforming conflict into positive change
Role transition
Negotiating successfully
Unconscious bias
Strategic planning
Developing financial savvy
Learning how to (and when to) say no
Wellness

What Else Needs to Be Done?

Legal and Societal Actions

Governmental action may be needed to accelerate the incredibly slow progress toward gender parity. In business, representation of women on corporate boards is mandated in several countries (e.g., France, Spain, Norway), and reporting on gender diversity and improvement is required of companies with more than 300 employees in Japan [31]. India requires that 33% of local government roles be held by women [31].

Pay equity laws have been passed in almost every state in the USA, but either the lack of consistent enforcement or limited scope makes them less effective than they could be [7]. In addition, banning private employer access to salary history has resulted in increased wages when women change jobs [14]; this is a change that could be widened to cover both public and private organizations in all states.

Supportive actions to advance women in leadership include increased education and training, mentoring and sponsorship, flexibility in work practices, and adequate and affordable child care options [7].

Challenging the Future

For gender parity in leadership to occur, we must start at the beginning of women pediatricians' careers. There is much work to do, as they start already behind men. Early to mid-career women pediatricians earn 76–94% of what male pediatricians do [22]. By mid-career, the inequities are compounded. In their manuscript "Is Academic Medicine Making Mid-Career Women Physicians Invisible?", Lewiss et al. conclude that women in mid-career "are at continued risk of being made invisible" due to lack of equal reward for accomplishments and that "It is especially important for the academic community to recognize that women…continue to lose ground at this juncture and are unable to be equitably represented at all levels of medicine including top leadership positions" [30]. Ultimately, this leads to the gaps in promotion and leadership we currently have.

But, we have hope! We are close to a critical mass of women in pediatric leadership positions and know more about how to develop and support women leaders. We can combine this with challenging current pay structures and lack of transparency. Implementing gender parity metrics and making those transparent to employees is a step that layers upon the prior steps and supports leadership opportunities for women. To improve the health of pediatrics as a specialty, it is time for us to make changes needed to achieve leadership equity that represents the stake women have in the specialty.

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