were substantially underrepresented relative to the proportion of practicing clinicians in their age cohort. We report here our investigation to determine whether the influx of women into medicine has been accompanied by equal progress in attaining leadership positions or academic promotions across 15 specialties. We included program directors in our analysis because program directors focus on teaching and trainee development, in contrast to department chairs, who typically have more executive responsibility. We examined the comparative gender distribution of program directors, chairs, residents, and practicing physicians.

The gender, age, and specialty of physicians and department chairs were obtained using American Medical Association and Association of American Medical Colleges data from 2008 to 2010. Program director age and specialty were obtained using an anonymous survey with a 38% response rate (n=1,100). The proportion of female program directors ranged from 5% in orthopedic surgery to 49% in pediatrics, and the proportion of female department chairs ranged from 0% in orthopaedic surgery to 21% in obstetrics and gynecology. The likelihood of a woman being promoted to program director compared with department chair ranged from 1.88 times more likely to be a program director (confidence interval [CI] 1.30–2.70) in obstetrics and gynecology to 10.06 times more likely in orthopaedic surgery.

Although both chairs and program directors were significantly more likely to be male across all specialties, for the majority of specialties, the proportion of female program directors was comparable with the proportion of practicing female physicians in the same age cohort. Female department chairs were significantly underrepresented across all specialties. Despite increasing numbers of women entering medicine, female faculty may be substantially less likely to be promoted to chair than to program director. Although this finding is reassuring in terms of the promotion of women into the role of program director, it highlights the concern that female physicians are not being advanced equally in all types of leadership positions within academic departments. Consistent with previous research, female physicians are underrepresented as department chairs in obstetrics and gynecology; however, this effect is the least pronounced of all specialties examined.

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In Reply:
The research findings by Kimball et al of a gender-leadership disparity within academic medicine corroborate the findings presented in my article.

Although it is heartening that obstetrics and gynecology has a less profound deficit of female leaders than in other specialties, it remains concerning that department chair and program director positions are uniformly male-dominated across medical specialties. The study described in the letter by Kimball et al included residency program directors as a surrogate for “academic promotions.” I question the assumption that program directorship is a surrogate for academic promotion. It has been suggested that the position of program director tends to be a terminal position rather than a stepping stone to other leadership positions. In fact, women with leadership potential being recruited to terminal program director positions actually may be contributing to our gender-leadership disparity. Women should not be discouraged from pursuing these positions; however, we must ensure that promotion committees value medical education and education research to the same extent as clinical accomplishments and clinical research. Lastly, research indicates that women in academic medicine are not promoted to the same extent that men are promoted, even after controlling for seniority and achievement. We must continue to investigate and mitigate the influences contributing to this gender-leadership disparity, and I thank Dr. Kimball and colleagues for doing so.

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REFERENCES

Ovaries, Estrogen, and Longevity and Long-Term Mortality Associated With Oophorectomy Compared With Ovarian Conservation in the Nurses’ Health Study and Variation in Ovarian Conservation in Women Undergoing Hysterectomy for Benign Indications

To the Editor:
One of the many blessings that accrue from practicing medicine for more than 50 years is the ability to reflect on the cyclic changes that occur in our approach to caring for women. The editorial by Chalas and the articles by Parker et al and Perera et al illustrate some of these changes.

In the 1960s, the late Paul Mc Donald advocated bilateral oophorectomy at the time of hysterectomy for women older than 35 years of age to prevent ovarian cancer and...
deleterious progestogen effects. He then recommended estrogen replacement therapy forever.

Subsequently, the age threshold was increased to 40–59 years. Parker et al and Perera et al now present evidence that it may be beneficial in low-risk women to preserve ovarian function over the age of 60 years to reduce cardiovascular and overall mortality.

Since the initial results of the Women’s Health Initiative (WHI), which negatively affected our beliefs about the putative benefits of estrogen, numerous publications have broadened our concepts of the importance of timing in estrogen administration. These include pleiotropic mitochondrial responses,4 signaling pathways of estrogen, and estrogen as a critical regulator of metabolism.5 The editorial and two articles are additional evidence for these concepts.

It now appears that estrogen may be viewed as a hormone of homeostasis (euestrogenemia)6 in reducing overall mortality if administered during a critical period of time.

The rush to publish the initial findings of the WHI, before thorough in-depth analysis by the world’s scientific societies, prompted many women and clinicians to halt hormone therapies or to adopt the strategy of “the lowest dose for the shortest period of time” to acclimate the woman to the chronic hypoestrogenemia of the final decades of her life. This became an epidemiologist’s wonderland as millions of U.S. women abruptly became chronically and forever hypoestrogenemic. We call this cohort of women “Rossouw’s Cohort.”7 How they fare compared with those women who continued “hormone replacement therapy” will be the final lesson that we learn from the WHI. To paraphrase Dr. Chalas, we will learn whether Jacques Rossouw is “the scapegoat” or “the savior” in defining the use of the “silver bullet,” estrogen.

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**References**

**Editor’s Note:** Chalas, Parker et al, and Perera et al declined to respond.

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**Is Breast Always Best? A Personal Reflection on the Challenges of Breastfeeding**

**To the Editor:**
As physician mothers who also struggled with breastfeeding and who counsel others with their struggles, we sympathize with Dr. Shah.1 We applaud the strong stance the medical community has taken to encourage breastfeeding, but we also strongly reject using fear or coercion as manifestations of good intentions. There are risks to risk-based counseling for breastfeeding,2 and continuing to emphasize that formula is not ideal to the mother who chooses to or has no choice but to formula-feed is potentially harmful. Further, lack of medical education about breastfeeding creates difficulties when it comes to troubleshooting problems or finding resources to help patients. Physicians’ personal experiences with breastfeeding do (for better and worse) affect the counseling they give their patients.3,4 Regardless, we have an obligation to present the most current medical evidence and advice to our patients.

We believe that the best way to help those mothers who desire to breastfeed at the time of delivery reach their goal is with supportive hospital policies; breastfeeding medicine training for residents in obstetrics and gynecology, pediatrics, and family medicine; covering breastfeeding support in insurance plans; and providing more support for those who work outside the home as they return to work. The creation of Dr. MILK, a live online community of physician breastfeeding mothers, has helped to bridge the large gaps in knowledge and provide support to this population (www.drmilk.org). We agree with Dr. Shah and others5 that we must provide family-centered, longitudinal breastfeeding support with attention to emotional, behavioral, and cultural barriers to help mothers achieve their goals.

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