PRECIPICE

OUR VIEWS OUR VOICES

PUSHING THE EDGE OF FAMILY MEDICINE

2019 NO. 05

INTRODUCTION

For the past four years, a small team of us at the University of Colorado have edited a publication called *Precipice: Pushing the Edge of Family Medicine*, which deals with interesting and difficult issues in family medicine today.

This issue of Precipice, and the salons that will follow its publication, will address the rising predominance of women in family medicine, what this means for the women themselves, and how it can inform the future of our field. What are the welcome changes and opportunities this trend is bringing? What insights, challenges and calls to action accompany this change?

To contribute to this conversation and to spur good thinking prior to the salons, we wanted to begin by hearing directly from women involved in family medicine.

To paint the richest picture possible, we reached out to a diverse set of contributors. Our goal was to include a range of vantage points—women in different roles, at different points in their careers, working in different places.

WE ASKED EACH CONTRIBUTOR TO THINK ABOUT THE FOLLOWING QUESTIONS:

WHAT IS YOUR EXPERIENCE AS A WOMAN IN FAMILY MEDICINE?

HOW DO YOU INTERPRET YOUR EXPERIENCE?

WHAT DOES YOUR EXPERIENCE SAY ABOUT HOW WE CAN IMPROVE FAMILY MEDICINE?

The following essays and interviews with 11 exceptional women describe a range of experiences and points of view, and raise many of the themes present in our society as a whole; but in the context of healthcare and primary care.

All of the contributors had a great deal more to tell us, and we wish it were possible to include everything here.

We look forward to furthering this conversation with you at our salons.

Colleen Conry MD

Colleen Conry is a professor of family medicine at the University of Colorado School of Medicine, where she is the Senior Vice-Chair for Quality and Clinical Affairs, and president of the University Hospital Medical Staff. She is on the board of directors of the American Board of Family Medicine.

COLLEEN CONRY——INTERVIEW——JULY 2019

ON HOW THINGS HAVE CHANGED FOR WOMEN... AND NOT...

You sent me the questions ahead of time, and I realized how sad it makes me to think about that, how difficult it's been, and how much of that experience I actually suppress and don't even think about. It goes back to even when I decided to be a doctor and being told over and over again, "Women can't be doctors. Women don't take physics and get As." When I finished my first year of college, I had straight As, and my pre-med advisor said, "Don't expect to get straight As again, and don't expect to get into medical school." I was smart enough at that point just to change advisors, but that was a message that I was given from the very beginning. I shouldn't expect, I can't do it.

And women still hear that message today. Once you get through the middle years and you're doing the higher-level leadership, you're back in the world where it's still mostly male and mostly male values. When I was a resident, my medical school class was half women, my residency class was half women, and I don't remember there being huge amounts of discrimination – a little bit of sexual harassment but it wasn't terrible. Then, I remember, I joined the faculty, and my very first medical staff meeting at Rose, I was the only woman in the room, and it was like, "I had no idea." By the time I got to be the acting chair of Rose Hospital Department of Family Medicine 20 years later, it didn't look a whole lot different. It was still older white men, and there had been one woman who had been president of the medical staff at Rose in that 20-year timeframe. Family medicine is better than all the other specialties. That helps. More women have gone into family medicine, and there has been a nice push for women in leadership positions.

"We absolutely pay attention to those criteria. The men are just better." They're good people, that's important, they're good people, but it's really hard for people in the majority and the privileged to see that there is a problem and to actually act on those beliefs.

> "WHEN WOMEN DO ATTAIN LEADERSHIP ROLES, OFTEN THEY ARE NOT REALLY POWERFUL POSITIONS."

For instance one of the national organization boards that I'm aware of works really hard around diversity. When they talk about diversity, it means gender, race, location, and academic versus non-academic practice. And yet just a few years ago they elected three men, two of whom were older white men. Then this last year the board again nominated two older white men. It never changes. When one asks about it the response is

When women do attain leadership roles, often they are not really powerful positions. There are many more women family medicine chairs around the country. I don't know the breakdown, but my sense is that many women are leading smaller departments, departments that are in branch campuses and—I hate to say this, but many are smaller departments. Getting women to lead the really powerful departments has been much harder.

"TODAY'S YOUNG WOMEN ARE COMING INTO TRAINING PROGRAMS WHERE A LOT OF THEIR FACULTY ARE WOMEN. THEY'RE YOUNG WOMEN. THEY'RE FINDING A HOME. THAT FEELS REALLY GOOD."

ON WHERE BIAS EXISTS AND HOW IT AFFECTS WOMEN AND THE PROFESSION...

Women are inherently drawn to family medicine, and they're finding what they want. The relationships that matter to a lot of women are played out in family medicine. So that's really awesome. Today's young women are coming into training programs where a lot of their faculty are women. They're young women. They're finding a home. That feels really good. The positives are great. They have role models who have navigated the baby years, role models who are in leadership roles and who are not fighting every step of the way, and that is just really wonderful; but as we think about implications for the specialty, there are a couple:

1) Gender bias is still out there, but our current young women, faculty and residents, don't know it's there. They either don't believe it's there, or they haven't experienced it, or they're just blind to it. So, when something happens, they take it on themselves as "I did something wrong." They don't look at it and say "That person treated me that way because I'm female." They look at it and say "That person treated me that way because of who I am intrinsically." That is horrible. We are putting young women at risk for their self-esteem being smushed because they don't even recognize that this is happening to them.

For instance, you see me as a strong leader. But I often feel fearful, incompetent, not very powerful, and not very articulate. That's a gender thing. Does that make sense? Over time, we protect ourselves against this kind of micro-aggression by putting on "armor." Women talk about this all the time, whether we have our Kevlar on for that particular day. It's about making a conscious effort to not let other people's opinions about you get through, because you don't know their biases. But that's dangerous, because then you're not being a real person.

Also, women are expected to behave in socially acceptable ways—to be nice. But there is a difference between being kind and being nice. We're expected to be nice, and that means saying "yes," and doing what other people want us to do. That's not the same thing as being kind.

2) I don't believe that women are on equal footing with men in the world of medicine. I believe that family medicine, in general, is not on equal footing with the rest of the specialties. You put those two together and you take a female-dominated specialty that's already a second class, you're going to decrease the prestige or viability of that specialty.

This shows itself in leadership.

ON THE IDEA THAT WORK-FAMILY BALANCE SHOULD NOT BE A 'WOMEN'S ISSUE'...

I had my first child when I was a chief resident (it was a fourth-year position), and my second when I'd been on the faculty for two years. There was no such thing as maternity leave. But both the world and the profession are changing. When my daughter was three, I made dinner, and my daughter said, "Mom, what are you doing? Moms don't cook; dads cook." I don't think my kids figured out that men could be doctors until they were much older. They grew up with a very skewed sense of the world.

Our millennial faculty and residents are helping this kind of change along. They're trying to redefine what does it mean to work, and they aren't willing to do the 60-, 80-, 100-hour work-weeks that we grew up with. They really are putting limits on what they do, and they're saying I'm only going to work this much. You can't have my weekends, you can't have my nights, and I'm going to raise a family. Maybe I'm only going to work 70% or 80% time because that's a pretty good living. Then I'll have some free time to take care of my family. Then they get pushback from people of my generation saying, you're not working hard enough. Where are your values?

But change comes slowly. We now have a breastfeeding policy that allows women to take half-hour breaks twice a day for pumping, and there's no reduction in base salary, but it does impact incentives. We have a doc who decided that she was not going to pump during clinic and have protected time. She would just fit it in. It also sent us on this crazy goose chase and it turns out there are actually breast pumps that you can wear while you're working, and nobody knows; they're very quiet. To me that is the saddest thing in the whole world that you would do such a thing or that you're even on a computer while you're pumping, that your work is taking over that piece of your life.

The way to solve this problem is not to say it's a woman's problem, but to say this is a problem in our discipline, this is a family's problem. We need to look at how do we make family medicine a sustainable career. The big thing is changing the payment model because if you are held to, "I only get paid if I generate this much RVUs," you're going to fail and it's not set up for good patient relationships, it's not set up for flexibility and spending time with people. You have to create workplaces that are flexible, where 60-hour work-weeks are not the standard. To do this well, we need to make sure that people are equally represented at all levels and all meetings because we could see a flip where women are making all the decisions, and men are not. That would be bad too. We need to have this equal representation with acknowledgment that men and women are just going to approach the world differently, and that's a good thing. I can think of a great male rural doc. He feels uncomfortable in our current clinical world because we're not doing those things. He holds a different set of values and has a different affinity for the way he provides care. We shouldn't lose that.

Ultimately, we need to examine our root values. In many ways, it is about competition and getting ahead. Depending on your specialty, it's how many papers do you have? How many grants do you get, etc.? Family medicine doesn't play that as much, but it is still there. The world of medicine is really based upon making more money, generating more RVUs, being better than everybody else. That is what medicine is about, and that's very male. That's probably a bias on my part, but that's where we are.

Most family physicians would share the values of relationship, caring, and continuity. Everybody would agree with that, but there are values below those values about our roles in the world, whether it's roles as doctors, or roles as a parent, or something like that. Those don't get talked about very much, the choices we make as professionals.

ON WHAT IT WILL TAKE TO CHANGE THINGS.....

I don't know if I have any advice other than, don't stop. Look at the scars on my forehead. I've spent a lot of my career banging my head against walls, but eventually they come down or we find a way around them. You can't give up. You have to work within the constraints of the world, but you can't give up because you're doing the right thing. The good ones are making cracks in the wall.

Valerie Gilchrist

MD

Valerie Gilchrist is the chair of the University of Wisconsin Department of Family Medicine, her third chair position. She is or has been on the board of directors of the North American Primary Care Research Group, the Society of Teachers of Family Medicine, the Association of Departments of Family Medicine, the Council of Academic Societies of the American Association of Medical Colleges, and the Family Physicians Inquiries Network.

VALERIE GILCHRIST——————ESSAY——————JULY 2019

It was a perfect Wisconsin summer evening. There was laughter, lots of laughter, and good food for the five people around the table. Four other women chairs could not make it that night. As I reflect on my 22 years as a family medicine chair, I appreciate even more this easy camraderie; the sharing of tips, of problems, frustrations and many stories. It represents a community that I treasure.

Although women are approaching majority among medical students, residents, and practicing physicians, there are still few women leaders. During my first chair position (1997-2005) I was the only female chair. In my second chair position in (2005-2008) I was the only female chair. In my third chair position in 2008 I was the second female chair and over the subsequent decade of 17 clinical chairs we are now nine women.

My professional mentors were mostly men. They bestowed kindness and wisdom and became treasured friends. Mentors may be traditional guides, sponsors and/or coaches. People in power, for me, mostly men, were my sponsors and mentors. My coaches were women. These women offered encouragement. They had all been ignored at meetings, called nurse innumerable times, or received comments on how they look. They could offer strategies around pregnancy leave and childcare, confronting sexism, and how to be true to myself, for example. Discussion of those issues is still rich within, for example, the women's network of STFM. You might find coaching now at the back of any large plenary talk at a national meeting. While watching toddlers there is a discussion of how to manage a career with young children. You will find dads but still mostly moms.

Numerous studies document how women physicians make less than men, have less mentoring, less research support, get promoted less often and there are still few women deans. While there are many and complex reasons for these outcomes, challenges exist for women everywhere. I thought we had won the right to control our own bodies but reproductive justice is diminished and what about the #MeToo movement? I remember as a medical student being pulled into a back hallway by a surgical fellow. Then and apparently now women are at risk. I remember the gun laid on the desk in my exam room as the husband of my badly beaten patient glared at me. Three women a day, in the United States, die because of intimate partner violence.

Will more women leaders in family medicine make a difference—yes, but not always and very slowly. As a woman physician I was socialized to be decisive and action-oriented—I was advised to "act like a man." Women physician leaders have likely been very successful adapting to those cultural mores. Women leaders have walked a tight line of acceptable behavior. Women who talk more in meetings, studies show, are judged less likeable and also less effective by both male and female evaluators. There is a common expectation that women leaders will behave differently than men. Direction from male leaders is decisive, assertive; women leaders are labelled aggressive, maybe bitchy. Female leaders are expected to be more "understanding." These assumptions will only decrease as we have more and more women leaders who are no better and no worse than leaders who are men.

So what's a woman to do? I love my work and believe that all of us can make a difference, especially the women. I would encourage any of my colleagues to seek leadership, especially female colleagues. However go in "eyes wide open." It may be lonely. Other women who you might expect to be friends may be competitive. Staff may be mean-spirited if you are critical, but remember that they are often disempowered. Your attention to your family will be praised yet don't miss that early morning meeting lest you be found unreliable. And never, ever, become "emotional." Find your people. Beyond family, my women friends have supported me. These women come from my neighborhood and across two countries. They can see me as Valerie, not the chair.

Lauren Hughes

MD, MPH, MSc

Lauren Hughes is a policy-savvy, mid-career family physician who just ended a stint as the Commonwealth of Pennsylvania's Deputy Secretary for Health Innovation. She earned her MPH at George Washington University, where she also worked for Senator Tom Harkin. She was a Robert Wood Johnson Foundation Clinical Scholar and has extensive global health experience.

LAUREN HUGHES——INTERVIEW——JULY 2019

ON THE POSITIVE EXPERIENCE OF BEING A WOMAN IN FAMILY MEDICINE...

For me it's been largely positive. With the significant percentage of family physicians that are women, I have had ample access to female mentors and numerous learning opportunities that have paved the way for me in terms of clinical practice; pursuit of unique careers; and balancing work and life. I have found family medicine to be an incredibly encouraging environment from the moment I shared my choice to enter the specialty. And as I pursue physician executive and health policy roles, I have found being a woman in senior leadership roles to be incredibly advantageous, particularly when it comes to negotiation, emotional intelligence skills, and the ability to foster trusting coalitions with stakeholders.

ON THE SPLIT-SECOND CHOICE OF HOW TO RESPOND TO BIAS AND DISCRIMINATION...

For the most part, when I started as Deputy Secretary for Health Innovation with the Pennsylvania Department of Health, I was welcomed. I did encounter early on a difficult situation with a senior colleague who had been in the department for a long time. One day, this particular individual pulled me aside and said, "Now, I want you to know that everyone over there..."–"over there" was code for state lawmakers–"...already does not like you because you're a woman in this position, you are a physician, you're not married and you don't have children." In a moment like that, you have a split second to decide how to respond while also managing swift emotions. Over the years, I have formulated three possible responses to these situations, all of which could be appropriate. One option is to have a little bit of a professional tantrum and ask the person what was the point of that particular statement and make clear that their words were completely uncalled for and ridiculous. A second option is to use your response as an opportunity for education and dialogue on gender, gender roles, leadership, and the like. The third option is to choose to ignore it and just move on to other business and not give words like these the light of day. So, when someone throws something like that at you, you really only have a split second to run through the options in your mind. In that particular instance, I chose option three and said, "What's the next item on your agenda?" and I think the message was loud and clear that I wasn't going to pay any attention and that I'm here to do good work.

In my clinical work, I most certainly have been the recipient of comments from patients about my looks, my height, my age, and these sorts of things. My approach is to let them know right away that we are here to discuss them and their concerns, not me or mine. I have found it has been helpful to be explicit, "We're not here to discuss my looks today." I try to give people the benefit of the doubt while handling the situation professionally and moving quickly to clarify the reason(s) they wanted to see me. I'm not saying these things don't affect me—they do. But I don't dwell on them in the moment because that would disrupt my whole line of thinking in trying to be present to help that patient.

It is important for me to acknowledge that I am a white woman, so while I may relate to gender-based issues of bias and discrimination, I do not understand the intersectionality of gender and race, for example, nor would it be appropriate for me to pretend that I do. In my conversations with peer physicians who are women of color, they have shared more intense and explicit stories of bias and discrimination different from what I have ever experienced. We must address these issues beyond gender.

ON COPING WITH BIAS, AND HOW THE PROFESSION CAN DO BETTER...

Formally or informally, women creatively find many ways to take part in a sisterhood that helps support and sustain one another. It's important to engage in self-care; establish boundaries; seek mentorship; and find support in peers both inside and outside of medicine. From the profession's standpoint, we need to engage both women and men—at all levels of training—in learning how to recognize and respond to gender-based bias and discrimination. Beyond education, it's critical to enhance awareness of bias women face through open and honest dialogue with men and women at the table. For example, if I were to sit down and ask a male physician colleague if a patient has ever mistaken him for being someone other than a physician or being too young or made comments about his looks, I'd likely get some blank stares in return because that wouldn't be a shared experience. I think it's paramount to have these joint conversations to increase awareness. Awareness leads to understanding and then to action and education.

Susan McDaniel

PhD

Susan McDaniel is the Dr. Laurie Sands Distinguished Professor of Families and Health in the University of Rochester Departments of Psychiatry and Family Medicine, where she directs the Institute for the Family in Psychiatry, and is the department vice chair in family medicine. She has written 16 books and more than 100 papers that have defined much of the field of integrated care, and was recently elected president of the American Psychological Association.

SUSAN MCDANIEL——————ESSAY——————JULY 2019

In 1982 when I joined the faculty of the University of Rochester Department of Family Medicine, I was the first female on the faculty, a PhD clinical psychologist trained in medical settings with a postdoc in family therapy. The warm, friendly male faculty told me they needed to hire a woman as there were female residents on board, and they were getting pregnant! Never mind that neither my talent nor skills were mentioned, nor that I was single and—like them—had never been pregnant.

There wasn't then a sensibility that we *all* have biases; that they're impossible to escape. The fact that the men in the department were liberal, interesting, and became my friends made it hard at the time to call out any of the gender bias.

Fast forward to 2019, I have been Vice Chair of this same Department for 16 years. As of this month, we have our first female chair of family medicine, Colleen Fogarty, MD, MSc. So both positions at the top of our department, and some of the vice/associate deans in the medical school, are held by women. Progress! Above that, we still have a ways to go. We've had one female interim dean, but all other medical school deans and positions at the very top have been and are now held by men. However, we have a brand new female president of the university—a first—and she's a psychologist!

We make tremendous progress, and then come face-to-face with the next layer of issues, such as the far-too-frequent sexual harassment (something we're now studying in our department). I thought we had solved most of the gender bias problems during the Women's Movement when I was in college in the 70s, and women do have so much more opportunity now. Yet we still have so far to go culturally and structurally, to assure even the basics such as pay equity.

ENVISIONING OUR FUTURES.

We all internalized who we are to be as women or men. I was told that one could not be both a physician *and* have children. It didn't occur to me at the time to ask the male physicians telling me this how they did it! And this internalized gender socialization has not been eradicated for younger generations. I conduct leadership seminars for our residents, and I start by asking how they see themselves as leaders. Inevitably the male residents have *no* problem telling me how they have been, are and will be leaders. The women, on the other hand, rarely perceive themselves as leaders—past, present, or future. These are women who were at the top of their medical school classes! Often they say they "just" want to take good care of their patients, their children, and their families. Now, you may say that that's an admirable choice, and I'd agree with you, EXCEPT that these are the very same women who are running virtually everything in the residency! They're developing projects, writing papers, winning awards, and show no sign of stopping. They're leaders! Clearly there's a disconnect between the way they actually function and their internalized sense of themselves (McDaniel & Kaslow, 2014).

TRANSITIONAL CONFLICT AND GROWTH.

We're in a period of rapid transition—transition in what's acceptable behavior by men in the workplace, what we view as admirable and effective leadership models, and what women see as possibilities in composing their lives. Yet working through these conflicts means inevitable backlash, revisiting old beliefs to see if they offer, for some, comfort from the storm.

Family medicine has always been at the progressive, innovative tip of medicine. And we are hopefully at the precipice of transformation. We need to figure out how to make our clinical practice, education, science, and community service truly equitable, and embrace leaders with a diversity of styles, choices, cultures, and approaches to being human.

References

Hippel CV, Wiryakusuma C, Bowden J & Shochet M. (2011) Stereotype threat and female communication styles, *Personality and Social Psychology Bulletin*. 37:1312-1324.

McDaniel SH & Kaslow N. (2014) Stepping up to the Plate: Opportunities and challenges for women in leadership. *The California Psychologist.*

Lucy Candib

MD

Lucy Candib is a professor of family medicine at the University of Massachusetts in Worcester. She is one of our field's preeminent educators. She has practiced exemplary family medicine her entire career in a safety net clinic, caring for underserved and disadvantaged patients.

LUCY CANDIB——ESSAY——JULY 2019

Women medical students are attracted to family medicine because of its emphasis on families and relationships, and the potential to work on women's health, maternity and newborn care within family medicine, and end of life and palliative care (without doing it to the exclusion of other kinds of care within families).

Women also choose family medicine because of the potential to serve vulnerable populations and work in community settings where underserved and needy families, including immigrants and refugees, often reside.

These settings as well as the access they offer to loan repayment programs may lead women to federally qualified health centers (FQHCs), where like-minded family physician attendings and educators see patients and teach.

Unfortunately, these settings are often dysfunctional, partly due to chronic underfunding, low staff salaries, adoption of poorly functioning EMRs, current federal hostility to the populations of focus, and inability to adopt modern methods of patient care such as team-based care, modern EMR systems, use of scribes, and so on.

Although some teaching FQHCs have attempted to integrate newer models of care, most are stuck with a mixed hash of fee-for-service, ACOs, member-based plans, population-specific federal and state subsidies, and free care. The result is chronic underfunding leading to a dependence on maintaining a high volume of patients per hour to generate sufficient income. Complex patients from vulnerable populations do not easily fit into a model based on visit times of 15 minutes or fewer. Seeing these patients with an interpreter, arranging the appropriate auxiliary services and consultations, following up on these referrals, and documenting all of the above essentially guarantees two to three hours of work at home every night for every day of patient care; then there's the additional paperwork that comes from the patient care of the previous days and weeks.

A clinician who adds to this load, hospital rounds; night-call coverage; maternity care with nights (and days) spent with laboring patients, and the length of the work week rises to 60-80 hours at a minimum. This is a recipe for professional burnout, immediate change of employment after loan repayment requirements are met, and restriction of clinical work to aspects of family medicine that allow clear-cut hours such as urgent, emergency or laborist shift work.

Add to this scenario that about half of women medical students marry other doctors (mostly men). Most of those male physician (or future physician) partners have never considered working part-time themselves, and even in households where pre-childbearing household responsibilities were divided evenly, the burden after children almost always falls disproportionately to the mother physicians. Women doctors put in about 20 hours a week to provide for their families—in addition to the 60 hours a week of work described above.

In some countries, nearby extended families meet these needs. But in the United States, the lack of reliable, convenient and culturally appropriate child care and the lack of a national policy for reasonable maternity leave force child-bearing women doctors into an unsurmountable time lurch.

This means women physicians either need to become "part-time," meaning 40 hours in many settings, that brings their total work week down to 60 hours—or they must limit the scope of practice in some drastic way, pulling them away from the very thing that appealed to them about family medicine. Those men physicians who want to be actively involved in raising their children, managing their households, and having a career are in the same boat—there are just fewer of them.

What kinds of answers are there? I would propose a 28 hour in-office work week, with seven, 4-hour sessions, of which two are administrative time. This arrangement should be considered full time, fully paid, in the current medical practice setting, with adjustments for OB, hospital rounds, and night call; so that no one is expected to work all day after being up all night. This could be livable, would result in about 40 hours of total work if at-home EMR work is considered in the mix of work that is being done. This arrangement is completely compatible with team-based care whenever it can come to FQHCs or other settings where women family doctors are attracted. Neither women nor men doctors would burn out in this arrangement and could continue at health centers and in busy family medicine practices, and could serve as models of healthy family-career integration for learners coming after them. We need to model this to keep our women family doctors healthy and sane and IN OUR FIELD!!

Moira Stewart

PhD

Moira Stewart is a distinguished university professor emeritus in the Centre for Studies in Family Medicine at the University of Western Ontario. She is one of our field's most important and productive researchers, having done groundbreaking work in patient-centered communication.

MOIRA STEWART——ESSAY——JULY 2019

What I have learned about leadership over the decades is that there are two things that matter: structure and process. As I tell a bit of my experience growing up professionally in family medicine, I will come back to these two ideas.

Before I came to family medicine, there were several principles guiding my life. First, I needed to be economically independent. I had noticed that people (usually women) who were part of middle income families but had not form of income themselves, were not free to make choices about how the household money was spent. Second, I wanted reproductive freedom of choice because I came of age when the birth control pill was becoming available around 1970. These two principles (economic independence, and reproductive choices) are rights in our society. Societal structures must be in place for all people to be able to enact these principles; these rights are basic and worth fighting for.

When I became a faculty member on soft money in 1979, I was the first female faculty member in the family medicine department, but now the department faculty is approximately 50% female. The only time I heard rumblings about gender was in 1997 when I was being considered for the leadership position at the Centre for Studies in Family Medicine; the selection committee apparently (I learned a decade later) discussed at length whether a woman would be acceptable but the department chair (a man) and board chair (a woman) were in my corner, so the argument was overcome, no big deal.

Looking back over the decades, my gender was neither an asset nor a detriment. Success in research in family medicine depended on: superb science (the technical knowledge of how to ask a research question and write successful grant applications); several process skills such as nuanced collaborations (requiring interpersonal attributes par excellence); and organizational savvy (to run large teams and keep on track and on time). It also required imagination, not only to dream up the original research questions but to put oneself in the place of the other, to truly listen, in order to collaborate with persons of all types at all levels. It could be argued that this list of essentials applies to family physicians too.

How you are going to take care of your patients depends a lot on how you have experienced care yourself. You may seek to emulate family physicians who were effective in your treatment in the way you wanted them to be, whether that was excellence in diagnosis and therapy and/or excellence in caring and concern. My personal experience was not gendered in the way you might expect; the illness which set me on the road to improve patient-centered communication, occurred when I was 22 years old and the family physician was female. She was insulting and deliberately demoralizing and she did not give me the full picture of the laboratory findings so that I was left to worry about possible reasons for my lack of recovery.

Over the years I have had mostly excellent care in all respects from two male family physicians who delivered our two children. Recently I had stellar care from a female orthopedic fellow during the first visit after breaking my arm. The lesson is that, regardless of the type of patient in front of you, you need to start by asking what matters to them and then make that all-important intuitive leap to imagine what this event/problem/situation/illness means to the patient and offer them the best care and treatment, the kind that you would want to receive. Therefore in my personal experience, excellent care does not appear to be enacted by gender.

A gender-neutral stance is wise when teaching a class, meeting with a patient, conducting research and/or facilitating a meeting, being especially sensitive, in that class or meeting, that there may be only one male, only one gay person, only one immigrant, only one person of a visible minority, who is therefore feeling especially vulnerable. Let us also note the diversity among female students, researchers and leaders. With all these kinds of diversities being the reality in our work places, we need to nurture in students, practitioners, researchers and leaders, the capabilities to engage in fruitful discussions across all artificial boundaries. In our training programs for research leaders in Ontario, Canada, we insist on heterogeneous learning groups (including patients, practitioners, researchers and policy-makers). Facilitators must sometimes become quite assertive, so as to provide an experience of collaborating with all kinds of individuals to produce the best possible research or care for patients.

At the level of the small group, the institution, and nation, one must advocate for and rely on structures and processes to help us enact the principles of equity.

Stacy Ogbeide

PsyD, MS, ABPP

Stacy Ogbeide is an associate professor in the University of Texas Health Sciences Center San Antonio Department of Family and Community Medicine. She is expert at integrating behavioral healthcare into a variety of primary care teaching and clinical settings.

STACY OGBEIDE——INTERVIEW——JULY 2019

"WOULD MY DEPARTMENT BE WILLING TO MAKE ADJUSTMENTS WITH MY SCHEDULE?"

ON GENDER AS A HINDERING FACTOR (OR NOT)...

There are two things that have created a bit of an uphill battle for me more than my gender. I'm early in my career, and I'm not a physician.

I think that the level of detail and the level of care that I take with all of my work catches people by surprise because of how "seriously" I take my role in the institution. Others are caught off guard by my knowledge of primary care systems and behavioral integration, my area of focus and expertise. I get a lot of comments like, "Oh, wow. I didn't realize you knew all of that," or someone looks at my curriculum vitae and they say, "Wow, you've done quite a bit for being out of training for only five or six years." I'm taking this at face value. It could be something else, but no one has come out and said that it's because of my race or because of my gender. The comments have been focused more on my early career status.

The other contextual factor that I think impacts my career is the fact that I am a psychologist in a department that doesn't have many of us; and people not understanding the role of behavioral health in primary care and trying to figure out how that fits with the grand scheme of primary care. I believe if I was a physician I could have moved things forward faster in terms of behavioral integration within our system at this institution. Non-physicians just have a tougher time getting things done.

ON THE REAL CHOICES WOMEN STILL HAVE TO MAKE BETWEEN CAREER AND FAMILY...

Yes, I have heard from other faculty members who have families, especially those who have little or school-aged kids, that it has been difficult especially when there are institutional policies that are not supportive in terms of time off, having flexible schedules or flexible call schedules. If I decided to have children, I'd have to really readjust and relook at my priorities. I know my work level would change. I'd have to really consider the type of faculty position I have, especially because of how heavy my clinical load is at this time. I would have to really decide if it's sustainable. Would my department be willing to make adjustments with my schedule? Just in our institution, I've seen it go both ways. I've seen some female faculty able to alter schedules. Some even go down to half-time. Then I've seen some people ask for the same thing and they get told no. It's really up in the air in terms of what it could look like, but I don't imagine I would be able to continue working 70-, 80-hour work weeks with small children, with family. It would be very hard to do that. I would say women are uniquely disadvantaged. Generally speaking in U.S. culture norms for many families women are the ones "in charge" of family and home, and a lot of the institutional policies haven't caught up, either.

ON THE DIFFICULTY OF FINDING MENTORS AMID SOCIAL AND GENERATIONAL CHANGE...

People are feeling stuck figuring out how to talk about changing things and not really sure what to do. I know a lot of women don't have formal mentors. They might have a faculty member who is assigned to them though not necessarily a female. People often don't feel comfortable going to their assigned mentors.

It's been harder to connect with some of the male faculty who are typically later in their careers. Many of the women are early or mid-career, so our view is a bit different than someone who has been indoctrinated by the institutional culture for 25, 30 years.

We might challenge the system a bit more than some of the male faculty. We say, "let's talk about doing things differently here," and we keep getting, "Yes, that's nice, but this is how we've done it so we're going to keep doing it this way." That's not mentorship. And it's not good for the future of the profession.

Shanta Zimmer

MD

Shanta Zimmer is the senior associate dean for education and the associate dean for diversity and inclusion at the University of Colorado's School of Medicine. She is leading a radical transformation of this school's curriculum.

SHANTA ZIMMER——ESSAY——JULY 2019

As a second-year medical student at Emory University, I moderated a panel discussion for our student group on women in medicine. Our panelists were early to late career faculty. The audience was mostly first and second year students.

The two more senior women shared with us the hardships of balancing work, grant-writing, administrative duties and their families. One even told us that she hoped we knew what we were getting into because the glass ceiling was still "very much impenetrable." While the panelists argued among themselves about best approaches to work and life matters, as well as the perils we were about to walk into as new women in medicine, their inexperienced moderator began to fret. My fellow classmates glanced uncomfortably around the room. I interjected a few platitudes thanking them for breaking so many barriers such that we didn't feel overlooked in our classrooms where a full 50% were women. "Thanks to women like you, we are confident and poised for leadership…" "Just wait," one snapped, "It gets worse the further along you go."

Twenty-five years later, most of us are well into our mid-careers in practice and mid-lives as mothers, partners, children to aging parents. The workplace is far from perfect for women, and I consider myself forewarned by my admirable panelists, all chiefs or chairs in academic medicine today. Many of the inequities they described such as being overlooked for career opportunities; being talked over at meetings by louder, more confident men; watching panels of men ("manels") from the audience at national meetings and sitting in conference rooms while women are described by leaders as "lovely and sweet" but often not as "smart and capable;" are part of my life in academic medicine today. Among the major differences, however, are the real efforts and actions to change these glaring problems and delve into the causes. Institutions and individuals are being held accountable for the change. As is true with all types of diversity; gender diversity in clinics, labs and classrooms produces better outcomes.

I am grateful to so many women role models who have paved the way. I am also grateful to the men who have mentored, sponsored and pushed me to excel. When I listen to our students (more than 50% women entering this year), I notice that young women are asking me about the future of medicine and how they can "do it all." Their partners are asking too. Rather than focusing on the challenges of gender differences, competing responsibilities or the "perfect balance sheet" for success; I am likely to remind them of the privilege of being a physician and the completeness it can bring to our multiple roles and identities.

With more women in the workplace, we have better working conditions for all physicians with benefits for families, equal pay, extended promotion timelines, and opportunities for leadership positions. It is no longer taboo to admit you have children when you apply for a job or to be ashamed for not wanting to have them at all. Once afraid to show images of my children in my Powerpoint presentations lest I appear unfocused, I now embrace the multiple identities required to be most fulfilled at home, in the classroom and at the bedside. Still, there is more to be done. While more than half of medical school matriculants nationally are women, representation of women at higher leadership levels still lags behind, and stories of discrimination and harassment remain common. In administrative leadership positions we can shape the dialogue, and more importantly the actions, around gender equity while also remembering that our identity as women is only one part of the gift. Deliberate steps can and are being taken to promote the careers of women by putting processes in place to require gender equity in committees, award nominations, hiring decisions and promotions. Institutions have tools to assess pay equity across specialties and to place more women in decision-making positions in medical centers. The University of Colorado School of Medicine has more women in department chair positions than most national peers. At the national level, professional societies and organizations like NIH are also stepping up efforts to make gender equity a priority. Fortunately and necessarily, men are partners and champions in these efforts. We have recognized that gender equity is not an issue for women to lead alone but one that is a priority for all of us who care about excellence in the field. With legions of talented, smart, driven women leaders in our pipeline, the future of medicine is bright. I am confident that the panelists of yesterday really have paved the way for me and the students behind me. I am committed to showing them cracks in the glass ceiling and also arming them with tools to break right through.

Jeannie Ritter

Jeannie Ritter is the mental health ambassador for the Mental Health Center of Denver. She is the former First Lady of the State of Colorado, and co-chaired the legislative task force revising Colorado's civil commitment laws. She is a tireless advocate for high-quality, integrated primary care, and is on a million advisory boards, steering committees, and task forces.

JEANNIE RITTER——————INTERVIEW——————JULY 2019

ON THE POWER OF CREATING A SAFE SPACE FOR PATIENTS...

Some women, including me, are more comfortable with women as doctors for certain things, especially in family medicine. But that brings us to a much more important point about how we create space in our profession for caregivers and patients to relate to one another. To feel safe.

I recently had eye surgery, and the doc was nothing like me at first glance, but we absolutely got to a place that was shared and that, I would say, augmented the care. I don't want people to feel that they have to be all things to all people, but recently I heard a statistic: 13% percent of how I can do something better in my shop would be technological; 87% is relational. It's not just your knowledge, it's how you relate that knowledge to me, in a way that's meaningful to me, so that we have a small lane of kinship of sorts.

There's a guy who asks his young entrepreneurs to think about how we can operate differently. He says "imagine that in my health record is a one-pager that I dictated about who I am. Why I joined the military. Why I got out of the military. What that injury has kept me from—it's a one-pager." That is a game changer for a provider. It's this humanity, right? It's this insight into who this person was that builds the common ground. And don't kid yourself, this is about outcomes!

ON HOW THE PROFESSION CREATES A SAFE SPACE FOR WOMEN...

Who's the Ruth Bader Ginsburg in your field? I should know her freaking name. That's shame on me. We should all know her name. So, how do these women make the profession their own? They've met all the standards. Now, how do we help them to bring their shoulders down? How do we help them to have some room around the edges that helps them be curious and be themselves inside this practice? That's who I want to find when she comes into my office and takes that little stool, and spins it and sits in front of me and I'm on the butcher paper, right? I'm sitting there in my—not even my undies, on the butcher paper. So, I'm already vulnerable. Maybe she'll do a better job thinking about where the doors face, and how there's natural light without the guy in the parking lot checking us out. Do you think I want those fashion magazines in the lobby when I'm about to get on a scale? Just one more opportunity for diminishment. So, it sounds like all tiny trite stuff. But it adds up to a collective experience that isn't trite or small at all.

ON VULNERABILITY AND THE POWER OF TRULY ACCEPTING DIVERSITY, INDIVIDUALITY... . . .

If we're not careful, if we're not tracking all the tiny things that allow space for people to be vulnerable, to be themselves and to build trust, which builds relationships, then we're not living up to the promise of our profession. We are supposed to be trusting.

In family medicine, you have an opportunity to change that. You have these women showing up, snapping the buttons off their blouses and exposing the giant "S" on their chests. Not that male doctors are not compassionate. That's not the point here. But do we create the space for these women and men to show up so I know they're on my side? We're making progress, but we're still dealing with this old system. How much are these incredible women still constrained by it? If the systems they're coming out of don't let them express their Indianness or their blackness or their transness, then I'm not getting what I think I want as a consumer. We need to be allowed to be ourselves and to create safe spaces for our patients to be themselves, and we need the time and space to share who we really are with each other.

"13% PERCENT OF HOW I CAN DO SOMETHING BETTER IN MY SHOP WOULD BE TECHNOLOGICAL; 87% IS RELATIONAL."

Sarah Hemeida

MD

Sarah Hemeida is an assistant professor in the University of Colorado Department of Family Medicine, and a scholar in the Eugene S. Farley, Jr. Health Policy Center.

SARAH HEMEIDA——————ESSAY——————JULY 2019

The world is simultaneously celebrating the milestones achieved in pursuit of equity; yet, still we face the vocal minority that wish to uphold the structural power disparities of the past.

There are times when I think that the post-modern cultural evolution has influenced our nation's sense of justice such that we could never again turn a blind eye to overt bias and discrimination. How could we after the Civil Rights Act, gay marriage, repeal of "Don't Ask, Don't Tell", Brown vs Board of Education, so many other monumental wins? Once the #MeToo movement made the cover of *Time Magazine's* "Person of the Year" issue, like many of my friends, I felt the tide had truly turned.

That magazine issue was published in December of 2017, and within six months I found myself the target of gender-based harassment in the work place.

I think this is a good time to stop the story for a flash-back like they do in film. As a resident, I actually worked with my future boss while he was attending on the in-patient service. Naïve and eager to achieve clinical excellence, I remember feeling a sickening pit in my stomach when we had direct interactions. At the time, I didn't know why I had these feelings. It may have been the nature of his eye contact, or the compliments he made which teetered on excessive, or his subtle exercise of paternalistic power.

Three years later, I was working in his clinic, listening to the complaints of a female coworker he had followed to the restroom, timing her length of stay. He later confronted her about what she was doing in the restroom. Within the same year he requested our nurse manager require the nurses to wear tighter scrub pants. During this same timeframe, he called me into his office to complain about my clinical dress. When I questioned what specifically should be changed in my attire, he suggested I dress more like certain other women who wore tight, body-forming clothing. What I can tell you is that to this day when I think of the progressive and unending harassment I endured for 10 months as his subordinate, the memory of my discomfort as a resident haunts me. I will never ignore that feeling again.

"HOWEVER, I WAS NOT PREPARED FOR THE PROPAGATION OF THESE SYSTEMIC INEQUITIES BY WOMEN IN POSITIONS OF POWER."

After months of experiencing fear and loneliness, my emotional conclusion when looking back is abounding fury. Despite a stockpile of evidence in the form of emails, audio recordings coworkers who corroborated my stories and had witnessed the harassment, despite high employee turn-over rates at our clinic, and a concurrent harassment complaint by another employee, nothing functionally changed. My boss kept his job. Notwithstanding my deep desire to excel in the workplace and a 9-star rating from patients, once I opened the HR investigation on the charge of personal harassment, I was subjected to a formal performance improvement review and moved out of the clinic.

The exploitation of institutional power-hierarchies by middle-aged, sexually provocative, and prejudiced white men is of no surprise. However, I was not prepared for the propagation of these systemic inequities by women in positions of power. The inter-generational trauma that is cycled back by the older more established women in power against younger women in the workplace harnesses two primary principles of ageism and learned self-hate. It manifested as a result of incredibly strong and courageous women who managed to beat the system and rose in the ranks at a time when there were few, if any, female colleagues. Too often, women who beat the odds of their generation and rose to power are afraid to use it to help other women.

It is the same institutional practice that has led to generations of surgeons who traumatize their trainees because that's how they were treated, and they can. We get convinced that there is no reason to stop the cycle because some person at the top survived, and

"LOOKING BACK, I KNOW THAT THE INTERACTIONS AND MICROAGGRESSIONS THAT PROGRESSED INTO A PATTERN OF HARASSMENT RESULT FROM THE COMPLEXITIES OF HUMAN PREJUDICE AND POWER."

it's unacceptable. It's detrimental to clinicians and their families, and this rippling toxicity must have some impact on the patient.

These systemic, enduring, and deeply subconscious beliefs are rarely confronted in the light of day. This is how they take root generation by generation influencing the decisions made at the top when grey situations arise. We are conditioned to recognize and reject abject racism, sexual misconduct, or discrimination. But I challenge the reader to consider the nation's increasing tolerance for prejudiced rhetoric which has resulted from decades of cowardice when faced with less overt situations. This allows offenders through complicity to pursue the next level. Harassment that is ignored only grows in frequency and severity if there are no repercussions, as I discovered in my personal experience. The willingness to protect white men in middle management by large bureaucracies and the active support of institutional bias by women against other women, ageism, and numerous other seemingly small infractions when a grey situation arises erode the strength of our moral compass. It provides the crack in our wall that shuts out the horrifying injustices of our American past and might let it relive again.

My experience highlighted the importance of "grey" situations. I learned that since there was no explicit civil liberty violation, I had no legal standing to press charges for retaliation.

Looking back, I know that the interactions and microaggressions that progressed into a pattern of harassment result from the complexities of human prejudice and power. Personally, I wouldn't be surprised if it were in direct response to my strong personality, my sass, my sauce, my QUEEN energy! These characteristics are something I will never apologize for.

HOW TO BREAK THE CYCLE:

Recognize when you have a "grey" situation—talk about it, acknowledge it, be willing to get uncomfortable

Do what is morally right—even when it is the more difficult path

Trust your gut—listen to the little voice inside when its talking to you, believe women, trust your experience

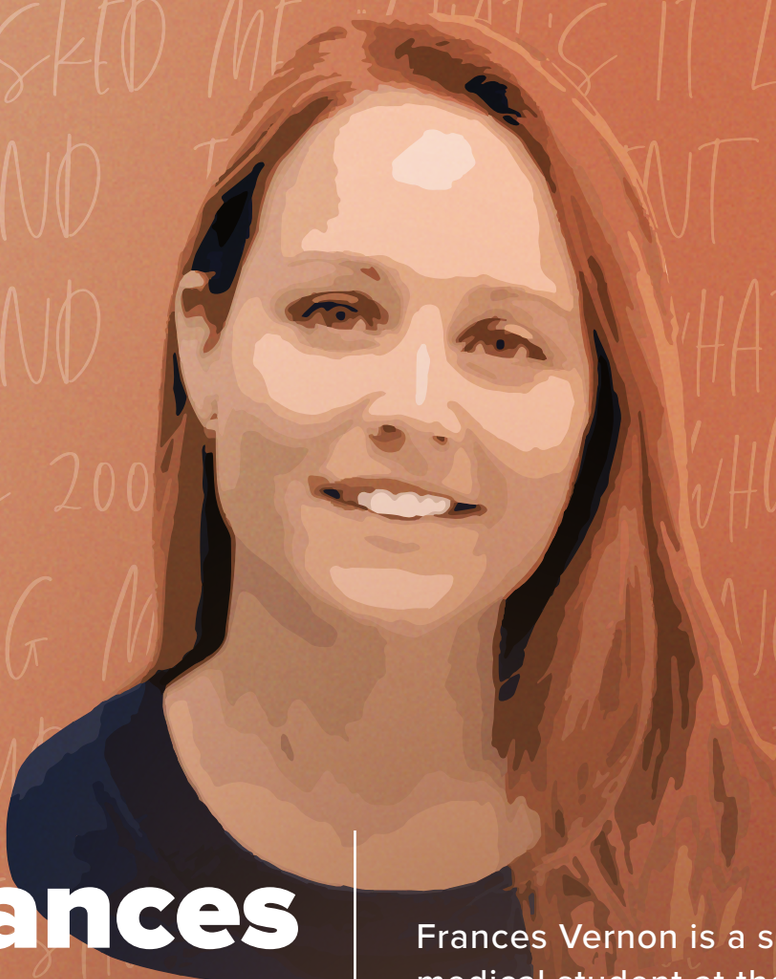
Stop being afraid of healthy conflict—function from a position of courage, do not be threatened by young, bold thinkers

If conflict is escalating, consider audio recording your interactions—check if you live in a "one-party consent" state first

Stop promoting men for no damn reason—does it matter that your men and women are paid the same amount if the women are working twice as hard as the men?

Look in the mirror—look at the makeup of your institution and evaluate whether we are exercising the values we promote

FIRE people who deserve it—even if it means taking the time for the right hires



Frances Vernon

Frances Vernon is a second-year medical student at the University of Colorado. Prior to enrolling in medical school, she worked as an analyst in the investment banking division of Goldman Sachs & Co. and as a manager and associate in several venture-backed companies in Silicon Valley. She has extensive experience working in street clinics, free clinics, and global health programs.

ON THE INSIDIOUS LEGACY OF STEREOTYPE...

Often when you read literature about why it's valuable to have women in leadership positions, it will say things like women are more thoughtful in decision-making, the have a higher emotional intelligence, are more risk-averse and therefore help to ground decision-making on solid footing. That might all be true, but sometimes by defining those parameters, aren't we limiting how we think about women and what they can achieve or cannot achieve—especially as leaders?

For example, I was the president of my undergraduate class at Dartmouth. I got to know the wife of the college president, and she asked me, "What's it like to be a woman and the president of your class?" and I thought, "What do you mean?" It's 2006 at the time. "Why is someone asking me this?" I had never thought until that moment there was something peculiar about me being a woman and being the president of my class. On one hand, it's really interesting that I made it 18 years without having to question that being a woman meant that there was something atypical about being in leadership roles. And that caused me to consider the reason for such inquiry.

WHAT DOESN'T KILL YOU MAKES YOU STRONGER?...

Prior to coming to medicine, I spent my early career in finance, which is male-dominated. I have plenty of stories of my experiences as a woman in that industry. Some were minor, but they sent a message—like people always assuming I was an assistant. Others were more egregious.

I worked in natural resources in investment banking, and there was a certain amount of emphasis on being able to go out and drink like the guys, and I could do that. I can drink beer. I can hold my own. But then you'd be out, and you'd realize all of a sudden that some guy has his hand on the small of your back, and you're like, "Why is this person...?" This is one example of the power of human touch, and it's not a good one. I had a very senior guy in our group start texting me and asking me, "Is there a Mr. Vernon?", and so on... I was 22 at the time.

This was a whole new world for me. Was I here because I deserved to be, or was I here because someone saw something else in me, something that actually makes me wish I wasn't here? This kind of thing continued through my next job and made me question myself in a way that I wished people didn't have to do. But I didn't do anything about it. I never said anything. I had all these texts, but from people who could kill my career. Even in mild cases, where you don't know someone's motivation, you can't even say, "Hey, that made me uncomfortable," because the power dynamic strips your agency when there's risk to your future. And you know what? It pained me because I was proud to be a person of strength and justice, yet in my own life I couldn't find the strength to confront the issue on my own.

> "THIS WAS A WHOLE NEW WORLD FOR ME. WAS I HERE BECAUSE I DESERVED TO BE, OR WAS I HERE BECAUSE SOMEONE SAW SOMETHING ELSE IN ME, SOMETHING THAT ACTUALLY MAKES ME WISH I WASN'T HERE?"

I think a lot about how that has impacted who I am and how I showed up to medicine, and how it will shape me going forward. I've personally tried to live by "What doesn't kill me makes me stronger," but you don't always consider the extra challenge that puts on women—the extra layer we carry around as we enter a room.

"I DECIDED I WAS GOING TO DO WHAT I COULD TO PREVENT THAT FROM HAPPENING TO THE NEXT WOMAN WHO COMES ALONG. IT SEEMS VERY SMALL, BUT I APPRECIATED THE WOMAN AHEAD OF ME AND WHY SHE DIDN'T SAY ANYTHING."

Obviously, this is not just specific to gender, you can talk about this in the construct of race and other issues.

Fast-forward to my interview at the University of Colorado. An interviewer said things that made me feel uncomfortable, commenting on what I was wearing. Later, I met a student, a year ahead of me, and I was still frazzled by the interview. She asked how it was going. I said, "Well, I just had this interview, and I was so surprised because they started off the day with this inspiring speech delivered by an amazing woman and about what the University of Colorado stands for, and then I went to my first interview and was completely rocked by what was on the other side of the table for me." She asked me the name of my interviewer, and she said, "I had the same guy." I asked her about her experience, and she said hers was similar.

I decided I was going to do what I could to prevent that from happening to the next woman who comes along. It seems very small, but I appreciated the woman ahead of me and why she didn't say anything. She was selected, and it didn't limit her; but I didn't want to see that happen again, so I went to the admissions team and described my experience. It was a small feat for me, but I felt I used my strength to make things different. My input was well received, and I believe it's why the interview process has been changing. This situation involved a senior male physician in medicine whose been recognized by the school so it's tricky, but I hope to keep living with the confidence to be able to call out those situations, as they weren't always easy for me, and I appreciate why it isn't easy for other women as well.

ON THE MANY FACES OF LEADERSHIP...

I really do think about this a lot: why do women have to be the thoughtful, risk-averse kind of leaders. Why can't they also be the visionaries who are willing to take a risk and push the envelope into a new world? I know that we can be all these things, and I know such women are out there, and I can't even imagine the hurdles and barriers that they have pushed through to get there.

But let's be clear: leadership does not have one definition. How do we communicate to those we're educating that leadership really means you have to dig deep and figure out who you are and what your strengths are and what kind of leader you are going to be?

We don't have explicit conversations about that. That's a big miss in our general profession. My generation is very driven to find purpose, so we shouldn't separate that connection between professional and personal identity.

For instance, ever since I was born I've been known as a hugger. I have an uncle who went to Vietnam and is incredibly closed off. At my wedding this summer, one of my cousins said to me, "I don't know how you did it, but you took my old crotchety dad and you taught him how to love us again, and how to show us affection." To me, as a clinician, this concept of human touch is so important.

When I worked at Ward 86 at SF General in Adult HIV Urgent Care, one of the physicians I worked with, taught me that sometimes patients come to us because they have a shingles outbreak. Other times they come to us because they need a hand put on their shoulder that says, “Hey, I’m here. You’re here. You’re real. I see you. I see you in this world. I see you and you’re here and we’re here for you. We’re going to do what we can to make sure you never forget that.”

You can have a steady job and a stable home and still need to hear that. I need to hear that. In family medicine, when you reach across and touch another human in a kind way, it also opens opportunity for vulnerability. That makes someone feel a connection in a way that you wouldn’t believe. Sometimes, it’s been a long time since someone has held another hand or felt a hand on their back or been asked if they want a hug. It’s amazing what that does to change the way that person might move through the rest of his/her day, week, life—and also potentially open them up to trusting you and allowing you to learn more as a provider about who this person is and what their life’s like and how you might just get a glimpse into what you might be able to experience with them and allow them to feel like you’re there and you’re listening. That is healing.

I’d like to go back now to what makes a good leader and how we put women in a box where they don’t necessarily belong—and therefore we also limit our understanding of leadership. Sometimes this notion of me being a hugger and the power of human touch feels like it’s in direct conflict with what people might think about my potential as a leader. My abilities to come in a room and lead a meeting or run a hospital system. It seems like the world might be skeptical that I can be a person that is okay with vulnerability and values the concept of human touch so much and has this emotion inside of me—that I can also be this human who can lead a massive organization or achieve profitability—that I can also be a “take no prisonsers” kind of leader. And I do feel that conflict as a woman in this profession.

"SOMETIMES THIS NOTION OF ME BEING A HUGGER AND THE POWER OF HUMAN TOUCH FEELS LIKE IT'S IN DIRECT CONFLICT WITH WHAT PEOPLE MIGHT THINK ABOUT MY POTENTIAL AS A LEADER."

ON WALKING THE TALK...

Right now, there’s this attitude that we should talk about sexual assault in medicine. We should talk about race. We should talk about gender equality. But in our current education system these conversations are so superficial. We don’t do a good job of touching the souls of these students that we’re training to be future leaders in family medicine. And it’s a total missed opportunity.

Classmates and I were recently in a conversation with a faculty member who’s very much in-charge of this type of curriculum for our education and she said, “Well, we’re not going to solve racism here.” Wait, what? I mean something has clearly gone wrong. This is exactly where we should start. This is where we should start to understand the constructs.

I’ve talked to classmates, and I can’t imagine what it’s like when you go into a small group and there are eight people and you are the only black woman, and you think about that

every single time you walk through that door, yet we don't talk about it. Then you want to know why we have problems further down the line in our healthcare space and in leadership and in women in medicine. If we can't have these conversations now, what kind of signal does that send? But we just don't have the environment for it, and it's this tug between teaching clinical things we need to know and balancing that with all these other things. That's not to say our school leadership doesn't believe in the same thing. It's just the nuts and bolts of figuring out how to do both.

Every single one of us holds both what I probably would call privilege and oppression inside of each of us, for different reasons. Some people have faced way more challenges than I have or the person next to me. We must acknowledge that. How do we bring light and explore who each of us are as individuals? If we can't do that with each other, how are we going to do that with our patients?

But it begs the question that I recently had with another faculty advisor of mine: "Can you teach any of this? How?" When you bring 184 students into this class for medical school is there hope?

> "FIRE THAT PERSON AND GET A NEW ONE. YOU CAN'T TELL ME THERE AREN'T BETTER MENTORS."

Are we already established human beings at that point? I don't know, but I do know that we're taking a pretty defensive approach in saying, "We can't solve race here. We can't solve gender inequality here, so we're not even going to try."

ON THE MEANING OF REAL CHANGE...

Once we had a reading on the scientific method. It contained a paragraph that essentially said physicians were men. I thought, "This is interesting." I woke up to a few texts from a few women in my class saying, "Did you see this? Did you read this? Why are we reading this?" It's from 1964. Is this serious? So I thought in the spirit of gaining my own strength, I decided to politely bring this up to our male block directors. The immediate reaction was a completely defensive one. They basically said, "That's not the point; it's a good paper about scientific method." So are you telling me you can't find another paper written since 1964 that does just as good a job explaining the damn scientific method without completely bullshit gender constructs?

You want to know why we have problems? It's because we retain that person. Why is that person the leader of a huge clinical block in our medical education? Fire that person and get a new one. You can't tell me there aren't better mentors. It doesn't even have to be a woman, but at least another white male who can respond differently.

It's almost as if having women in medicine is the endpoint, as opposed to figuring out what that means for the kind of program we should have/develop. What does that mean in terms of our opportunity to learn? At a minimum we should say: "Hey, we want to let you know we brought in more women than we ever have before in the medical school class, and we understand that when you look up, you won't see as many women around you at higher levels as you will see around you in your everyday world. We don't want you to get discouraged by that. If you have questions, concerns, ideas; come talk to us."

It's not that students don't have a voice. It's not that younger women aren't feeling these things. We're willing to speak up and take the risk of doing it, but for what? Will it fall on deaf ears, or are the ears listening?

CONTRIBUTORS

Colleen Conry

MD

President, University of Colorado Hospital Medical Staff

Professor and Senior Vice Chair for Quality and Clinical Affairs, Department of Family Medicine

University of Colorado School of Medicine

Valerie Gilchrist

MD

Millard Professor in Community Health

Chair, Department of Family Medicine and Community Health

University of Wisconsin, School of Medicine and Public Health

Lauren Hughes

MD, MPH, MSc, FAAFP

Sarah Hemeida

MD, MPH

Assistant Professor

Scholar, Eugene S. Farley, Jr. Health Policy Center

University of Colorado, Department of Family Medicine

Susan McDaniel

PhD, ABPP

Dr. Laurie Sands Distinguished Professor of Families & Health

Vice Chair, Department of Family Medicine

Academic Chief, Division of Collaborative Care and Wellness, and Director, Institute for the Family, Department of Psychiatry

Director, URMC Physician Communication Coaching Program

University of Rochester Medical Center

Lucy Candib

MD

Professor Emerita, Department of Family Medicine and Community Health

University of Massachusetts Medical School

Worcester, Massachusetts

Moira Stewart

PhD

Distinguished University Professor Emeritus

Centre for Studies in Family Medicine

Western University of Ontario

London, Ontario, Canada

Stacy Ogbeide

PsyD, MS, ABPP

Associate Professor/Clinical

Director of Behavioral Health Education, Family Medicine Residency

Integrated Primary Care Behavioral Health Track Coordinator, Psychology Internship, Dept. of Psychiatry

ReACH Scholar, Center for Research to Advance Community Health

UT Health San Antonio

Shanta Zimmer

MD

Senior Associate Dean for Education

Associate Dean for Diversity and Inclusion

University of Colorado School of Medicine

Jeannie Ritter

Mental Health Ambassador for the Mental Health Center of Denver

Long time advocate for behavioral health and integrated care initiatives

Frances Vernon

Second year medical student

University of Colorado School of Medicine

EDITORS

Frank deGruy

MD, MSFM

Woodward Chisholm Professor and Chair

Department of Family Medicine

University of Colorado

School of Medicine

Janet Meredith

MBA

Strategic Projects

Department of Family Medicine

University of Colorado

School of Medicine

SALON INFO

From the ancient Greek symposia to Gertrude Stein's famous Paris gatherings, salons have always been the incubators of provocative—at times even dangerous ideas—the frontiers of cultural change. People who might elsewhere have been socially ostracized were included in salons, welcomed for their wit, intelligence, charm, and insight. And passionate conversation often led to passionate action.

We will host three salons to discuss the perspectives and ideas raised in this edition of Precipice. Contributors will be present at each salon to talk, lead discussion, and answer questions. These are issues that affect everyone in primary care, and we hope to engage you in further thinking and conversation.

THE QUESTIONS WE WILL HASH OUT IN THE SALONS ARE:

1. HOW SHOULD THE RISING PREDOMINANCE OF WOMEN IN FAMILY MEDICINE AFFECT HOW WE THINK ABOUT AND MANAGE OUR PRACTICES? HOW CAN IT INFORM THE FUTURE IN OUR FIELD?

2. WHAT DOES THE RISE OF WOMEN IN PRIMARY CARE MEAN FOR THE WOMEN THEMSELVES?

3. WHAT SHOULD WE BE DOING TO IMPROVE THE EXPERIENCE OF WOMEN PHYSICIANS IN PRIMARY CARE?

University of Colorado
Anschutz Medical Campus

ABOUT THIS PUBLICATION

CONTACT US
inquiry@precipiceonline.org

FIND US ONLINE
www.precipiceonline.org

SALONS 2019-2020

NAPCRG
November 18, 4-6 p.m., 2019
Toronto, Ontario

ADFM
February 14, 4-6 p.m., 2020
New Orleans, LA

STFM
May 2-6, 2020 (Time TBD)
Salt Lake City, UT

**TO RSVP FOR A SALON,
VISIT PRECIPICEONLINE.ORG**

ILLUSTRATIONS
Brad Todd

PHOTOGRAPHY
Lisa P. Martinez, Jon Alonzo

DESIGN + LAYOUT
This/That