Chapter 8
How Leaders in Pediatrics Can Support Women

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How Leaders Can Support Women

It is well known that women face unique challenges in work, with specific challenges in medicine. As noted in other chapters of this book, women often carry disproportionate home responsibilities, often have lower salaries, and are less represented in promotion and leadership. Sexual harassment unfortunately continues to exist. The disruptions of the COVID-19 pandemic have had a disproportionate effect on women [1]. Recognizing these inequities, there are several ways leaders can act to support the careers of women. We review some of the basics and draw from the sentinel report by the National Academies of Sciences, Engineering, and Medicine on "Sexual Harassment of Women" ([2]) and the article by Narayana et al. [3] focusing on gender equity issues during the pandemic. These recommendations are an excellent framework for institutions and individual leaders.

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Support for Diversity and Inclusion from Leadership

Clear support from leadership on the importance of diversity, inclusion, and racial and gender equity is essential. The organization's mission, values, and example must recognize that diversity and inclusion enrich our culture, and improve quality of care and quality of ideas. Support and funding need to be aligned with goals of supporting all faculty. This support needs to be explicit. Funding needs to be targeted to increasing diversity and inclusion. Involvement and regular communication with women in medicine groups or women advisory boards should be usual practice to remain abreast of issues and co-create solutions. Ensuring a culture of inclusion involves ensuring a space for women to freely share experiences and support each other and a safe space for disclosing unfair treatment.

Strive for Strong and Diverse Leadership

It is important to publicly state that support of women leaders is among the highest priorities. There is much literature about the dearth of women in leadership and the multiple possible reasons. Diversity and inclusion involve intentional work to overcome implicit biases that exist. This involves inclusion of women in leadership roles and representation on important committees, projects, speaking engagements, and search committees. Open searches for faculty positions should be part of the hiring process to ensure a diversity of candidates. Search committees should undergo implicit bias training and pay attention to the diversity of the candidate pool and finalist lists. Active outreach to candidates is needed to ensure diversity.

Some hiring search committees have ascribed to the Rooney Rule, a 2003 National Football League policy [4] that required teams to interview ethnic minority candidates for head coaching and senior operation jobs. This established an interviewing quota but not a hiring quota. While this is positive to ensure diversity in candidates and finalists, sometimes they are token candidates checking off a box with no chance for the job. This can have the harmful effect of raising expectations and wasting the time of diverse candidates. It can also have the unintended effect of self-doubt among the token candidates who are forever finalists. It is critical that active outreach be combined with sincere consideration for leadership positions.

Create Diverse, Inclusive, and Respectful Environments

Leaders must take purposeful steps to improve cooperation and establish respectful work behavior and healthy inclusive environments. There needs to be an evaluation of all policies and procedures to ensure that opportunities are equal for all and behavioral standards are clear. Changing behaviors is essential. It is more than just saying that gender inequity or harassment is not tolerated. Transparency and

accountability on standards of behavior are critical with methods for evaluation and tracking of outcomes. Faculty and staff must be evaluated on professionalism in hiring and promotion. Reporting from individuals cannot be the only method of understanding institutional vulnerabilities. There needs to be routine assessment of culture and climate. There needs to be collaboration among all that oversee faculty and learner work environments.

Ensure Gender Equity in Compensation and Professional Effort

There exists gender inequity in compensation for women in society as a whole, in addition to women in medicine [5, 6]. It is also known that women disproportionally have more uncompensated service-related tasks [7]. Finally, the pandemic may worsen salary disparities because of budgetary tightening and has caused women to leave the workforce [8].

A shortage of women to invite to the table may result in the same women doing a disproportionate amount of committee work resulting in a "minority tax." For instance, women are underrepresented in basic science research. As a result, they often serve on more committees taking them away from their own research. Being a women of color, one of the authors can attest to this double minority tax as she has been on more search committees in her career than most of her peers. While wanting to represent and support the cause, the extra work and opportunity cost are real. It is known that women tend to take on more uncompensated administrative tasks often without leadership titles. Other taxes include handling gender affairs in diversity initiatives, outreach and media to demonstrate diversity, and disproportionate recruitment, retention, and mentoring responsibilities [9]. Acknowledging and "paying" the minority tax should be considered by allowing time for these activities and recognizing their efforts in title and compensation.

Salary reviews for gender equity must be built into institutional systems assessing base salary, call pay, incentive pay, merit pay, and leadership stipends. In addition to equity review when changing an individual salary, periodic comprehensive assessment and correction are critical. Less discussed but also important is standardization and calculation of individual professional effort in areas of clinical care, research, education, and service. This avoids inequity between individuals and raises the visibility and value of important tasks that may need compensated effort in time or salary.

Address the Most Common Form of Sexual Harassment: Gender Harassment

This is harder than it seems. It is much easier to understand and recognize overt sexual coercion and unwanted sexual attention. Verbal and nonverbal behaviors that are subtly insulting, hostile, or degrading are often not easy to spot. There has to be

attention to long-standing processes and attitudes to better understand where the problems are and how they can be addressed. Sexual harassment needs to be addressed as a culture and climate issue not just one to meet legal standards (https://www.justice.gov/crt/title-ix). Improving work, education, and training environments needs to be much more than avoidance of legal liability. Institutions can be in compliance with regional, state, and national rules and still be perpetuating unhealthy environments.

There must be support for the reporters of unfair treatment. Reporting issues should always be considered an honorable and courageous action. There should be formal and informal means of recording information about experiences. If reporters are not comfortable filing formal reports, there needs to be a meaningful way to record their experiences informally. Fear of retaliation is a real barrier. Everyone needs to feel comfortable in expressing their concerns.

Strengthen the Pipeline of Women in Science

While there are record numbers of women entering medical school and pediatrics residency, the pipeline of women in science is leaky. Strengthening this pipeline involves ensuring strong supports for women, including strong mentoring teams. Leaders must make sure that junior faculty are connected to committed mentors that address the eight types of or "Cs" of mentors: content mentor, connecting mentor, coaching mentor, cheerleader mentor, critiquing, challenging mentor, career mentor, colleague peer mentor, and clinical mentor [10]. Occasionally, one or two mentors can successfully guide a mentee in all of these "Cs," but often it is a team of mentors. Individuals should reflect on whether their mentoring teams address all of these "Cs." If not, it is critical to actively seek out additional mentorship.

In addition to individualized career development plans and periodic meetings with mentors, leaders should regularly monitor mentoring support and frequency at scheduled evaluations with direct follow-up with identified mentors. Often mentoring relationships are not formalized. In one author's experience, after annual evaluations, she routinely thanks the faculty member's mentors by email for their support. Occasionally, she has heard back from the identified mentor that they did not know they were considered a mentor!

Finally, support and participation in STEM programs for girls early in the pipeline are essential to widen pipeline inflow.

Provide Family Support and Family Friendly Employment Practices and Policies

Leaders in pediatrics should take the lead in ensuring family friendly employment practices and policies. This is critical for the children we serve as well as for our pediatric workforce. These policies should include parental leave for childbirth and

adoption that honors time for parents to bond with their new child and also include lactation rooms and schedules that allow breastfeeding time. Available quality childcare including episodic care is a tremendous support for families and increases employee productivity.

Some women may have different trajectories of productivity across their career span with some data showing women having a slower start likely related to child-rearing responsibilities and higher productivity later. Allowing part-time employment often results in high productivity and job satisfaction. Alternate (including remote) and flexible work schedules are important especially in this pandemic time. Promotion policies must allow flexibility for these trajectories and in time clocks at the risk of losing the talent. Additional guidance is available in Chap. 7, "Childbearing, Adoption, Motherhood, and Eldercare by Women in Pediatrics."

Promote Career Development Opportunities

Development and facilitation of women leaders at every level is essential. While women make up nearly half of all US medical students, there are few women in hospital or academic medicine leadership [11]. There needs to be active development of skills in leadership, conflict resolution, mediation, negotiation, and de-escalation and other leadership competencies. Developing a diverse leadership is not passive.

In addition, mentoring, networking, and sponsorship are necessary for academic success. It has been found that the professional networks of women are less extensive compared to male colleagues [12, 13]. A strong mentorship team is critical in academics as described above. Sponsorship and encouraging involvement in national professional organizations are important strategies.

Measure Progress and Conduct Necessary Research

Institutions should work to evaluate and assess efforts to create a more diverse, inclusive, and respectful environment. Formal reports should not be depended upon alone. Data on outcomes in improvements is essential. Information should be shared internally and externally. Not all data will be complimentary to an institution. It is important that everything is shared: improvements, failures, and works in progress.

Research is needed to understand how inequities in opportunities based on gender are perpetuated over time. There should be evaluation of best practices and research on what incentives or deterrents actually help. There needs to be more research about the true levels of sexual misconduct and gender harassment and research to better understand why women are significantly underrepresented in leadership roles in pediatrics and across organized medicine.

Encourage Involvement of Professional Societies and Other Organizations

While most gains will be measured at the level of institutions, it is important that professional societies help accelerate the efforts of members of the organization. Organizations should provide support and guidance for members. National organizations should use their influence to address the issues of gender harassment and gender inequity.

Initiate Legislative Action

Leaders should be concerned beyond their own institutions. Leaders should be advocates for new legislation with the goals of gender equity such as parental leave and protecting all from sexual harassment and other hostile work environments. Related to sexual harassment, it is important to support initiatives such as prohibiting confidentially agreements, banning mandatory arbitration, and making disclosure uniform for all.

Leadership support is essential to achieve gender equity. Continuous improvement involves listening, a culture of inclusion, zero tolerance for gender harassment, equitable policies and procedures, and periodic reassessment.

Personal Stories on the Road to Academic Leadership

Doug Carlson, MD

A few years ago, I received a thank you note from a woman physician that I have deep respect for. In that note, she thanked me for helping sponsor her throughout her career. She wrote the note after attending the Mid-Career Women Faculty Leadership Development Seminar through the Association of American Medical Colleges (AAMC). At the time I was just becoming familiar with the differences between sponsorship and mentorship. I thought, "Why does someone need to thank me for something that is expected of me as a leader?" I reached out to this person to tell her how much I was moved by her thank you note but also to explore my curiosity of the need. Through that point in my career, I believe that I had treated faculty of all genders equally and fairly. In thoughtful retrospect, I am not sure that I had. I cannot think of any specific examples where I have not treated everyone the same, with blindness to gender, but certainly have uncovered implicit biases that I have held through my life and career. I hope that I have removed many of these implicit biases, but it is likely in a few years I will better understand those that still remain today. I have learned that treating everyone the same, giving similar support, or advocating

for opportunities is not a passive endeavor. It is something that needs attention in an active, ongoing way.

How does a physician who is a man become recognized as an advocate for women faculty and be referred to as a male ally? I often find it mildly perplexing. I believe it is just treating all faculty the same, but clearly it is more than that. Do I, as a leader, truly treat all faculty the same? Do I give the same opportunities to women and men? Am I more likely to suggest an opportunity for a male colleague than a female colleague with small children? Am I more likely to give a second opportunity than to give someone else a first opportunity? I do believe that while I have always been supportive of women faculty, I may not have been as supportive as possible. I have moved the support of women faculty from something that I believe I did naturally to something that I think about often. While support of women faculty within health care hopefully is coming more naturally, it is clear that we have not yet made all gains needed in support of faculty regardless of gender.

Pediatrics has been a majority women specialty for several decades. Yet we continue to hear that that the issue of gender disparity in leadership positions is one of pipeline. The current state of leadership within pediatrics shows that is more than that. It is not a pipeline issue. At least not the number of women entering the pipeline. When I was a resident in the 1980s, the majority of my colleagues were women. The majority of residents on a national level were women. Yet nearly 40 years later, women are underrepresented in leadership positions in pediatrics. This includes deans, department chairs, and hospital leaders. Why is that? What is underlying, even in pediatrics, which causes disparity in career advancement and salary for the same work?

The causes of disparity of opportunity within pediatrics must be systemic. What are those causes? A couple of years ago I was asked by Judy Schaechter, MD, to be a male colleague on a task force for gender harassment sponsored within the American Association of Medical School Department Pediatric Chairs (AMSPDC). Dr. Schaechter suggested that I read "Consensus Study Report: Sexual Harassment of Women: Climate, Culture and Consequences in Academic Sciences Engineering and Medicine."[2] Even though I am a physician who is a man and is labeled as being an advocate and ally for women physicians, I realized how little I understood. Awareness of the issues based on reading the study and actively trying to get insight has made me more aware of the issues that I had poor understanding of. I thought I understood the issues of sexual harassment. Mostly, I was aware of the potential for issues in regard to the overt types of sexual harassment: unwanted sexual attention or sexual coercion. I rarely saw that, but I also know that it was occurring without me being aware. Without my direct awareness, I felt that I worked in environments that were completely healthy for women. The National Academies of Sciences, Engineering, and Medicine report has made me aware that the overt categories of unwanted sexual attention or sexual coercion are still occurring at a rate far more often than I understood. Most importantly for me was a highlighting of the concept of gender harassment. Gender harassment is the most common type of sexual harassment. As defined by Fitzgerald, Gelfand, and Drasgow, gender harassment is a "broad range of verbal and nonverbal behaviors not aimed at sexual coercion but

that convey insulting hostile and degrading attitudes about members of one gender" [14]. I did not fully understand the impact of this type of sexual harassment. Implicit gender harassment by institutions and individuals likely has a large role in the underrepresentation of women in leadership positions within pediatrics and medicine broadly.

As I look at my career, there are some facts that I find distressing. Not in things that I overtly did or inadvertently did not do but in review of the history of institutions that I have deep gratitude and respect for. I have never had a woman boss. I certainly have worked with women in more senior leadership roles than mine – hospital president and chief clinical officer – but never someone that I directly reported to. I did not seek that out as opportunities arose but the fact that I have never had a woman direct supervisor in a 35-year career in pediatrics is telling. When I started as the Chair of my current department, there had been one woman full professor in the history of the department. I am working to correct that, but still women are significantly underrepresented at the professor level. There have been five chairs in the 50-year history of my current department, all white men. At my previous medical school, there have only been white male Chairs of the Department of Pediatrics in over 100 years. Does this make my Department of Pediatrics guilty of not supporting women faculty as well as we should have? I think it does. The issue is hard to trace back to individuals. I believe it is the little decisions that were made in hiring, support, sponsorship, mentorship, and promotion that have all added up to get us where we are. We need to do better at all levels: support of individuals, changing local institutions, and changing national attitudes. There is no one-step solution. Solutions are complex and need to come from all of us.

It is important for leaders to support all that report to them in their career development. It is important to develop a welcoming environment where all can thrive. It is important for leaders to understand the institutional biases that may disproportionately affect diverse groups of developing leaders. Setting the proper environment that leads to equitable opportunities is not passive. It is an active pursuit that needs to be reviewed often. I am honored whenever anyone refers to me as a leader that understands the issues of my women co-workers, a leader that provides support for all. I am not sure that I deserve this recognition, but I am on a journey to appreciate, advocate, and elevate women to the best of my ability.

Tina Cheng, MD, MPH

I owe a debt of gratitude to all the women before me who have paved the way. The first was my mother, a Chinese immigrant who faced many obstacles but had a long career as a kindergarten teacher. My father was a biochemistry researcher. It was no wonder then that their daughter became an academic pediatrician merging both of their occupations. As the middle of three sisters, my parents instilled in us that we could achieve anything that we set our minds to, regardless of gender. Though it was

thought to be "unlucky" to have three daughters, my parents valued education and set high expectations for us to excel in our chosen fields and do good.

Born in Toledo, Ohio, I grew up in Coralville, Iowa, where I wanted to become a doctor starting in grade school. My parents kept a School Days book that documented each year of my primary schooling (Fig. 8.1). It is notable that my School Days book had a section on "when I grow up, I want to be…." The choices were divided by gender. Boys could choose from fireman, policeman, cowboy, astronaut,

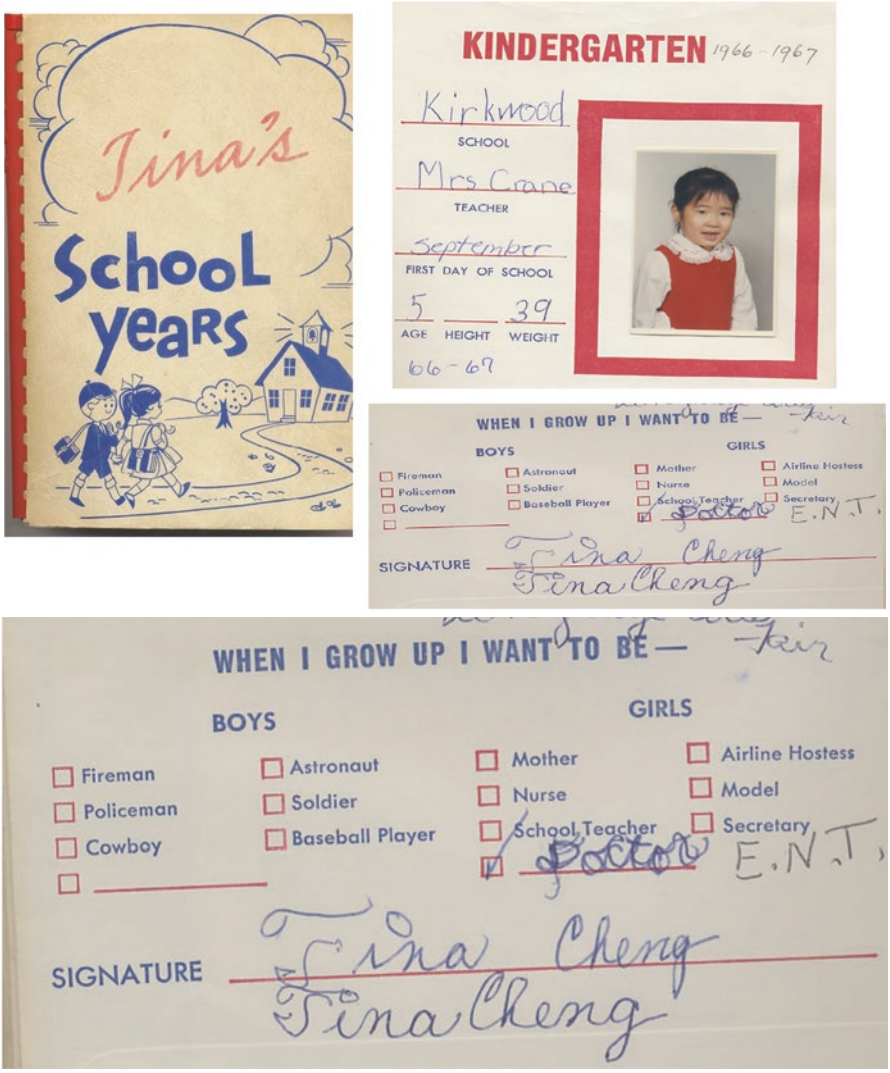

Fig. 8.1 Photo of Tina Cheng's childhood "School Years" book, 1966–1967

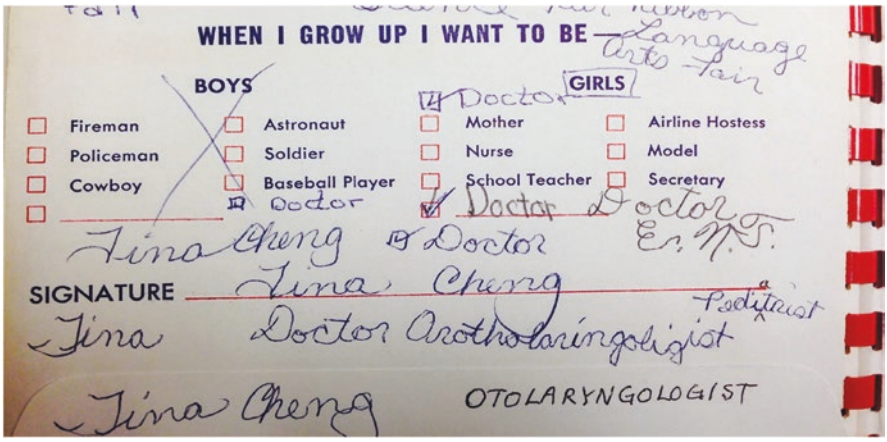

Fig. 8.1 (continued)

soldier, or baseball player. The choices for girls were mother, nurse, schoolteacher, airline hostess, model, or secretary. Starting in kindergarten, I filled out the "other" box and wrote in "doctor, ENT." Why an ENT? I had frequent nosebleeds as a child. I went to several physicians and decided I wanted to help other children by being a doctor.

My dream of being a doctor continued throughout my childhood. Unfortunately, there are too many children today, and too many women, who aren't taught to dream or do not have circumstances that allow them to reach their dreams. When I would share my dreams of being a doctor, I was told, "Hmmm, well pediatrics is a good field for a woman." This increased my desire to succeed. Unfortunately, it also made me discount going into pediatrics early on.

While my medical school class was over a third women, there were few minorities. Our anatomy professor showed Playboy centerfolds during class. While this itself was objectionable, the reactions by others that the women students were "oversensitive" and "what's the big deal?" were more upsetting. Discussion of the impact of social determinants of health and health disparities by race and ethnicity was rare. There was little diversity in teaching pictures with the exception of depictions of all dark-skinned individuals when learning about sexually transmitted infections. My medical school experience led me to co-found the Women In Medicine Group and American Medical Women's Association Chapter. It also reaffirmed my career commitment to ensuring health equity.

While pediatrics was not really on my list going into clinical rotations, I loved working with children and realized that children were the foundation of health with great potential to for lasting impact. While I enjoyed working with adult patients and had great empathy for their challenges, I saw real opportunities to make a difference working earlier in the life course.

As a woman physician in my residency and throughout my career, I was often mistaken for a nurse. As one of two Asian women in my residency class, we were

often thought to be the same person. The number of times I was called her name, and vice versa, was too numerous to count.

Because of my interest in individual and population health, following chief residency, I pursued a Master's in Public Health Degree at UC, Berkeley, and a Preventive Medicine Residency. I then moved to the east coast for a fellowship in Academic Pediatrics focused on research followed by my first academic job at Children's National Medical Center. My first child was born during fellowship and at the time I was unsure how academics and research would meld with family life. I soon learned that research was a creative outlet, provided autonomy to focus on my scholarship and family, and offered an important path to improve child health practice and policy. I was able to attend many of my children's events because of the autonomy provided by academic time. Writing grants and manuscripts occurred around my family's schedule. I always had reading available while waiting for soccer practice completion. A natural early bird, work was often completed prior to my family's wakening.

Today, I show trainees my publication trajectory over time demonstrating slight downturns after the births of my two children but with acceleration in time. I was fortunate to have healthy children, the salary of a physician, and supports including a husband with a more flexible schedule, and a long-term wonderful babysitter.

Early in my career, I was offered leadership opportunities, and I almost always said yes. It started when I was asked to be nominated as the Accreditation Council on Graduate Medical Education Pediatrics Residency Review Committee Resident Representative. I was fortunate to be selected and had the opportunity to meet luminaries in pediatrics. It was a lot of work between my every third night call schedule but well worth it. Through that experience, doors opened. I co-founded the American Academy of Pediatrics (AAP) Resident Section and served as the resident representative on several AAP committees. Often the youngest and among a minority of women, I learned from so many leaders in pediatrics, realized the power of these professional organizations in shaping practice and policy, and slowly found my voice. Mentorship was a critical factor in my development and I was, and continue to have, wonderful, mostly mentors who are men at each stage of my career, many who have remained lifetime mentors.

Seven years into my position at the Children's National Medical Center, I was promoted to Associate Professor and was called to look at a Division Director job at Johns Hopkins University. I was unsure if it was the right time to become a Division Director and my mentor told me that "looking can be dangerous." Nonetheless, I entered the danger and ended up moving to Johns Hopkins University as the Division Director of General Pediatrics and Adolescent Medicine. My daughter was 8 years old at the time and I told her this new job would involve being the boss of more people. When I asked her, "Do you think I could do this?" she didn't skip a beat and responded, "I can teach you!"

Amid the academic environment at Hopkins, my career flourished, and more opportunities came for leadership at Johns Hopkins and in professional organizations. In the history of Johns Hopkins University School of Medicine, I became only the 138th woman professor in 2008. I have asked what the number is for men and

have been told it is not counted. I went on to become the Chair of Pediatrics and Pediatrician-In-Chief in 2016, only one of two women and one of three persons of color (one African American, two Asians) among the 21 clinical Department Chairs at Johns Hopkins University. I went on to become Chair of Pediatrics, Chief Medical Officer, and Director of the Cincinnati Children's Research Foundation to focus on children. While there are more women in pediatrics, there continue to be unique issues for women in academia including a dearth of women leaders. While there has been progress since the time Playboy pin-ups were tolerated in medical education, there is still much work to do.

My clinical, educational, and research career has focused on health equity and how we can stimulate young people who may not have the same opportunities as I did, to dream big and to have the possibility to achieve their dreams. It has taken a pandemic and a video of a murder to raise the country's consciousness about the urgent need for equity and social justice. I believe diversity and inclusion enriches all of us and improves our missions in clinical care, education, and research. We need to lead the way for the next generation.

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