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Gender Equity in Clinical Dermatology—Reason for Optimism

Mackenzie R. Wehner, MD, MPhil,

Department of Dermatology, Perelman School of Medicine, University of Pennsylvania, Philadelphia

Haley B. Naik, MD, MHSc,

Program for Clinical Research, Department of Dermatology, University of California, San Francisco, San Francisco

Eleni Linos, MD, MPH, DrPH

Program for Clinical Research, Department of Dermatology, University of California, San Francisco, San Francisco

It is not news that medicine struggles to achieve gender equity, particularly in leadership, academics, and research. In an analysis of more than 90000 academics in 2014, only 12% of women were full professors compared with 29% of men. Even when accounting for experience, productivity, specialty, and age, women were still statistically significantly less likely to be full professors.¹ Women are so scarce in senior leadership positions that chairs of academic departments are more likely to be men with mustaches than to be women.² Women in medicine also report high levels of discrimination.^{3,4} Junior faculty women receive less start-up support,⁵ and women are more likely than men to leave academics.⁶ Salaries are lower for women, even when adjusting for specialty, rank, leadership, publications, and research time.^{7,8} Women speakers at grand rounds are introduced informally statistically significantly more often than their male peers.⁹

Dermatology appears to fare a bit better than other specialties with regard to gender equity: 52.5% of board-certified dermatologists in 2017 were women, a number that has increased over the last several decades.¹⁰ However, this specialty still faces issues related to gender equity. National Institutes of Health funding through the National Institute of Arthritis and Musculoskeletal and Skin Diseases is awarded to 3 men for every woman for R01 awards and to 2 men for every woman overall.¹¹ Compared with men, women in academic dermatology are more likely to have clinician or educator roles rather than investigative roles, and women are more likely to consider leaving academic dermatology. As of 2015, fewer than a quarter of dermatology department chairs were women.²

However, much of the published research in medicine overall, and in dermatology specifically, focuses on physician-scientists and academia. Clinical leadership and expertise are underexplored topics in dermatology addressed by 3 Research Letters in this issue of

Corresponding Author: Eleni Linos, MD, MPH, DrPH, Department of Dermatology, University of California, San Francisco, 2340 Sutter St, Room N421, Mail Code 0808, San Francisco, CA 94143-0808 (eleni.lin@ucsf.edu).

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JAMA Dermatology.^{10,12,13} Two of these letters examine the gender of speakers at the American Academy of Dermatology (AAD) meeting—a primarily clinical conference—and the third examines the gender of authors of nonresearch articles published in clinical dermatology journals.

In their letter, Stratman and Stratman¹⁰ report that the proportion of women speakers at AAD annual meetings has been increasing over time. In 2017, the number of women speakers reflected the number of women board-certified dermatologists (0.92 women speakers for every 1 woman board-certified dermatologist). The authors also found that the representation of women as session directors and as members of the Scientific Advisory Committee was also increasing. Mujahid et al¹³ also analyzed the gender of speakers at AAD annual meetings, evaluating the amount of time each speaker had and the number of women speakers. This analysis accounts for the longer duration of some sessions and the fact that some sessions include multiple presenters. In their Research Letter, Mujahid et al¹³ found that both the percentage of women speakers and the amount of time allotted for presentations by women had increased over time. The findings of these 2 reports are consistent and complementary. Stratman and Stratman¹⁰ limited their analysis to physicians. This allows a direct comparison of AAD women physician speakers and women board-certified dermatologists, but it does limit the generalizability to women in dermatology, regardless of degree. Mujahid et al¹³ included all AAD annual speakers and reported similar findings.

In a Research Letter also published in this issue of *JAMA Dermatology*, Larson et al¹² report on their analysis of authors publishing nonresearch, perspective-type pieces in 2 leading dermatology journals: the *Journal of the American Academy of Dermatology* (Commentary category) and *JAMA Dermatology* (Viewpoint category). They found that, in these publications, women were in the minority of first authors, last authors, and authors overall. Specifically, 25 of 78 nonresearch articles (32%) had a first author who was a woman, and 21 of 63 articles (33%) had a last author who was a woman. The rationale for the selection of the 2 article types was to minimize skewing of results, which was more likely to occur in editorial or expert commentary-type article categories owing to previously reported underrepresentation of women among the pools of potential authors. Although their goal was to exclude editorial team authors and invited articles, the article types they included could be invited by the editors, could be written by editorial team members, or could be completely unsolicited. Additionally, some of the article categories have strict limits on the number of authors, whereas others do not, and the authors did not adjust for this. These limitations mean the analysis by Larson et al¹² is based on a heterogeneous group of articles, making their conclusions less clear. The most interesting finding is that women authors are much less likely than men to be solo authors (13 [87%] of 15 articles written by a single author were written by a man).¹² Furthermore, when the first author of an article was a woman, more than half of the coauthors were also women. One interpretation is that women authors may pursue sponsorship—especially of other women—more often than men when it comes to authorship. These findings are consistent with studies across the fields of medicine, economics, and physical and natural sciences, suggesting that women authors are more likely to share authorship and are also more likely to coauthor scientific manuscripts with other women.^{14,15}

Taken together, these 3 reports indicate that there is reason for optimism. Clinical dermatology is on the path to gender equity, with an increasing number of women speakers at the national meeting and women authors who are collaborative and demonstrate expertise and leadership through scholarly activities. The latter will likely continue to attract more women authors, thereby broadening the editorial pool of major journals to continue this positive trend. Although these reports of improved gender equity in clinical dermatology give us hope, they also raise important questions about the necessary next steps to ensure equity within both clinical and academic dermatology: (1) whether evidence exists of disparities in awards or invited opportunities such as lectureships, editorials, and national leadership roles; (2) how lessons learned from clinical dermatology can be applied to investigative dermatology (eg, the Society for Investigative Dermatology meeting and authorship of research articles) to set standards for the dermatology community as a whole; and (3) how to effectively support diversity and reduce disparities across race, ethnicity, and sexual orientation, as well as gender. Studying the problem, raising awareness, and implementing policies that specifically aim to support diversity in dermatology will be critical to the advancement of our specialty. We are optimistic. And we still have a lot of work to do.

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