

## Women in Medicine: Then and Now

Margaret Wood, MB ChB, FRCA

It could be argued that Dr. Virginia Apgar, creator of the eponymous Apgar Score for assessing the health of newborns,<sup>1,2</sup> is the most famous anesthesiologist of all time. There can be no argument, however, that she is the most famous woman anesthesiologist of all time. Virginia Apgar was Director of the Division of Anesthesiology at the College of Physicians and Surgeons at Columbia Presbyterian Medical Center from 1938 until 1949, when Dr. Emanuel Papper was appointed Director of the Anesthesiology Service in the Department of Surgery and Director of the Anesthesiology Service at Presbyterian Hospital. Virginia Apgar subsequently left Columbia to direct the research program at the March of Dimes.

It was almost 5 decades after Virginia Apgar was passed over to lead the Anesthesiology Service before Columbia University appointed its first woman physician to chair a clinical Department in 1995. I was that woman, and as Chair of the Department of Anesthesiology at Columbia University, I was asked by Dr. Shafer, Editor-in-Chief of *Anesthesia & Analgesia*, to share my personal reflections on women in anesthesiology.

Like many female colleagues of my generation, I have had a unique opportunity to observe the arrival of women in leadership positions in medicine and to bequeath to the men and women who follow us a more open and accepting career path for women in medicine. This legacy will allow today's women physicians to aspire to a career in medicine in the specialty of their choice that reflects their skills and commitment. It was not always so. Remembering what it took us to get here will, I hope, help to ensure the equal success of future generations of physicians independent of their sex.

The medical school class of Virginia Apgar looked very different from a class of today. Whereas the graduating class at Columbia in 2014 was 50% women, <20% of my graduating medical school class was women. Just as Virginia Apgar was advised not to enter surgery, many of us were advised not to enter competitive medical specialties. Reflecting the

idealism of the 1960s and 1970s, many of us chose to ignore that (and much other) advice and to enter the specialty of our choice.

What was life like for a woman physician in training at that time? I have mainly positive memories. All of my mentors were men, and not the "warm and fuzzy" kind. There simply were no women in senior positions or in many other positions for that matter. This was an age before political correctness. Women had to prove themselves. Women had to survive, and thrive, in a hypercompetitive pyramidal training system. On the other hand, when senior male colleagues accepted and respected our clinical skills, they were happy to treat us as equals, and at the time most surprising to me, they were willing to seek us out to treat themselves, their family, and their most difficult cases.

Patients were not always as accepting. On one occasion, the chairman of a surgical subspecialty department asked me to anesthetize his elderly mother. When I visited her preoperatively, she made clear that she was confident her son would want someone else (a man) to treat her. After a visit from her son, she could not have been more gracious, even though she continued to be astonished that a "girl" was doing this kind of work.

These (male) mentors taught what was a relatively small group of women faculty everything, including astonishing secrets of their political machinations, how "the system" worked, how to manage the department finances, and much else. I learned an enormous amount about the financial issues of medicine and about running a department, from the mundane to the esoteric, during daily interactions in the operating room faculty lounge.

It would be a tragedy for women leaders of the future if they felt they had to receive their education and mentoring exclusively from women rather than men. Both women and men need to receive their formal and informal mentorship from "the crowd," which is blind to sex. Women should neither be forced nor encouraged to follow the increasingly fashionable approach in academic medicine of receiving advice from academic deans for women's affairs. These niche experts may have no real-life combat leadership experience as chairs or in positions in which they had to make the tough political, financial, personnel, and other decisions associated with such positions. There is an important role for successful women leaders who "have been there" to provide individual mentorship to junior faculty and residents. One-on-one mentorship and coaching (and they are not the same) can "pull women up," providing strategic personalized advice that cannot be obtained in large groups or from generic advisors.

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From the Department of Anesthesiology, College of Physicians and Surgeons, Columbia University, New York, New York.

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Address correspondence to Margaret Wood, MB ChB, FRCA, Department of Anesthesiology, College of Physicians and Surgeons, Columbia University, 630 West 168th St., P&S Box 46, New York, NY 10032. Address e-mail to mw218@cumc.columbia.edu.

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This is very different from the sometimes-current model that focuses on social interactions and inspirational luncheons. True mentorship requires an investment in time, energy, and intellect, which is a commitment that current women leaders must make for the future women physician leaders. Like Virginia Apgar, my generation largely eschewed women-only organizations and integrated into the predominately male environment. How could we not? This is not to imply that there is not a role for interventional programs to reduce the gender gap in academic medicine, particularly at the leadership level.<sup>3-5</sup> At Columbia, we have created the Virginia Kneeland Frantz Society to provide a structured leadership mentoring program for women faculty.

The Editor asked me to use this editorial to share what I have learned over my journey. I do so in that context.

1. It is important to have a passion for what you do if you strive for excellence. If you have that passion, then the efforts do not feel like a sacrifice and “burn out” is not an issue. I cannot imagine that Virginia Apgar spent a single moment talking, thinking, or worrying about burnout.
2. The current fashion to complain about “life balance” can be self-destructive; however, pacing oneself is critical. You can have it all, just not all at once. The Chairman of Anatomy gave the inaugural lecture to my incoming class of medical students. His thesis was that as a physician/medical student you could have (i) an active time-consuming social life, (ii) a family, and (iii) a career, but to be successful you should have no more than two of these at the same time. I believe this to be true and have followed this advice since.
3. Women should be careful not to fall into the trap of feeling entitled to special considerations or engage in special pleadings. Our patients want their physician to be the best, whatever his or her sex. There is no room for a physician of either sex who is less qualified or less committed because of outside responsibilities.
4. Women no longer need to “prove themselves” against the sea of doubters who dominated medicine 40 years ago. Fortunately, we are now past that point and such doubts, are I hope, antediluvian. Women are where they are today, however, because many of us felt that demonstrating that women really could “do it” was a moral imperative and one to which we were fully committed.
5. Parents need to manage their work and family responsibilities to ensure that both receive their full attention. This will often mean ensuring that they have excellent childcare to allow them to have the confidence to focus on work when that is required. This may be expensive, but it is a critical investment by both parents in their family’s future. Successfully raising children is a joint responsibility of both partners; what is critical to women is also critical to men, and vice versa. Women starting out on this journey can be assured that it is possible to raise well-adjusted children in a home in which both partners have challenging and successful careers, provided there is a true partnership in the family. Unfortunately, even

in 2014, I hear from women medical students that because they are women, they have been advised against entering high-intensity specialties such as anesthesiology and various surgical subspecialties. I believe that advice to be wrong and to ill serve the medical students.

I have previously described in this journal<sup>6</sup> the training needs for the next generation of academic anesthesiologists. I view these training needs as sex agnostic. It may be helpful to women, however, to share experiences that are common and perhaps unique to women as they ascend the career ladder, if only to reassure them that they are not the first to have these experiences. Our society still has different expectations of women than men. For example, women are expected to be nurturing and I believe we are. This can be useful in building a department and developing its faculty and residents. There is nothing wrong with really, really caring about your faculty, fellows, and residents as the best male and female chairs or laboratory directors do; however, sometimes this nurturing expectation can be destructive. For example, shortly after I became Chairman, and following the annual meeting of the Association of University Anesthesiologists, of which I was President, I was summoned by a senior administrator. The administrator was concerned because a member of my faculty had complained that I had not smiled or talked to him enough at the Association of University Anesthesiologists cocktail party. It is inconceivable that any senior Association of University Anesthesiologists member would have made such a complaint about a male chair. It is even more inconceivable and problematic that a senior administrator would take such a complaint seriously or have thought it appropriate or worthy to carry forward. Fortunately, that was nearly 2 decades ago. Today, no competent administrator would pursue such a complaint.

Women are still handicapped by a prejudice against showing ambition, which is perceived as an unattractive trait in women. There is nothing wrong with aiming for what you want and planning how you are going to get there. As a department chairman, I want to recruit faculty of either sex with talent, ability, and ambition. If you (man or woman) want to succeed in academic medicine, then you need to fulfill the criteria for promotion and/or tenure. That will take work, commitment, and ambition. However, even with work, commitment, and ambition, I believe that the lack of women at the full professor rank (21% in 2014)<sup>5</sup> does not entirely explain the paucity of women department chairs (15% in 2014)<sup>5</sup> and medical school deans (16% in 2014).<sup>5</sup> There is a wrinkle, unique to women, which impedes women’s career trajectories: lack of professional mobility. It has always been recognized that a family may have to move to facilitate the husband’s professional growth and promotion. The recognition of that same need for mobility in the wife’s professional growth is still outside most family’s experience and that need for mobility is very difficult to manage. There is no easy solution to the need for mobility in a woman’s career. I certainly do not claim to have one. As more women climb the ladder of academic medicine, however, more families are going to have to grapple with this issue. Perhaps, the most important solution will come

from this issue being talked about more. When it comes up, it usually does so as a negative. Search committees believe they will not be able to convince a woman candidate to move because “her children are in school” or “her husband has a good job,” and the search committees may be right! That discussion never reaches the same level of seriousness about a male candidate. Although search committees need to be educated about this problem, couples themselves need to have these discussions long before the telephone call comes to invite one of them to look at a position. If women are perceived as unwilling to move to assume leadership positions, then they will continue to be underrepresented in positions of leadership, and we will continue to lack successful women leadership role models.

Virginia Apgar, the most well-recognized anesthesiologist of the past century, was passed over for an academic leadership position >60 years ago. The small number of current women leaders in academic medicine have bequeathed to the much larger numbers of women physicians who follow them an opportunity and an obligation to demonstrate that women have the commitment to lead departments and institutions. It was not easy for the women who preceded you and it will not be easy for you, but it can be done if you are prepared and committed to the task. I wish you good luck and believe that the world will be a better place for our sons and daughters if you succeed. ■■

## DISCLOSURES

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