DDS Perspective: Reflections of a Woman in Gastroenterology

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Published online: 6 August 2019

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Employment

When I finished my gastroenterology fellowship in 1999, only about 10% of the gastroenterologic (GI) attending physicians were women [1]. I always considered that an advantage, not an obstacle. At least 50% of GI patients are women, and women prefer female endoscopists [2–6]. I quickly realized that as a recent female GI graduate, I might have better career opportunities than my male colleagues. In 1999, multiple GI practices were recruiting women because that is what their patients demanded [2–4]. While there were long waiting lists to see the sole female endoscopist in a given practice, many male endoscopists were searching for patients. In general, women feel more comfortable talking about gas, bloating, diarrhea, pelvic pain, and menstrual symptoms with other women. I have heard male senior gastroenterologists say that only female gastroenterologists should care for female patients. Yet by relegating “women’s GI issues” to women physicians, the medical establishment diminishes not only female patients and their problems, but also the science behind the practice of medicine. A scientific approach to illness accounts for differences among all people and respects all patients regardless of gender.

Women gastroenterologists should have been equally compensated, but that was far from the case in 1999 and the early 2000s. Like the US women’s soccer team members who are widely popular and have gained world recognition with multiple stunning victories but are paid a pittance compared with the US men’s soccer team, women gastroenterologists have been consistently undervalued and under-compensated. Although I was specifically recruited as an inflammatory bowel disease (IBD) expert and not a specialist in women’s health (which was not thought to be a legitimate field at the time), my starting salary was significantly less

than that of my young male colleagues. One job offer in New York City that I did not take was for a year or two “until I got pregnant and was on the mommy track.” Such assumptions were disheartening after I had trained for 3 intense years at Mount Sinai, one of the best GI programs in the country. My male GI colleagues also became parents, but the powers that be assumed their wives would handle the home front. In 2017, 17.7% of the female practicing gastroenterologists were women, and US GI fellowships in 2017/2018 were training 32% women [1]. Although improved since 1999, women in GI still have a long way to go to attain greater numbers of professorships and positions as division chiefs and society presidents. When they negotiate salary and clinical and research support, women GIs should remember that they are more in demand than their male peers, since the 18% of female GI physicians are servicing most of the female patients.

Women’s Health

I am proud to focus much of my clinical and research interests in IBD and women’s health. I have always enjoyed treating pregnant IBD patients, as well as those struggling with infertility. A large part of my success and satisfaction in managing these patients is that I always have outstanding backup from colleagues in maternal–fetal medicine and infertility. We almost always manage patients as a team, and team members are both male and female physicians. This gender mix somehow legitimizes our clinical and research endeavors to colleagues inside and outside Brigham and Women’s Hospital. It says to the outside world that since male physicians are interested in women’s health, it must be important! I have often seen male gastroenterologists send their pregnant patients to their female colleagues. Yet the highest incidence of IBD is during the reproductive years, so treating pregnant women is not a sideline, but at the center of an IBD practice. One of my goals is to teach community and academic gastroenterologists how to manage pregnant IBD patients so that they will feel comfortable treating them.

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I was proud to be part of the Parenthood Project, a national committee that developed guidelines for caring for pregnant patients with IBD [7].

Sexual Function and Men's Health

Recently, our group has been doing research on sexual dysfunction in women and men with IBD [8–10]. With this research thread in IBD, it seems much easier to interest all IBD gastroenterologists, including men. Our sexual function research has taken off with a few prospective clinical trials by various investigators throughout the USA. My research in sexual dysfunction and fertility in IBD has inspired me to focus my current studies on men's health in IBD. The premise is that sperm take 70–90 days to develop and, during that time, are susceptible to drug or environmental toxicities. Recent studies have shown that paternal preconception exposures are critically important to child health. For example, paternal smoking, age, and occupational chemical exposures have been linked to an increased risk of cancer and neurologic disorders in children, presumably through epigenetic modifications in the germ line. The newly understood importance of paternal influences has important implications for men with IBD. Fathers are exposed to IBD medications as well as active inflammation around the time of conception, and this may have an effect on child health outcomes [11–16]. In fact, the effect on the fetus from the father may be equal to or greater than that from the mother. Imagine telling fathers that they cannot smoke or drink coffee prior to conceiving and that they should be in good health and of normal weight!

Colleagues

Salaries at Brigham and Women's Hospital are now equitable, and there is a set salary structure that is not gender-biased. We boast a GI program that has among the most female faculty in the USA. My colleagues, both male and female, are wonderful. My chief and clinical chief were smart and hired lots of young, bright, and eager young women as new attendings over the years. There is a hospital parental leave policy for faculty that is fair by US standards, and many men and women GIs have taken advantage of it. My colleagues are among the highlights of my job, and I enjoy working with all of them. I see so many male and female colleagues struggling with the responsibilities of raising young children. Trusted childcare is exorbitantly priced and difficult to arrange, and living in the Boston area is prohibitively expensive. It is difficult to have a full-time clinical job, do the expected amount of clinical research, and have a successful life with a partner, even without children

thrown into the mix. My most successful colleagues either do not have children or have parents who do the childcare or a partner who has a much less time-intensive job.

Family

When our son Sam was an infant, he would only sleep for an hour at a time and awaken consistently at 3:30 AM, ready to go. My husband Jerry, who is a pulmonary and critical care physician at Brigham and Women's Hospital, and I were tired all of the time. It was difficult to make it through our clinical day, much less write chapters, and do research. One of my most poignant memories is driving around the Chestnut Hill Reservoir with Sam in his car seat so that, while he napped, Jerry and I could write our chapters in the car: I was writing the IBD chapter for *Harrison's Principles of Internal Medicine*, while Jerry was writing a chapter on hemoptysis and alveolar hemorrhage for the *Intensive Care Unit Manual*. We would then repeat the process again and again so we could get work done. Sam is now 20, and we also have a 17-year-old daughter, Angela. Somehow, both want to go into medicine. Dr. Richard Blumberg and I have just finished our sixth iteration of the Harrison's IBD chapter [17]. I am lucky in that Jerry and I have always shared household and childcare responsibilities. I can only hope that I have supported him as much as he has supported me over our 23 years together.

Patients and Complications

About 70–80% of my patients are women, a population I have always been happy to treat. Few patients have called me by my first name without asking or acted disrespectfully because I am a woman. I think confidence in one's own clinical skills usually overcomes other people's gender bias. Overall, my patients appreciate having a physician who listens attentively and seems comfortable discussing personal questions regarding sexual function, mental health, and overall general well-being [18–20]. Additionally, patients appreciate it when I tell them I need to research a treatment or think about a plan rather than give them a quick answer. However, when mistakes are made, or confidence breaks down, the result can be worse for a female than a male physician. Although women physicians are sued less [21], I feel they agonize more about mistakes and tend to blame themselves rather than circumstances. Some of my most stressful days have resulted from the personal consequences of complications. I have seen several young female gastroenterologists leave medicine due to complications early on in their careers. I now view the increased empathy and attention to detail of female physicians as a double-edged sword. We

blame ourselves more after a complication occurs, and the guilt and self-doubt can linger for a long time. Perhaps this is why a wellness survey at our hospital reported decreased professional fulfillment and increased burnout among female faculty. Problem areas were difficulty with academic advancement, lack of respect, and insufficient work flexibility [22].

Final Thoughts for Women GIs

Overall, I think female gastroenterologists need to understand that they are essential to an outstanding GI program and start demanding working conditions and pay commensurate with their unique talents and expert clinical practice. Female GIs are a sought-after minority and therefore have superior bargaining power. An increased number of female gastroenterologists will only improve clinical care for both female and male patients. Female physicians engage in more patient-centered communication and have longer visits than their male colleagues, with no change in the quality or manner of medical advice [19]. This communication style inspires increased patient engagement, comfort, and partnership [19] and is an important move away from the ever-increasing corporatization of medicine.

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