

COMMENTARY

THE CRYSTAL BALL: THE FUTURE OF PEDIATRIC RHEUMATOLOGY IS XX

I believe that there are several recent trends in gender ratios in pediatrics and pediatric rheumatology in North America that bear some comment and discussion. These are: 1) Women are now the majority in many medical school classes and pediatric residencies in the US; 2) Women outnumber men at a ratio of over 2:1 in recent pediatric rheumatology fellowship classes. Historically, women have always been prominent in pediatric rheumatology and now more than ever.

Do I have a problem with this? You'll have to believe me when I say no. Aren't most of our patients female? Haven't female pediatric rheumatologists been outstanding in our area from Taplow and Barbara Ansell to 2003! Having grown up with 3 sisters, trained with 2 female attending pediatric rheumatologists of 5, worked with 2 female partners, trained 3 female fellows, and sharing life with my better half, I am comfortable with this situation. Yet these trends, assuming their continuance, may affect pediatric rheumatology as well as other subspecialties profoundly over the next 2 decades. This female predominance may require changes in how our rheumatology sections, our pediatric departments, and our medical centers function. It may affect the workforce needs of our subspecialty. I would suggest that it is past time for all of us, male and female, to advocate for changes that will make this transition smooth and beneficial for us all and, in the long run, our patients.

There may be an understandable reaction to a discussion such as this one. It may be that women do fine in academics and, in particular, in pediatric rheumatology, and no changes are needed. But recent literature in the last 7 years has shown that female academics in the US have not been promoted as quickly as male peers, do not reach full professorship or tenure as often, and are not picked to be chairpersons as often. (1-6) In an unpublished online survey that I sent out over 2 years ago, 29/43 female North American pediatric rheumatologists said that their gender had adversely affected their career, Thirty-one of 40 women reported that females were more likely to stay at a lower academic rank and not advance to a senior rank, and 28/45 believed that female physicians had less access to leadership positions in their setting.

The situation facing female physicians may be different in other cultures, countries, and regions. Responses of European pediatric rheumatologists to the survey revealed a mixed picture. Only fourteen of 43 female respondents noted that their gender had had a negative effect on their career. In contrast, 23/44 this same group of European female pediatric rheumatologists believed that females had less access to leadership positions at their medical center and 28/41 believed that females were more likely to stay at an academic position equivalent to Assistant Professor than male peers are. None of eight Latin American female pediatric rheumatologists felt that gender was a career obstacle, 1/8 responded that females had less access to leadership positions, and 0/8 felt that females were more likely to stay

at lower rungs on the academic ladder. Factors such as cultural differences, availability of extended family help, inexpensive child care, and higher percentages of female physicians in medicine may be factors in these variations.

Some of these obstacles in academic medicine may be attributable to difficult-to-alter issues such as child and family responsibilities and cultural practices and societal trends (e.g., decreased extended family child care help in North America). Clear personal choices that each female and male physician makes have an important role (How many kids to have, how much time should I spend with my children or spouse, etc?). Male and female physicians, as well as persons in other occupations, face a constant issue: "What's more important at any moment, your work responsibilities or your family/child/spouse/parent responsibilities?" But with increasing numbers of women entering pediatrics and pediatric rheumatology, and younger physicians very focused on family, it would behoove us in pediatrics and pediatric rheumatology to be proactive. We should begin advocating for needed changes, or there will be many future career disappointments plus tremendous loss of talent and potential, not to mention the possibility that diminished career satisfaction may translate to less pediatric rheumatologists to care for our kids.

So what can be done? Let's start with what some of the 47 female North American pediatric rheumatologists recommended in 2001: 1) equal pay for equal work-long a sore point; 2) increased part-time opportunities; 3) flexible promotion clock with allowances for pregnancy and other family issues; 4) medical centers providing child care services; 5) flexible work hours; 6) maternal and paternal pregnancy/childbirth leaves; 7) family-friendly conference hours; 8) better mentoring, leadership training, and networking. Add into those needs the view of the universe of the average 25-30 year old North American trainee compared to previous generations, especially the 40-56 year olds, as described by the 2000 US census data: overriding concerns about educational debt repayment, focus on lifestyle over workaholicism, preference for loyalty to their skills rather than organizations, and a very strong family focus with more equal male: female child care responsibilities.

Our trainees and young faculty may need new work conditions and benefits to thrive as pediatric rheumatologists. What are US medical schools and medical centers doing about these family issues in 2003? Preliminary results of a recent E-mail poll of 47 pediatric subspecialists representing 22 medical and surgical subspecialties in North America provided some answers. Only 1/36 North American medical centers had a program to help young fellows, male or female, with their potentially major educational debts (excluding limited government research programs such as the one offered by the National Institutes of Health in the US). Only 7 of 41 centers had family-friendly conference times avoiding the carpooling/child care times of 7-9 AM and 4-6 PM. Nearly 95% did have paid maternity leave while 75% had paternity paid leave. Only 34% medical centers provided their own child care center and only sixty-one percent of the medical centers took family/pregnancy issues into account in the academic promotion criteria and decision-making.

I believe that we can all help in advocating and pushing for change at each of our universities, medical centers, and at national levels as our peers have suggested: 1) Equal pay for women; 2) Availability of part-time positions and flexible hours without career penalties in salary, benefits, or promotion; 3) Promotion becoming pregnancy and family issue neutral; 4) Equal access to leadership positions in medical schools and universities; 5) Medical schools and centers providing family-friendly services such as day-care and noon conferences; Excellent mentoring for female and male pediatric rheumatologists. A dreamer, you say. C'est impossible. Maybe. But check with our peers in North America, Europe, Latin America, Asia, and around the world. Many of these policies exist at different centers and in different countries. These policies are just sporadic and piece meal and should be made more uniform and pervasive in our centers. We must attract more residents into our subspecialty and fill the gaps in our international workforce, and these changes may help to increase their desire to become a pediatric rheumatologist. As our subspecialty grows in the next two decade, as we all hope it will, there will be many wonderful female and male physicians coming out to care for our special patients. We owe it to them to provide the best gender-neutral, family-friendly academic environment we can achieve.

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