BLAZING *the* TRAIL

Women in dermatology continue to break ground while challenges still lie ahead

BY **EMILY MARGOSIAN,** CONTENT SPECIALIST

Fifteen years before women in the United States were granted the right to vote, the first female American dermatologist began seeing patients in 1905. And while some glass ceilings have proved to be more durable than others, in the 112 years since Daisy Maude Orleman Robinson, MD, began practicing, women in dermatology have continued to make subsequent strides in leadership and scientific discovery. However, despite the rapid growth of women in medicine over the past 50 years — now accounting for half of all U.S. medical school graduates and 38 percent of faculty positions according to the Association of American Medical Colleges — hurdles such as lack of representation in leadership, gaps in academic positioning, disparities in salary, and inequalities in federal funding persist. In response to these issues, female trailblazers, leaders, and faculty from across dermatology discuss:

- Early turning points
- Shifting demographics
- Leadership gaps: causes and solutions
- Navigating modern work-life balance
- Funding and pay inequalities
- Addressing gender bias >>

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Pioneers

"Being the first of anything is quite unique, and I was absolutely thrilled," recalls Wilma Bergfeld, MD, who served as the first woman to be elected president of the AAD in 1992. "I had run before and lost by 80 votes, but was encouraged to run again. Voting for a woman was a difficult culture change for the membership, but they did, although I did meet with some resistance at the beginning."

Dr. Bergfeld says that she was able to overcome initial doubts over her ability to lead the Academy through her successful navigation of several crises facing the specialty at the beginning of her tenure, including a national furor over dermatologists injecting non-FDA approved silicone for facial rejuvenation. "Within the first month of my presidency, the crisis hit the fan," Dr. Bergfeld recalls. This prompted her to lead a small representative group to the FDA to express the specialty's willingness to work with the agency on the patient safety concerns. "The management of this crisis was a tide-changer. I was 50 and by this time had held many major leadership positions, as well as having been exposed to big business, leadership, and organizational dynamics. I felt well-prepared to lead."

Not all turning points for women in dermatology operate at such a high-stakes level, with some personal victories helping to shape future generations' perception of women in medicine. Mary Maloney, MD, president of the Women's Dermatologic Society, recalls a pivotal past conversation with one of her children about her choice to pursue a career as a dermatologist. "When my oldest was about 18 she told me at one point that she wanted to be a stay-at-home-mom, and that was like a knife to my heart because I felt like I hadn't been home enough," says Dr. Maloney. "Now she's a pediatric resident with a little girl — clearly not a stay-at-home-mom — and she eventually circled back and said that she always knew I was still there for my children. My kids grew up seeing that women can do anything, and although it's been a slow metamorphosis, I do think that things are progressing."

Suzanne Olbricht, MD, the current president-elect of the AAD and chief of dermatology at the Israel Deaconess Medical Center in Boston, will be only the sixth female president in the Academy's 79-year history. Dr. Olbricht hopes to see continued dialogue in dermatology concerning the expansion of diversity within the specialty. "I'd like to think that service and effort aren't determined by factors such as gender or ethnicity. But patients would be better served if physician demographics better matched the patient population," she says. "Of course dermatology is nowhere near this point, so we have to make sure in the meantime that all of us are very aware of cultural diversity and how it affects what a patient hears us say and what a patient needs from us."

Shifting demographics: the future is female

As discussed in the 2016 September issue of *Dermatology World* (**www.aad.org/dw/monthly/2016/september/the-changing-face-of-dermatology**), the face of the specialty is beginning to change. As the general

Women in dermatology: a timeline

1905 Daisy Maude Orleman Robinson, MD, becomes the first female dermatologist to hold an academic position in the United States as a lecturer in dermatology at the New York Polyclinic

1906 A motion to admit women as members of the American Dermatological Association (ADA) is denied

1925 The ADA begins allowing women to attend historical lectures and its annual dinner, however membership is still prohibited

1938 The American Academy of Dermatology (AAD) is founded and women are offered membership

1950 Beatrice Kesten, MD, becomes the first woman inducted into the ADA

1953 Dr. Kesten becomes the first female director of the American Board of Dermatology (ABD)

1956 June Carol Schafer, MD, becomes the first woman to serve on the AAD Board of Directors

population of the United States has skewed more female, with the U.S. Census estimating that there were approximately 5 million more women than men in the U.S. in 2014, dermatology has followed suit. Data provided by the AAD's Access to Dermatologic Care Committee found that over a 36-year period, female dermatologists rose to represent 45 percent of the workforce, with women also now the majority of dermatology trainees at 64 percent (*JAMA Dermatol.* 2016;152(1):92-94).

These changes mark a dramatic shift from the past according to Dr. Bergfeld, who recalls "When I entered dermatology there happened to be two women out of a cohort of five, but that certainly wasn't the case across the rest of the country." Dr. Olbricht notes that women were underrepresented in medical school, too. "We had 11 women in my school of 160, which had been the first time that women had been in the double digits, and we actually thought it wasn't going to get much better than that. Now of course, it's approaching 50 percent or more."

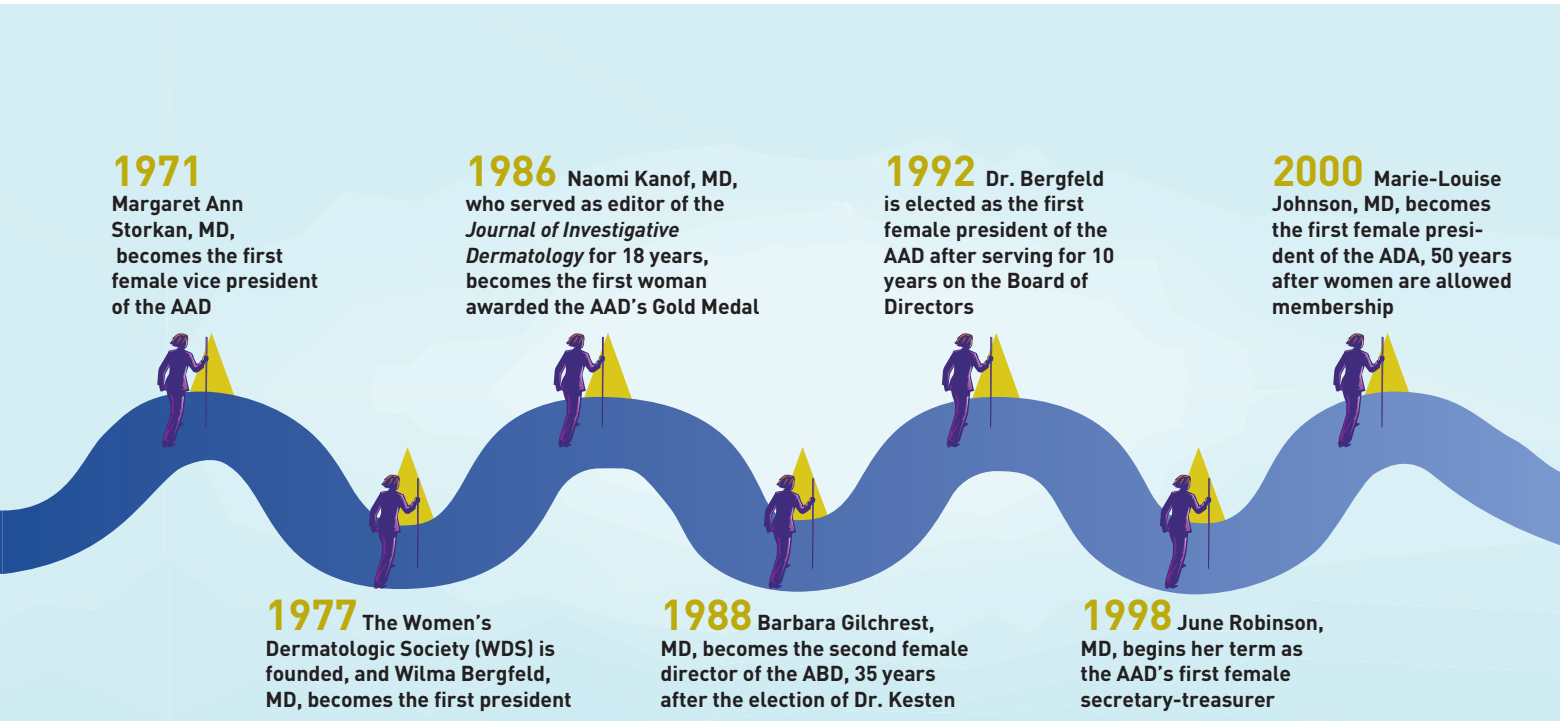
Leadership gaps

Despite the increased numbers of women entering the field, female representation within dermatology leadership and academics continues to be lacking. While the absence of female visibility in these roles may stem from a variety of factors, not limited to lack of mentorship and leadership training, differing communication styles, as well as persistent gender bias, it may also be indicative of leadership not having caught up to these recent changes in what has been a historically male-driven specialty.

"While women in dermatology have grown a lot, still the majority of women are in the first 10 years of their career, as opposed to someone like me who is someone in the last five or six," explains Dr. Maloney. "Because there aren't a lot of women at my career stage, we need the mid-career people to be stepping up into those roles going forward."

Kanade Shinkai, MD, PhD, associate professor of clinical dermatology at the University of California San Francisco School of Medicine, agrees that the gender gap present in dermatology leadership may be due in part to the early-career status of a large portion of women in the field. "My sense of it is that it's multi-factorial. I'm a program director, and when you look at programs now they aren't even 50/50 in terms of gender; it's actually tilted toward a predominance of female trainees," she says. "However I do think there is a bit of a catch-up phase as this has not always been the gender ratio. Most positions in leadership tend to come with more years under the belt, so my sense is that women just haven't caught up yet."

Sara Samimi, MD, assistant professor of clinical dermatology at the University of Pennsylvania, recently spoke at the AAD's 2017 Annual Meeting about the importance of mentorship for the increasing number of



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young women entering the specialty. Citing mentors from her own transition from resident to junior faculty, she says, "Having had strong female leaders that I've looked up to both as a medical student, resident, and now as young faculty, has helped get me to where I am today. As a woman with two kids, seeing women who have been able to strike that balance very successfully has been inspiring to me, and helped me stay strong in academics."

While a predominantly younger population of female dermatologists may account for some of the lack of women in more senior leadership roles, it is not the only factor, says Lynn Cornelius, MD, professor and chief of dermatology at Washington University's School of Medicine. "Many times it has been shown that women are promoted or brought into leadership positions based on their previous performance, whereas men are more likely to be brought into those positions based on potential," she explains. "So while mentors are important, as far as leadership goes, sponsors can play an even greater role in terms of moving up to a greater position of leadership. While someone may say, 'look I've trained all these women,' have you sponsored them or put them into positions of power? Have you been their champion in an area where they may not have been championed before?"

Continued challenges

While professional women both within and outside dermatology are less subject to the overt discrimination and rigid gender roles experienced by their predecessors, work-life balance in many cases still remains a primary hurdle for women to a degree not felt by male colleagues. "Women in medicine have a career, but also have a home and family, and they try to excel at both," says Tammie Ferringer, MD, a dermatologist and dermatopathologist in Danville, Pennsylvania. "By doing so, it's like trying to be superwoman. It's not possible to do both and do them perfectly well."

This dichotomy experienced by women in medicine can also feed into systematic inequalities in terms of job hierarchy and salary caused by perceived limits of availability due to child rearing. "Ultimately women are the ones who have the babies, and right when people are entering the workforce happens to be the time when most people have kids," says Dr. Maloney. "Women may start doing some part-time work, but I think the important message is that you can still be a vital force even if you're part-time. You don't have to be full-time necessarily to take on leadership roles or contribute in very meaningful

Dynamic Daisy: the first American female dermatologist

Born in 1868, Daisy Maude Orleman Robinson began what would prove to be an extraordinary life, only partly due to the fact that she would become the first American female dermatologist. The daughter of German immigrant parents, Daisy was the fourth of eight children to survive past infancy. Her early family life was defined by the frequent travels of her father, Louis Henry (formerly Ludwig Heinrich), a Civil War veteran and military cartographer who led the family across the United States on various assignments until his 1877 discharge stemming from accusations of an incestuous relationship with his eldest daughter, Lily.

Following this event, the family resettled in Washington, D.C., where Daisy began attending public schools and displayed an early interest in science. At age 19, she was accepted into medical school at the National Medical College of Colombian University in Washington, D.C. (at that time requiring no undergraduate study), after which she promptly wrote to the dean requesting a scholarship, which was granted one month later. Daisy received her doctor of medicine degree and obtained her medical license in 1890, as the only woman in the graduating class of 20. The only medical curriculum she preserved from school was notes relating to dermatology, indicating an early interest in the specialty.

In 1895, Daisy returned to Columbian University to finish work for her master of science degree, after a stint studying abroad at the University of Zurich in Switzerland, and then shortly thereafter at the University of Paris. Having obtained her MD and MS degrees, Daisy became the resident physician at the Peekskill Military Academy in New York, where she gave lectures on anatomy, physiology, and hygiene, in addition to coaching the school debate team. "It is interesting that the school catalogue used the initials D.M. Orleman, MS, MD, perhaps so that it would not be obvious that this young physician was a woman. That might have offended sensibilities of turn of the century male cadets at the academy" (*Clin Dermatol*. 2015;(3):396-406).

ways that set the tone for a division, a department, or a practice."

Broader societal changes in family norms and parental roles may help alleviate some of the tension between family and professional expectations, helping pave the way for more women in dermatology to assume leadership roles, observes Dr. Bergfeld. "Many of the male residents we're training now also want to be at home with the kids; they want to get out by five and have a paternity leave when their wife has a baby. So that's changing in terms of who does what in the family, and that certain responsibilities don't just fall on women anymore."

Dr. Olbricht has also noted similar shifts among male residents over the last 20 years. "Overall I have more men asking me about how to juggle family and work, and before those types of questions never came up. Even still, it can be very stressful to have young children at home and be working, so looking for places to develop leadership skills generally isn't on the priority list for women who are early or mid-career."

However, according to Dr. Ferringer, as a physician and a parent she has managed to make sure that leadership skills do make it on her priority list — by outlining a clear set of goals for her career. "I remember going through medical school not really thinking about what I wanted to do other than become a dermatopathologist. Once I did that, I finally sat down and said, 'Okay, now what do I want to do. I want to be on the American Society of Dermatopathology board of directors, so what do I need to do to make that happen?' If something was related to supporting that goal, it would rank higher on my priority list, and something else might have to come off the list in return."

Dr. Bergfeld also supports this strategy, citing it as part of reason behind her eventual successful election as the first woman AAD president. "You have to establish your goals in life, and you should set them very high. Early on when I was 30 I said I wanted to be president of the AAD, and it finally happened. What a goal! Be that as it may, you have to be prepared. You don't just get a position if you haven't done anything first. You have to have the skills to do the job and be present at the table."

Funding inequalities

While equal pay has been a major issue in gender politics for decades, financial inequalities in terms of research funding and salary disparities between male and female physicians continue to persist today. In a 2016 study published in *JAMA Dermatology*, researchers noted that

In 1904, Daisy married Andrew Robinson, her teacher of dermatology at the New York Polyclinic, where she would begin lecturing a year later (earning her the title of the first American woman dermatologist to hold an academic position). Andrew was 24 years her senior and had been previously married for 28 years, having been divorced by his first wife four months prior to his marriage to Daisy. Although both Daisy and Andrew continued to work at the New York Polyclinic, they also maintained a joint dermatology practice together in Manhattan from 1905 to 1916.

Over the course of her career Daisy accumulated a series of other firsts for women in dermatology. She was the first woman to present a case at an American dermatologic meeting in 1905 at the New York Dermatological Society, published research on the effects of syphilis in English, French, and German for which she won an award from the French Academy of Science in 1910 (the first woman to receive such recognition). Daisy would leave her joint practice with Andrew in 1916 to join the war effort in France, serving as a surgeon and dermatologist in French hospitals before returning to the U.S. in 1919.

Following the war, Daisy did not take the certifying examination of the American Board of Dermatology and Syphilology (first given in 1932), and never became a member of the American Academy of Dermatology, which was founded in 1938, coincidentally the year she retired. After a complication from an injury sustained on a train, she passed away in 1942 in Jacksonville, Florida. A known supporter of women's suffrage throughout her life, Daisy is significant as a pioneer for women not only in dermatology and medicine, but as a trailblazer who also navigated many societal barriers faced by women in American society at the turn of the 20th Century.

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although overall NIH funding for dermatologic research decreased by 4.6 percent between 2009 and 2014, despite this male investigators in dermatology saw an increase in NIH grants during that time period, while their female counterparts saw a reduction (152(8):883-887). The study notes that because the funding difference between genders disappears when adjusted for seniority and publications, the trend suggests a lack of female investigators in the academic pipeline rather than overt gender bias. "Our data highlights how the experience and productivity of an investigator translates into more NIH funding. Therefore encouraging and retaining women in academic positions is essential to overcome the male-saturated NIH landscape...the downward trend of NIH-funded women is especially concerning because NIH awards can play a role in career advancement. If women in dermatology continue to lose their NIH-funded research, the current gender gap in leadership in academic dermatology is not likely to improve," the study says.

Financial disparities between the salaries of male and female physicians also remain an issue. A much-publicized 2016 *JAMA Internal Medicine* study found evidence of major salary disparities between male and female physicians even after multivariable adjustment, noting "the salary distribution of women was skewed leftward compared with men, with a substantially higher proportion of women receiving lower salaries... Adjustment for faculty rank, age, years since residency, specialty, NIH funding, clinical trial participation, publication count, total Medicare payments, and graduation from a medical school ranked among the top 20 by *US News and World Report*, explained only a portion of the observed salary difference between male and female physicians" (176(9):1294-1304). The study found significant differences in faculty salary based on gender across specialties, with female academic physicians earning adjusted annual salaries 8 percent ($19,879) lower than those of male physicians, further noting that these disparities were found to be present across all faculty ranks. "In fact, female full and associate professors had adjusted salaries comparable to those of male associate and assistant professors, respectively."

Both studies imply that on a systematic level, notable differences in salary and funding between male and female physicians continue within dermatology and the broader field of medicine. The *JAMA Internal Medicine* study notes that possible causes for a gender salary gap among male and female physicians could include factors such as childrearing, greater difficulty in finding effective mentors, overt discrimination, and the possibility that women physicians may place less emphasis on salary negotiations compared with male counterparts (176(9):1294-1304).

Dr. Shinkai corroborates that female physicians are often forced to make choices in their personal lives that may have a negative impact on their professional trajectory and overall earnings. "There's definitely a hidden curriculum for women to be able to navigate their family lives in addition to climbing up the ranks. I don't think this is necessarily specific to dermatology, but in academic medicine there's a lot of focus on the ticking clock, in the sense that there's a bit of a feud between the biological clock and the tenure clock. Obviously taking gaps for family leave can deeply affect women's ability to progress into tenured positions, which can have financial implications as well."

How then, are medical centers and schools working to close these gaps? Alexa Kimball, MD, MPH, president and CEO of Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, weighs in that, "Many organizations are trying to tackle this problem. The first issue people generally encounter is getting good data. To do a real comparison, you need to control for research time, part time work, academic rank, seniority, and specialty and subspecialty area. Some of the problems are embedded in the payment structures of the latter. For example, Mohs, until fairly recently, lagged behind medical derm in terms of the proportion of women in the field and it typically pays substantially better." Citing the relatively small size of dermatology departments in comparison to other medical faculties, Dr. Kimball suggests that RVU-based compensation plans are one method of standardizing salaries across faculty departments, while noting that "Close attention has to be paid to research salaries which can also vary considerably by gender, and systematically reviewing initial offers is also important to make sure that the initial playing field is as balanced as possible."

Gender bias

While overt sexism in medicine is more rarely seen and less tolerated than in the past, gender bias can still persist in the form of underlying expectations of how women should behave in the workplace. "Still today, in many instances, certain behavior from men will be interpreted very differently than the exact same behavior from a woman. If a man demands something, he is being assertive, if a woman demands something, she is being aggressive," says Dr. Maloney, who spoke on these differences in perception during a session at the 2017 AAD Annual Meeting. "This can become a terribly complex activity for women, and I was personally caught in a trap where I was accused of being aggressive when I was instead stating a strong opinion. I learned the hard way that this still happens."

Dr. Cornelius agrees. "I think the business world is leaps and bounds ahead of us, both in the culture of accepting and embracing diversity, as well as helping people navigate these types of issues. Many times women are viewed as too soft to be a leader, or that a job is too

tough for a woman, however if a woman becomes assertive she is labeled aggressive." Dr. Cornelius also spoke at the same session, addressing instances of unconscious bias often present throughout academia and the broader spectrum of medicine.

"We all have unconscious bias; just by the terminology, it's not purposeful. However these untested assumptions lead to missed opportunities. In any professional network, if you are a minority, unconscious bias can lead to exclusion from some informal networks, difficulty understanding the unwritten rules, and can result in a lack of role models, which makes the cycle self-perpetuating," Dr. Cornelius says. She advises that one way to combat bias is to be prepared to respond in the moments in which it occurs. "You don't have to be obnoxious about it, but if you're in a meeting and a woman proposes an action and it's passed by, and then later a man proposes the same thing, instead of sitting there fuming you can say, 'Hey you know, that is a good idea, I'm glad you picked up on what she said.'"

Stretching for the summit

Despite the strides made over the years by women in dermatology, there's still further to climb. "I had a woman physician tell me one time, 'Wilma, not everyone wants to be a leader, but I'll give you my support,'" says Dr. Bergfeld. "It's consuming, competitive, and sometimes a little bit mean. You deal with a lot of prejudices."

While changes in diversity remain a hot topic both in and outside of medicine, as their numbers increase, women in dermatology continue to look toward the future in spite of continued challenges. "Someone once told me that your children will be proud of you for what you do, and that they look up to you as an example for what they want to be in the future, and that has stayed with me," recalls Dr. Samimi. "I want my two daughters to see me as a strong, independent woman who set an example for them in terms of what they want to achieve." ***dw***