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In considering the title for her talk at the Women in Medicine & Science Awards Luncheon at the AAMC Annual Meeting in November 2012, former American Bar Association president and partner in the law firm of Holland and Knight, Martha W. Barnett, noted the different message communicated by: “Gender Matters?”, “Gender Matters!”, or “Gender Matters.”


In this issue of GWIMS Watch, our theme is gender equity. The 2011–2012 Benchmarking Report included in this issue highlights the persistent inequity in leadership roles in academic medicine, as does the recent article in the AAMC Reporter (Leigh Page).

The articles highlight approaches important to our next steps aimed at truly achieving gender equity. They emphasize awareness, strategic development, being a proactive sponsor, and the importance of institutional culture.

We are very pleased to introduce a new content area, “Inspirations,” which will feature original contributions related to the humanities or the art of medicine. We invite readers to submit original narratives, poems, artwork, photography, or other expressions of creativity.

Most sincerely,

Rebecca Rainer Pauly, M.D., FACP
Chair, AAMC Group on Women in Medicine & Science; Associate Vice President, Health Affairs, Equity & Diversity; Vice Chair, Department of Medicine, Medical Student Education;

The 2011–2012 Women in U.S. Academic Medicine and Science Benchmarking Report is now available and can be found on the GWIMS Web site here. This report serves as a technical overview of current data regarding the representation of women in academic medicine. This report also highlights the fact that while progress has been made in some areas, there is still a long way to go. The reasons behind why women continue to be less likely to receive tenure than men, and are underrepresented in higher faculty ranks and in leadership positions, should continue to be explored.

Commitment to Equity: Salary and Beyond

At the 2012 AAMC Annual Meeting in San Francisco, Calif., the Group on Women in Medicine and Science, the Group on Faculty Affairs, the Group on Institutional Planning, the Group on Business Affairs, and Faculty Forward joined together to sponsor a session titled, “Commitment to Equity: Salary and Beyond.” The session provided information on how academic health enterprises can implement a commitment to equity, what the landscape of equity encompasses, and the critical role of leadership in the process.

The session featured the following moderators and speakers, whose presentations can be found here.

Perceptions, Environment, Cues, and Their Significance in Promoting Gender Equity

By: Manwai Candy Ku, Ph.D., Research Scientist, Stanford University School of Medicine

Women remain underrepresented in the highest positions of rank and leadership; the 2011–2012 AAMC Women in Academic Medicine & Science Benchmarking Report shows that women make up just 20 percent of full professors, 14 percent of department chairs, and 13 percent of medical school deans. While conventional explanations for gender disparities often focus on choice (e.g., career decisions and preferences), or constraint (e.g., discrimination and implicit bias), recent scholarship and discourse on gender inequality highlights the interrelationship between these two factors. In particular, perceptions about the academic environment may influence women’s career trajectories in a way that contributes to or maintains unequal outcomes.
There is abundant research in social psychology about the social identity threat—the threat that people experience when they believe that they may be judged or treated differently because of a particular social identity that they hold, such as gender. Studies have also identified potential sources of social identity threat. In addition to stereotypes about a social group, cues in an environment—such as the representation of that group or the perceived culture in an environment—can trigger a social identity threat. Conceivably, in academic medicine where men dominate senior positions, women faculty encounter cues that will trigger social identity threat.

We worked with the AAMC Faculty Forward team to see if women faculty perceive academic medicine differently than do men, particularly in terms of promotion. This study is a collaborative effort by the Faculty Forward team, Dr. Shannon Fox and April Corrice; Dr. Hannah Valantine, senior associate dean of diversity and leadership at Stanford School of Medicine, and her research associate, Dr. Candy Ku; and members from other Faculty Forward participating institutions including Dr. Linda Chaudron, Dr. Lynn Gordon, Dr. Susan Pollart, Dr. Valerie Williams, Dr. Leslie Morrison, Dr. Marian Passannante, Dr. Alonzo Walker, Dr. Lari Wenzel, and Dr. Rebecca Pauly. In our analysis of the 2009 Faculty Forward data, we found that women faculty across department types (clinical or basic science) and rank are significantly more likely than men to feel that women and men do not have equal opportunity to be promoted. Women are less satisfied with the pace of their advancement, and they are less likely to feel that their departments are successful in recruiting and retaining women faculty.

If women faculty perceive inequities in opportunity and advancement, in addition to women’s under-representation in senior and leadership ranks, it is likely that their sense of belonging and desire to participate or remain in academic medicine will diminish. At the 2012 AAMC Annual Meeting, I had the opportunity to share our research and interventions on implicit bias and threat/belonging with others, and also learn about other institutions’ initiatives to promote gender equity. For more information about our interventions, see slides 42–43 in this presentation. The foundation laid by these current efforts provides a great platform to continue efforts to address threatening environmental cues and provide resources to support women faculty success.
Commitment to Equity: A National Call to Action for Leaders

By: Claire Pomeroy, M.D., M.B.A., Chief Executive Officer, University of California, Davis, Health System; UC Davis Vice Chancellor for Human Health Sciences; Dean, School of Medicine

Gender equity at our academic health centers (AHCs) is a matter of social justice and is key to achieving excellence in our mission. The metrics of the number of women faculty and salary equivalence are important to improve, but they are just the observable symptoms of a challenge which must be addressed in deeper ways. AHCs need to treat the underlying causes of inequity, not just treat the symptoms. True wellness in our organizations will be achieved when we holistically embrace a culture of equity.

At the 2012 AAMC Annual Meeting, I participated in the session “Commitment to Equity: Salary and Beyond” and highlighted the role of leaders in promoting equity. I passionately believe that advancing equity requires more than policies and procedures; it requires an institutional culture that embraces and fosters opportunities for everyone to succeed and thrive. Leaders must establish, nurture, and secure an inclusive environment at their institutions—and, most importantly, must serve as the champions of change.

“...advancing equity requires more than policies and procedures; it requires an institutional culture that embraces and fosters opportunities for everyone to succeed and thrive...”

Leaders demonstrate their commitment to a culture of equity through their messages, their actions, and especially the priorities they set for their organizations—and themselves. For example, one of my first steps at UC Davis Health System was to establish the Center for Reducing Health Disparities to address the social determinants of health and eliminate health inequities. The new center sent a strong message that equity and social justice are guiding principles in our health system.

The institution’s strategic plan should articulate the core value of equity, and follow that core value as the plan guides the organization’s work each day. At UC Davis, we celebrate our commitment as a community that “combines academic excellence with a passion for social justice in order to transform health care and improve health for all.”

Equity must guide the development of the programs and initiatives that advance the health system’s education, clinical care, and research. Examples at UC Davis include:

**Education:** Rural-PRIME, San Joaquin Valley-PRIME, and TEACH-MS are educational programs which attract underrepresented minority (URM) candidates and train physicians committed to helping underserved rural and urban populations.
Commitment to Equity: A National Call to Action for Leaders…Continued

Clinical care: UC Davis physicians consult via telemedicine at more than 100 sites to overcome geographic disparities, and students and faculty volunteer at free health clinics in disadvantaged communities.

Research: Our faculty explore the causes and effects of disparities in programs such as the Asian American Network for Cancer Awareness Research and Training, and the Mothers’ Wisdom Breast Health Program for Native Alaskan and American Indian women.

At UC Davis, we reviewed and revised our faculty policies to ensure that both women and men can “stop the clock” for child-bearing and other family responsibilities, we routinely analyzed salaries, and established support systems such as our Women in Medicine and Science group. We have gone deeper to address issues such as unconscious bias and “face-time bias,” which may hinder advancement of women and minorities.

A leader’s personal actions are a critical component of an organization’s commitment to equity. For instance, I chair our Diversity and Inclusion Committee, am principal investigator on our Building Interdisciplinary Research Careers in Women’s Health program, participate in welcoming events for new URM students, and speak at our annual “Coming Out Day” event sponsored by our employee lesbian, gay, bisexual, and transgender community.

At UC Davis Health System, our vision is to create a healthier world through bold innovation. This includes taking the transformational steps that will enhance our institution’s position as a source of best practices and a national leader of progress in equity for all.

Career Development and Succession Planning: A Systematic and Equitable Approach

By: Leslie Morrison, M.D., Vice Chancellor for Academic Affairs, University of New Mexico Health Sciences Center

Equity is an emotionally charged word with many meanings. We typically associate equity with finance and fairness. However, there are many nonmonetary ways in which to create more fairness. Here, we explore ways to prevent career derailment through careful planning for success.

The lifecycle of a faculty member begins with the transition from a supervised work environment to a more independent life as a junior faculty member. The importance of establishing equity in this early stage cannot be emphasized enough. New faculty orientations, mentorship, and monitoring progress provide the essential groundwork for a solid career start. The first promotion should be planned for from the beginning so that faculty understand the
Factors upon which their work will be evaluated. Studies have shown that women and underrepresented minorities may take longer to establish their first and subsequent promotions, placing them at a disadvantage for opportunities that may require associate or full professors to be eligible. In addition, women and minorities may be encouraged to serve on less important committees, or to balance the diversity of committees, instead of being encouraged to focus on accomplishing career goals or participating on key committees with high visibility. The AAMC early-career program is an opportunity to establish ties with mentors and colleagues outside of one’s institution, is a reminder to focus on one’s career, and is an important time and place for self-assessment and reflection on accomplishments. Only a small percentage of women faculty are able to attend these meetings, so institutions can offer similar opportunities locally that include mentor training, goal-writing workshops, and promotion preparation support.

By the mid-career stage, faculty are usually on an established career trajectory. If, during the early stages, a faculty member did not have adequate voice or choice in that direction, they may be facing a new direction and losing valuable time toward promotion and opportunities for leadership development. Faculty who are successful may be progressing quietly on their career trajectory, but as opportunities begin to surface for leadership positions, they may need mentorship to advance their visibility among higher leadership. The AAMC Mid-career seminar and the Executive Leadership in Academic Medicine are excellent programs that help faculty stay on track. Once again, this type of opportunity may need to be supplemented within the institution for faculty unable to attend these programs.

As we reach the rank of full professor, we must continue to develop our abilities as mentors, and broaden our spheres of influence. We begin to influence policy and practice by serving as role models to junior faculty. Further training in finance (M.B.A.) or research (M.P.H.) can advance our own careers, and allow us to provide better mentorship to women coming along behind us. In the emerita positions, we can continue to mentor senior women as we advance in leadership.

Sex, Power, & Advancement: What Have We Learned? What Are We Learning?

By: Janet Bickel, M.A., Leadership and Career Development Coach, www.janetbickel.com

Academic medicine and science is a part of our “half-changed” world with regard to women’s advancement. The steady work of social change agents over the last century has resulted in a culture where young women can now take advantage of opportunities that their grandmothers could not have imagined. Concomitantly, efforts supporting women’s leadership development have matured from informal potluck dinners to reputable programs such as the AAMC Early and Mid-career Women Faculty Professional Development Seminars and the Executive Leadership in Academic Medicine (ELAM). These programs are funded and have generated solid scholarship. A potent model for evaluating women’s professional development has been one of several valuable contributions to the professional literature about women in medicine and science (Magrane, et al).
Commitment Sex, Power, & Advancement...continued

There has been an increase in the percentage of women in all professorial ranks. However, evidence from carefully designed studies continues to demonstrate that even men and women who prize objectivity still favor men over identically described qualified women. A recent randomized, double-blind study found that both sexes of science faculty unintentionally downgraded the competence, hireability, salary offer, and mentoring of female candidates compared with identical male candidates (Moss-Racusin, et al). That the faculty tend to like female candidates better doesn’t translate into positive perceptions of competence. Unconscious biases do not go away on their own (Bickel).

The fact that women continue to underestimate their own abilities and are less likely to be seen as having leadership potential is not a surprise. Another critical, persistent influence on the slower-than-needed pace of women’s progress is that women tend to have less “social capital” within their institutions, often because they lack a powerful mentor/sponsor. Family responsibilities also limit the necessary flexibility to travel and socialize for some. Thus, while clear progress toward gender equity is apparent from a talent development perspective, much work remains. Who will lead this work?

The December 2012 Mid-career Women Faculty Professional Development Seminar opened with an overview of this information to increase participants’ understanding of the continuing gender challenges in career-building. With greater knowledge of these issues, participants can develop strategies to minimize the impact of these biases. Although gender differences are less stark now than in previous eras, many women remain ambivalent about their ambition and are less comfortable (than men) about drawing attention to their work. Some women have difficulty with negotiation, and typically have greater family and household responsibilities than male peers.

The second aim of this opening session was to equip attendees with skills to allow them to play a larger role in their organizations in shifting the culture to one in which women, as well as men, can reach their full potential.

Participants broke into small groups and were challenged to address the question: “What gender-related challenges are you most aware of?” From a brief harvesting of the table discussions, it was apparent that the range of what mid-career women categorize as gender-related challenges was enormous. There was no common theme as to what matters most (e.g., flexibility more than salary) or what constitutes “inequity” (e.g., not being invited to play golf with the guys). Work cultures vary tremendously. In some organizations, women see frequent reminders of gender-related issues; one participant related that “men seem to be constantly networking, whereas women are just constantly working.” In other organizations, women haven’t noticed gender as a barrier; to these women, it makes more sense to keep the focus on generic career challenges. Some of these current problems may have a gender dimension,
but are more a function of the economy and generational differences (e.g., an unemployed husband or partner and the extra pressure on both the relationship and the working spouse or partner’s career choices).

Observations and Questions:

» Most attendees expressed confidence in their ability to develop themselves. Not surprisingly, addressing gender issues in their organizations is not high on their list—probably because of the need to stay focused on their own careers at this stage. Women often lack clarity about organizational change mechanisms, or lack role models who can teach how to influence “how things are done here.” Therefore, should the AAMC continue to build this objective into its Mid-career Women Faculty Professional Development Seminar?

» Since what is considered “gender-related” is very much in the “eye of the beholder,” it’s important to respect the range of experiences and needs that both sexes bring to these subjects. We must avoid polarizing people around this potentially divisive subject. One question to be answered is: “When is a focus on gender useful and when might it actually interfere with people learning from each other?”

These are not “women’s issues.” Both the near- and long-term health of academic medicine is inextricably linked to how effectively medical schools and teaching hospitals develop the enormous, growing talent of women professionals.

References


Sex and Gender in Health Care: It’s Not About Equality—It’s About Evidence

By Marjorie Jenkins, M.D., Associate Dean for Women in Health and Science, Chief Scientific Officer, Laura W. Bush Institute for Women’s Health, Rush Endowed Chair in Women’s Health & Oncology, Texas Tech University Health Sciences Center School of Medicine

In 2001, a landmark report from the Institute of Medicine, “Does Sex Matter?” stated that sex and gender are both basic human variables and important health determinants. Although broadly utilized, the two terms are often used inappropriately even in the scientific literature. “Gender” refers to the socially constructed roles and behaviors that society considers appropriate for men and women. Masculine and feminine are gender-related terms. “Sex” is a biological construct, and includes chromosomes, cells, and tissues. Male and female are sex-related terms. To further clarify these two terms, endothelial function in male and female rodents or comparative left ventricular function in human subjects are examples of “sex-based” research, while behavioral response to traumatic events or
referral patterns for knee replacement in patients with osteoarthritis would be gender-based research.

In medicine, sexes and genders are not considered equally, especially in relation to research. In fact, the medical research pipeline is lined with males. Basic science literature reveals that the majority of studies utilize male cells or male animals, or don’t bother to report the sex at all. If both sexes are studied, data analysis by sex is not reported. This statistic does not improve in human clinical trials where approximately 65 percent of subjects are men; when both sexes are studied, less than 15 percent report data analysis by gender. Considering this bias in the research pipeline, it is not difficult to follow the linear pathway from male cell lines, to male animals, to males as human subjects. However, at the final critical juncture of translating research findings to patient care, the approach suddenly broadens to include both men and women. This leads to overwhelming and predominantly male data being applied clinically to females.

Let’s hypothesize that there is no need to perform sex or gender-specific scientific analyses. We would essentially accept the sameness of the “nonreproductive” organs: a man’s brain is the same as a woman’s brain; a woman’s heart is the same as a man’s heart, and so on. This would lead to the rather logical conclusion that women are simply men with a few different parts—a preposterous assumption that does not hold true. Yet, clinical medicine, fed by a biased pipeline, leads to the practice of “one size fits all” medicine, irrespective of sex and gender. In light of the burgeoning scientific understanding of sex and gender differences, it is incomprehensible to think that “personalized medicine” will be achieved without including sex and gender in the medical care equation.

To learn more about sex and gender differences and available resources visit: www.knowthedifferences.com

Sponsorship: Championing Gender Equity & Inclusion

By: Leilani Doty, Ph.D., WESH (Women Executives in Science & Healthcare) Communications Chair
Director, University of Florida Cognitive & Memory Disorder Clinics

and

Elizabeth “Liz” Travis, Ph.D., FASCRO
WESH President
Professor & Associate Vice President for Women Faculty Programs
MD Anderson, University of Texas

How do women negotiate the barriers of the existing traditional culture in academic health and science; address challenges such as career ceilings, higher scrutiny of female applicant CVs, and difficulty morphing traditional (male) styles of leadership and communication into more nonhierarchical female styles; juggle multiple responsibilities of job, community, and family; and rise to upper levels of leadership?1–5

In a September 2012 keynote address, “Sponsorship vs. Mentorship: What’s the Difference,” at the University of Florida, Liz
Travis, Ph.D., challenged medical academics to sponsor the advancement of women. Dr. Travis, professor at MD Anderson, University of Texas, and president of WESH (Women Executives in Science & Healthcare) revealed how women need more than mentoring and coaching to propel them up the career ladder.6,7

Dr. Travis explained that sponsors do more than mentor and coach. Sponsors champion their sponsees by actively opening doors into higher levels of leadership opportunities. While a mentor offers listening, guidance, and encouragement, and a coach helps build new behaviors, relationships, and steps to success—the sponsor is proactive. The power of their position and network eases the sponsor’s opening of doors, such as introducing the sponsee to prominent researchers at national meetings, submitting the sponsee’s name for awards, or appointing the sponsee to join an important national committee or team developing a consensus paper.8

Data highlight the need for sponsorship. U.S. medical school classes of 31.4 percent of matriculating females (1982–83) grew to 49.6 percent of females during 2003–2004, but now measures at 47.0 percent (2011–12).9 The 2011–2012 AAMC Women in Academic Medicine & Science Benchmarking Report highlights that the percentage of women medical school faculty has increased over time; however, women still remain underrepresented in the ranks of assistant professor, associate professor, and full professor, as well as in leadership positions.10

“... to expand the diversity experience of others ... A critical mass of the underrepresented faculty and academic leaders is crucial ...” (p.542)

Sponsorship is essential to change these data. Sylvia A. Hewlett, founding president of the think tank, Center for Talent Innovation, warns that hard work, being smart, skilled, prompt, and publishing are not enough.12 Corporations such as American Express, Intel, and Harris Financial Corporation have adopted sponsorship programs while universities such as Columbia and Stanford have done extensive research in the area, but not yet developed sponsorship programs.7,13

Sponsorship7,13–15

Sponsors help sponsees realize their skills and potential positive impact on others. Sponsorship should be open, transparent, and occur on individual as well as systemic levels such as policy changes, revamping institutional mission and goals, intergenerational education (more experienced faculty and current leaders educating less experienced faculty and potential leaders, such as at the annual WESH Spring Executive Leadership Summit: www.weshleadership.org), implementing performance-based metrics, succession planning, and recognizing success such as awards of protected time or funding. Sponsors should:

» be in a leadership position
» know how to enjoy taking risks to improve themselves, colleagues (senior and junior to them), know the setting, and the institution
» uphold integrity with personal and professional values to achieve sponsee success
» be a change agent; persevere and use skills to overcome sponsee barriers and errors
Sponsors can teach sponsees to:

- stretch a comfort zone, take risks, and expand a career trajectory
- polish communication skills, such as speaking succinctly and with timeliness
- accept offered leadership roles, note rising needs for leaders, and volunteer
- increase impact of assignments; start small projects (a health center newsletter), then later, a larger project (initiate fund-raising for a new institute)

**Sponsee Roles and Activities**

Sponsees should approach the path of leadership as a nexus of sponsee-sponsor-leader, for example:

- more than one year of work with a sponsor to identify five higher levels of responsibility and take a lead role in one
- commit to standards of trust, excellence, and perseverance despite inevitable obstacles
- work with the sponsor to change each step backward to a stronger step forward

**Performance Metrics for Sponsor Outcomes**

Performance metrics keep accountability for individual and institutional progress toward gender equity and inclusion. Annual evaluations may track the number of women sponsees who rise up the career ladder, receive national/international recognition, and obtain appointments to national/international positions of leadership. Performance metrics should link to pay.

**Summary**

In June 2012 news journalist, Tom Brokaw, postulated that “the 21st century is already the century of women…” Gender equity and inclusion are essential to translate Tom Brokaw’s words into reality. The AAMC and academic campuses should demonstrate the national best practices model for embracing gender equity, diversity, and inclusion.

**References**

6. Travis, E. Sponsorship vs. mentorship: what’s the difference? University of Florida, College of Medicine, Gainesville, FL. Invited keynote lecture, 9/27/12.
The New Face of Orthopedic Surgery

By: Lisa Cannada, M.D., Associate Professor, Department of Orthopedic Surgery, Saint Louis University

During my residency in the late 1990s, females represented only six percent of orthopedic residents. Now, that number has doubled with females averaging 12 percent of orthopedic residents. Despite the increased numbers, change at all levels still remains slow. Females represent only four percent of fellows in the American Academy of Orthopaedic Surgeons (AAOS). There is yet to be a female chair of an academic department and no woman has broken the ranks of the presidential chain of the AAOS. Yes, we have made progress, but we still need to forge ahead. Where can we start?

In an effort to increase interest in orthopedic surgery as a career path, exposure to musculoskeletal education in medical school is important. Yet in some schools, this content is taught as a computer guided rotation. Exposure must start early and must be personal. Females may have preconceived notions that to be an orthopedic surgeon, you must be “big” and a “jock.” This will not change the face of orthopedic surgery. Understanding what orthopedic surgery involves and knowing that there are several subspecialties to choose from are important messages to convey. I encourage each medical school to have an information booth at student orientation, manned by residents and faculty from orthopedic surgery. If there are not females in the orthopedic department at your medical center, there are national interest groups which should be promoted for women. In orthopedics, the Ruth Jackson Orthopaedic Society (RJOS, www.rjos.org) offers mentoring and has books and scholarships available for female students to attend the RJOS and AAOS meetings.

The numbers of women in orthopedic surgery have not grown in comparison to those in general surgery. Perhaps the subspecialties in general surgery appear to have more attractive options than a career in orthopedics. There certainly are more role models in some general surgery programs when females comprise more than 50 percent of some residencies. If there are not female residents or faculty in orthopedics to staff an orientation booth, consider starting with a women in surgery group and invite speakers who reflect the diversity of the field.

It is much easier for a young student to envision herself as an orthopedic surgeon if there is another female role model. I ask all female orthopedic surgeons, residents, fellows, and staff to take it upon themselves to be role models, promote the idea that females can succeed in orthopedic surgery, and change the face of orthopedic surgery.
Advancing Women’s Careers Through a Focus on Writing

Why Should Writing Matter to Women in Medicine

By: Regina Barreca, Ph.D., professor of English at The University of Connecticut. She is the bestselling author of eight books and editor of 17 others. She has lectured worldwide on women, humor, politics, and power. She writes regularly for several major media outlets. Her Web site is: http://www.ginabarreca.com

What is the first thing physicians and other medical practitioners ask patients to do? Tell them a story.

Every time you ask someone, “What happened,” “What’s wrong,” or “What brings you here today,” you’re proving that the ability to construct a narrative is essential.

Learning to master the art of writing, in all forms, is mastering the art of narrative and is therefore essential for any woman with a career in medicine.

Your skill, training, and knowledge have prepared you to act; you know how to handle events. But if gender equity, especially in governing, policy-making, and organizationally significant leadership positions in medicine is to become a reality, women will also need to learn and practice the skill of explaining those events and justifying those actions—or proposals for future action—in writing.

Learning to write well increases our ability to think well; it forces us to become aware of the need to put abstract impressions into specific language. In organizing our ideas and experiences and then putting them into words, we become adept at selecting the precise details necessary to convey our specialized knowledge of the patient, case, study, and subject. We learn to provide readers with a sense of proportion and context. We illuminate our understanding of the underlying principles.

The more effectively we learn to write, the sharper our powers of observation and articulation become; the more adroitly and persuasively we craft our arguments, the more convincing our point of view becomes. The more authoritative our position, the more reputable our position becomes in the profession.

Writing well is not easy, but it is simple: it’s crucial to observe, listen, and structure the details coherently so that they reveal a pattern of significance that is discernible to others who were not present. The best writing reflects, although rarely insists upon, the writer’s own perspective. With so much else professionally immediate and imperative to take in, soak up, and wade through, why should the study of writing matter to women in medicine?

To create an accurate and effective gauge of a situation, it’s necessary to reduce it to a sequence without misrepresenting either its complexity or diminishing one’s own distinctive viewpoint: in other words, it’s important to tell your story about it. To be of consequence, every narrative you construct—from notes on a case, to letters, reports, articles, grant proposals, and books—should not merely be a catalogue with scattered pieces of information, it should, in contrast, be a meaningful chronicle.

A word, when used eloquently, should be like a scalpel: it should have an edge and leave an impression. When used efficiently by savvy and experienced professionals in any field, writing can also help to reveal, improve, heal, and discover.
New Section!

Inspirations

This new section will feature original contributions related to the humanities or the art of medicine. We invite readers to submit original narratives, poems, artwork, photography, or other expressions of creativity.

Life, Work, and Poetry

Johanna Shapiro, Ph.D., Professor, Department of Family Medicine; Director, Program in Medical Humanities & Arts, UC Irvine School of Medicine

In my generation, there was a saying, “The personal is the political.” It meant that nothing that happens to us as individuals is only about our small, singular lives; rather, our private lives also reflect and comment on events occurring on a larger stage. I would extend this to include the possibility that the personal can also be the academic, in the sense that what affects us in our personal lives can also profoundly influence how we engage as academicians and scholars. This was certainly true for me.

I have written elsewhere about several medical events that gave me “a brush with mortality.” (The Inner World of Medical Students, postscript, 2009; Writing Rings around Death. http://www.litsite.org/index.cfm?section=Narrative-and-Healing&page=Perspectives&viewpost=2&ContentId=989) Although initially I approached my situation as a technical glitch in the physical mechanism and diligently searched the scientific literature for solutions, nothing I discovered there was in the least consolatory. It was only when I began reading (and ultimately writing) poetry about illness, doctors, and patients that I discovered both insight and healing. Poetry showed me the infinite possibilities embodied in things that once seemed implacably fixed by parameters of anguish.

These small, personal experiences ultimately led to my shifting my professional focus (for 15 years I worked as a behavioral scientist in academic family medicine) in the direction of the medical humanities. If I had developed such breadth and depth of understanding from literature and the arts, maybe they could teach my students as well to apply both a more critical and a more compassionate lens to health care interactions and relationships. I started by organizing a first-year elective, “Patients’ Stories/Doctors’ Stories,” in which three students were enrolled. It was one of the most wonderful and inspiring experiences of my life. Over the next 15 years,
that class expanded into elective and required curricula across all four years of my medical school training. Now I (and many of my physician colleagues) use theater, reflective writing, poetry, and the arts to help learners reflect on the human condition, the nature of suffering, and the role of the physician in modern society. I would like to think that they will be better doctors because of this work.

Bach Cantata

By: Johanna Shapiro, Ph.D., Professor, Department of Family Medicine; Director, Program in Medical Humanities & Arts, UC Irvine School of Medicine

Maybe it was because a Bach cantata was playing in the background

I am on the pre-op surgical floor stashed away in a curtained cubicle awaiting my turn in the morning’s surgical line-up

The curtain divider is only a thin piece of cloth (it has yellow butterflies and green dragonflies on a blue background) and I can hear them chatting indistinctly a funny story about one of the grandkids (we are telling those too) a whispered endearment. They seem nice.

His wife is called first I see her wheeled past supine on the gurney her hands folded across her chest maybe in prayer maybe to prevent her elbows getting scraped as the team navigates the narrow corridors

For a moment suspended in time there is nothing more Then I see her husband walk past my cubicle He is alone I am alone (my husband is looking for coffee)

He hesitates, then makes eye contact and smiles at me Our eyes are full He doesn’t stop, but continues to follow his wife wherever her new path will lead I am heartbroken Maybe it was the Bach cantata ◆

Relevant AAMC Meetings

May 2–4, 2013
Executive Development Seminar for Interim and Aspiring Leaders
AAMC
Washington, D.C.

July 13–16, 2013
Early Career Women Faculty Professional Development Seminar
The Inverness Hotel and Conference Center Englewood, Colo.

August 9–11, 2013
Group on Faculty Affairs Professional Development Conference
Hilton Minneapolis Minneapolis, Minn.

September 20–23, 2013
Minority Faculty Career Development Seminar
New Orleans, La.

November 1–6, 2013
2013 AAMC Annual Meeting

December 14–17, 2013
2013 Mid-career Women Faculty Professional Development Seminar
AT&T Executive Education and Conference Center Austin, Texas
The GWIMS (Group on Women In Medicine and Science) is a professional development group of the Association of American Medical Colleges. Learn more at: www.aamc.org/gwims.

The opinions expressed by the authors of this newsletter do not necessarily reflect the opinions of the AAMC or its members.