

*When You
Don't Fit
the Mold...*

Make a New One

*Personal Stories
≈ of ≈
Women Physicians*

Preface

*W*hen You Don't Fit the Mold...Make a New One originated in 1999 as a workshop seminar sponsored by the Committee on Women in Medicine. The workshop presented ideas and approaches to practicing medicine alternative to those traditionally accepted, and served as a mentorship and networking opportunity.

The medical profession is a demanding career, but coupled with well-established attitudes regarding physician responsibilities, practice and lifestyle options have historically been limited. Despite this conventional perspective, women crafted new options to achieve successful professional careers as well as fulfilling personal lives.

Women know the meaning of wearing more than one hat at the same time. Meeting multiple obligations and expectations and fulfilling responsibilities — while striving to satisfy personal needs — is a great challenge. A challenge each of the women in this book has approached differently.

The experiences of these women, the decisions they made, and the opportunities they chose to follow can be attributed to their individual strength of character. The knowledge that conformity is unnecessary in the quest to become a skilled physician was the key that allowed these women to pursue their dreams.

Through innovative ideas, personal balance and professional careers are possible.

It is our hope that this book, a collection of the unique journeys of women in medicine, will serve to mentor and inspire others.

CLAUDIA L. KOPPELMAN, M.D.

Committee on Women in Medicine

Co-Chair 2001–2003, Vice Chair 1997–2001

The Massachusetts Medical Society
Committee on Women in Medicine
dedicates this book
to honor the
25th Anniversary
of the
Committee on Women in Medicine
(1981–2006)

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Table of Contents

INTRODUCTION	1
1. MARYLOU BUYSE, M.D., VIRGINIA T. LATHAM, M.D., AND BARBARA A. ROCKETT, M.D.	3
2. ROBERTA J. APFEL, M.D.	25
3. SOPHIA B. BAMFORD, M.D.	33
4. SELMA DEITCH, M.D.	41
5. CLAUDIA L. KOPPELMAN, M.D.	45
6. MARY KRAFT, M.D., M.P.A.	59
7. KWAN KEW LAI, D.M.D., M.D.	73
8. CINDY B. LEVINE, M.D.	77
9. ELLIN (LOURIA) LIEBERMAN, M.D.	81
10. WINIFRED C. LOUGHLIN, M.D.	85
11. IOLANDA E. LOW, M.D.	95
12. JENNIFER E. POTTER, M.D.	101
13. KAREN L. REUTER, M.D., F.A.C.R.	111
14. ELIZABETH A. RIDER, M.S.W., M.D.	113
15. SHAKTI S. SABHARWAL, M.D.	119
16. DIANE K. SHRIER, M.D., AND LYDIA A. SHRIER, M.D., M.P.H.	127
17. MARGARET E. TOMPSETT, MB, BCHIR	137
18. INGEBORG VAN PELT, M.D.	147
19. ASHA P. WALLACE, M.D.	155
COMMITTEE ON WOMEN IN MEDICINE MEMBERSHIP	161

Introduction

J clearly remember stomping into a meeting of the Massachusetts Medical Society's Committee on Women in Medicine in 1999. I was chairing the meeting, but before beginning the formal business, I needed to vent about my most recent episode of bucking conventional wisdom to accomplish something administrative. After some discussion, I calmed down. My wonderful women colleagues on the committee reassured me that they all had similar experiences — and thus was born the idea for this book.

On the following pages you'll find 22 inspiring stories from 22 women physicians. Their medical school and practice eras span more than 60 years! Not one of us did exactly what our families or society expected of us. Each woman created a unique mold for herself. Perhaps the only common threads are the passion and dedication we bring to medicine and patient care. All of us are committed to following our "personal legends" (Paul Coelho, author of *The Alchemist*, HarperSanFrancisco, 1993). As Coelho so eloquently writes, "Whenever we do something that fills us with enthusiasm, we are following our legend."

It is with pride that we publish the legends of these 22 women. We hope they serve not so much as instruction, but as inspiration and encouragement for future generations of women in medicine to pursue their dreams and each make their own unique stamp on the world.

MARY KRAFT, M.D.
Concord, Massachusetts
2006

Transcript from

*An Evening with the Women
Presidents of the MMS*

MARYLOU BUYSE, M.D., VIRGINIA T. LATHAM, M.D.,
AND BARBARA A. ROCKETT, M.D.

Wednesday, June 30, 2004

The Committee on Women in Medicine was established in 1981, 200 years after the founding of the Massachusetts Medical Society. The Committee serves as an advocate for women physicians and provides a forum for networking, mentorship, and leadership development. In the history of the Society, three women physicians have attained the rank of president within the organization. What leadership qualities characterize these unique and outstanding women?

The Women Physicians Lecture Series was established by the Committee in 2003 as a mechanism to identify, address, and educate women physicians on professional issues of interest to women in medicine. On June 30, 2004, the Committee on Women in Medicine sponsored “An Evening with the Women Presidents of the MMS.” Its purpose was to present an opportunity to gain insight on the leadership styles of these women presidents and learn how they navigated obstacles as they challenged tradition and attained leadership roles in organized medicine.

In the following transcript, the women presidents share their thoughts on networking, prioritizing, maintaining balance, and mentoring. They take you on a journey that reflects their

optimism, humor, resiliency, and an impressive ability to embrace life with all its complexity and challenges. This evening presentation continues to stand out as one of the highlights of the lecture series. We hope you find their stories as illuminating and inspiring as we did.

EDITH JOLIN, M.D., M.P.H., *Chair (2003–Present)*

NAJAMOSAMA NIKRUI, M.D., *Vice Chair (2005–Present)*

Marylou Buysse, M.D.

GOOD EVENING. IT'S REALLY A PLEASURE TO BE HERE. I WOULD like to thank the Committee on Women in Medicine for inviting us here and for dreaming up this program. I think it is a great idea and I know that each of us is delighted to be here. We have all had different experiences and different leadership roles and different issues to deal with — not only along the way to the presidency, but also while we were presidents.

It's not always the same. It's a lot like health care. You know what happened last year is different from what is going to happen next year. It's always hard to predict what the big issues will be. At this stage in my life I have to say that life did not quite turn out the way I expected it to. For those of us who are perhaps older than 40, we were starting to realize that you might have planned things to be in one direction, and things come out in another direction. I would never have dreamed when I was a student or resident that I would end up in organized medicine since I had no interest in it, or in any political sphere whatsoever. Nor did I have any skills whatsoever. There is hope for everyone.

Why get involved in organized medicine? When I finished medical school, less than 5 percent of women were physicians. Graduating classes are now about 50 percent women or there-

abouts. That is a tremendous sea change. Certainly the whole education process is different just because the numbers are different. When I went to school and did my rotations and my internships and residency, all the women went to the nurse's quarters for changing their clothes, bathrooms. They didn't have women's locker rooms for women physicians. They just weren't there.

Things have changed a lot. One thing that has not changed is the power of networking. I would say the reason I got involved in organized medicine in the first place was because a good friend of mine asked me to get involved and talked me into it. I couldn't understand what I was going to get out of it, but I have to tell you after some 30 years being involved in various organizations in medicine, that you get a lot out of it. Probably one of the most important things to me both personally and professionally has been networking. I feel we don't really understand as women professionals the power of networking. I have gotten some of my most interesting jobs through networking — just through the people I know who have said, "Oh, Marylou, this job is perfect for you — Go for it!"

Networking is something that helps you in your career, helps you in your personal life, and helps you manage the two of them. In terms of organized medicine, whether you have male mentors or female mentors, organized medicine allows you a safe place to meet other peers who have similar interests. Gender or race doesn't matter as much because you are brought together in the interest in your profession. I would say that in organized medicine, whether it is your professional society, the AMA, the Massachusetts Medical Society, or AMWA, that each of these organizations gives you a different viewpoint and each has a different perspective on medicine. It is medicine as a profession that

brings you together. There is a sharing there that is so special and so different. It gives you a kinship. You make friends and you go through your professional lives together. It is just a very wonderful thing that organized medicine gives you. I wouldn't think of it as something as your giving in terms of volunteer time, because I think you get back just as much as you give, if not more.

I started my career in academic medicine. I spent the first decade of my career on the faculty at Tufts and then at Harvard Medical School. It never occurred to me that I was not going to do anything but academic medicine practice, research and teaching. That didn't work out for a number of different reasons. I decided I wanted to make some changes. It was due to my networking in organized medicine that I was able to make a successful intracareer change.

First, I went into clinical family practice with a friend of mine who I know from organized medicine. I tried full-time practice. That, too, really wasn't for me. I love practicing medicine and still practice part-time. It didn't take me long to figure out that what I really wanted to do would be more of an executive job. I've spent the last 15 to 20 years as a physician executive. I really, really enjoy it. My medical specialty was esoteric but broad enough that I could easily make that adaptation again, through the help of my friends.

Again, through networking and the friends I made in organized medicine I was able to have a very interesting, very dynamic, and very diverse career. This could have never happened if I stayed in an academic medical center early in my career or never gone to a Massachusetts Medical Society meeting, AMWA meeting, or just went solely to professional specialty society meetings. It just never would have happened.

I think a lot of what has happened in my life has really been because of the networking and friends I have made in organized medicine. That is when you think of the time investment (and it is a large one) but you get back two to three times what you give. That is the really great part of it.

Very few women were in medicine when I finished my residency in the 70s. I can remember my first Massachusetts Medical Society meeting. It took me several years to come back. It was a smoke-filled room filled with much older middle-aged white males all talking to each other, totally ignoring me. I was under 30. I just didn't feel as if I fit in. At that time, they didn't have a Committee on Women in Medicine. I know I am dating myself. I just didn't see a place for me. Through a friend, a number of years later I was asked to get involved in an MMS committee and it was through the committee structure rather than large meetings that I found my niche in organized medicine. Through the committee structure, you are working with small groups and you generally have an agenda of things that you are interested in, whether it is public health, or public policy, or some area of medical practice. It is something we as professional women have in common across the board whether we are anesthesiologists or oncologists or internists or surgeons or psychiatrists. We all have in common a similar training, a similar background, a similar outlook — that makes it very special. It is one of the areas where women can come together. I am delighted that the Massachusetts Medical Society Committee on Women in Medicine has been a success. I am delighted to be here.

I don't think I would have been involved unless I had that friend who thought I would do a great job at the Massachusetts Medical Society and got me involved on the Bylaws Committee. I learned a lot about bylaws, and guess what? I started two organizations, and

everything I have learned about bylaws helped me in those organizations. It was through a lot of my work in organized medicine and my leadership skills built year after year that I really found what I was truly interested in and what I really liked the best. It really gave me a place to role-play and practice and try different things out without risking my career or anything else. It was just a terrific experience.

I moved into an executive role very early in my career because I had a grant where I was the principal investigator. I was running a multi-million dollar grant in the late 70s, so that was really my first type of executive experience. I didn't think about it then, but that gave me a number of responsibilities including all of the reporting, budgets, and everything else. I learned my executive skills there. Then I started a 501(c)3 not-for-profit where I had to learn about forming corporations, raising money, and all of that. I then did get a job being the medical director of a facility and had about 14 to 15 physicians work for me, about 30 nurse practitioners, and a specialty staff of part-time consulting staff of about 40 to 50 people. I did that for six years. During that time I realized there were some gaps in my toolbox or knowledge base. So, I went back mid-career and got a business degree and a preventive health degree. That does open certain doors for you. Some people who get a management degree do it earlier, and some people do it later and that's kind of how I did it mid-career. What I did is talk to other people who were doing it. I've always asked people for advice if I needed help. People are usually very happy to help you. If I needed information or advice, I called somebody I knew who was knowledgeable, and they'd say, "Oh Marylou, you can do it like this." Or they would say, "You don't want to do that because...." I always say I learned management by the seat of my skirt, and in those days I wore skirts all the time.

Another challenge is time. Believe me, no matter where you are in life you never have enough time. The older you get the worse it seems. I still have that problem. In fact it is worse now than ever. I would say that you choose a career path you are interested in because there is nothing like passion to keep you going — whether it be a topic, whether it be your specialty, whether it be women in medicine, whatever — spend your time on something that you feel good about, you care about, because that will be the place you will want to go. Start where your heart is.

Virginia Latham, M.D.

MY TALK IS SUPPOSED TO BE ABOUT BALANCING MEDICINE AS A career and having a family. I have to make a couple of disclaimers. The first disclaimer is my family would probably tell you that I practice *disorganized life*, so this is strictly a “do as I say, not as I do” type of discussion that is coming up. My second disclaimer is that I tend to take these things rather light-heartedly even though they are serious subjects, so don’t get too concerned about my “tongue in cheek” slides.

Balancing work and family. Is this an impossible dream? Remember what it was like before you went to medical school? Your ideas about perfection? I guess I should make a third disclaimer before I start. I didn’t go to medical school when I finished college. I lived in the antique world, which perpetuated the idea that you couldn’t possibly be a doctor and a wife and mother. When I got an engagement ring for my 20th birthday, I thought long and hard about whether I was going to be a doctor, or marry my husband who was an MIT student and have a family with him. It never crossed my mind that there was a possibility of doing both. I got to the career second — after 16 years of marriage and 5 sons. Although I am probably older than Marylou, I just

finished my residency 20 years ago. Anyway, I remember what it was like to think about what I was going to do as a doctor. It was going to be so neat. I was going to have a perfect smile on my face every day, and a nice white coat.

How can you keep that dream alive? Can you avoid having those pre-med dreams become nightmare realities? I think that many of us are old enough, that we are way past our pre-med dreams, but that means that it is time to start thinking about tips for the overwhelmed. I am going to give you a few of Ginger's tips for the overwhelmed.

I think the first thing you have to do is sit down and really think, what are the things that are going to go well? What are the things that, no matter what you do, aren't going to be winners for you? What in the world can we all try and do about dealing with our lives?

First let's talk about the good stuff. There's lots of good stuff about being a doctor. There's lots of good stuff about having a family, too. The good stuff about being a doctor includes getting respect from people outside your family. (Don't even try within your family — you might get a modicum of respect, but they know the real you too well for much.) Other people respect physicians — at least other people who aren't doctors or lawyers, or nurses.

You are going to have the joy of a lifelong career that really is lifelong. You can always be doing something that is exciting and rewarding.

Personally, I have been "structurally challenged" (using crutches to walk) over the past few years, but there are some interesting things I can still do in medicine, though I no longer have a practice. You will have a sense of accomplishment when you look back on your life because no matter what you do, even if you are just seeing patients every day, you are accomplishing a lot. When you

reach the age I feel I am rapidly approaching, called the “rocking chair review,” when you look back on your life, you’ll have things to feel good about.

And, you’ll have adequate financial security. You are never going to be in a situation where your family has to live in a shack or you don’t have clothes or you don’t have meals or you don’t have shelter. It is a profession where you are guaranteed some of the basics in life that many people are not guaranteed. Even if we think that sometimes we don’t get fairly recompensed for what we do and the hours we put in, we are almost always able to live comfortably. These are the good things — the respect, the joy of doing something you love, the feeling of accomplishment, and basic security.

What about the bad things — the frustrating stuff? This is stuff you really can’t do very much about. Your friends and family are not going to have endless patience with your work demands. They may have a lot of patience, but nobody can have endless patience with someone who never comes home to dinner when she says she is going to; who gets to the school play just as the little kids are taking a bow at the end; who doesn’t quite make it to her husband’s Christmas party because she is on call.

You’re not going to have adequate down time — at least not by my definition. Maybe there are some part-time professions in medicine where you can have adequate “personal time,” but most of us don’t get as much as we would like. I bet not many of you have sat on the back porch this past week with a glass of lemonade and read a book for two hours for pleasure. Unless you are sneaking thyroid pills, you probably do not have a body that can tolerate as much action as you could put into a day.

You’re not going to have a perfect Martha Stewart household, and I’ll clue you in, you probably wouldn’t even if you weren’t a

doctor. I've been there. You're not going to have plenty of quality time with the kids. It's more likely you're going to be going on a ski trip somewhere and there'll be so much fighting going on in the car you'd like to open the door and step out into a convenient snow bank and let them all drive on somewhere.

And you're not going to be Ms. Super Doc if you're trying to balance a career and a family. You're probably not going to re-design health care for Africa or be the guru of medicine for the United States. Because everything in life is a balance, and if you are trying to be super at something, something else has got to give, as we all know. That may be your child's riding lesson. That may be your grandson's football game. Heaven knows what it may be for you. But what happens when that frustrating stuff hits you? How can we try to do something about the mounting frustration of trying to be perfect in all of these different roles?

What do I advise?

Most importantly, you've got to prioritize. Over and over again, we have to sit down and think about what really is important to us personally. What's important to Barbara may not be what's important to Marylou, may not be important to me. But each of us has to find our own ground of what is most important.

Do put off until tomorrow whatever you can was a maxim that my mother learned from her great aunt. I took strenuous objection to it when I was a child because I thought our household was rather disorganized. The truth of the matter is, I live in a house right now where all of the windows on the front of the house are so dirty that every afternoon as the sun shines in, I think, I've got to wash those windows, or, I've got to call someone to come wash those windows. Who will I call? I'll do it in the morning. In the morning the sun is on the other side of the house, and I don't see the grime on those front windows. You know what? It

doesn't make a wit of difference in the world if my windows stay dirty for the next few months. Nobody else who comes to my house probably notices. If you have somebody who comes to your house and notices whether you have grease on your stove, I don't think they're the person you're going to want to be buddies with anyway.

Don't feel obligated to volunteer. There are two kinds of volunteering: there's volunteering because you want to do something — you hear about a van delivering care to the poor, or you want to go abroad with the Smile Train and you volunteer to do it. But there's also the railroading kind. Your kids' schoolteacher calls up and says, "Tommy volunteered you to be the class mother for the year. We know you'd be wonderful at it, because you're so organized and we don't have anyone who can do it."

Pretty soon the guilt level rises. And let's face it, as doctors, we go into medicine partially with a real sense of altruism to help other people, so when someone calls up and says, "We have to have you," it's sort of like when the patient says, "You're the only one who has ever taken such good care of me." It's a very good stroke for getting you to do whatever they'd like. They want you to be class mother. There are probably 20 other kids in the class and probably at least 10 of the other mothers are not nearly as busy as you are, and could do it.

Do pick the things to volunteer for, regardless of whether it's someone who says you have to join the ACP and become a governor for the American College of Physicians, or it's the Massachusetts Medical Society. If you take the time to pick the things that really matter to you, you'll feel good about them. I was mentored into the medical society by a male radiologist at our hospital who took me by the arm one of the first days I was at the hospital. He told me, "You must join the Massachusetts Medical Society. There's a

Committee on Women and you should be on it.” At that stage I hadn’t learned the word “no,” so I agreed. I’m so glad that I did! I have really enjoyed the work I’ve done at the Medical Society, but several times I have resigned from committees because there’s a point of balance you probably all know very well. There’s a point of balance between doing things that you really care about, well, and doing so many things that you feel like you’re not doing any of them well. “I promised them I would get that in.” “I said I would do this.” There’s constant guilt hanging over your head, and the feeling that you’re an ant climbing up the ant hill and the sand’s just pouring down on top of you.

I was on a number of very interesting committees at the Medical Society, which over the years I’ve resigned from because I felt I couldn’t make a contribution anymore. I was too overwhelmed. So, I do think it’s very important that you figure out what’s right for you.

Do value what you *do* accomplish. It may not be a great deal in the big scale of things in the world, but you’ve got to have this macro sense of balance between what’s most important to you in terms of life, career, family, and the day-to-day balance. The phone’s ringing, the dog’s barking, the child is playing in the dog’s water. What do you grab for? Or back to the office scene (slide of chaos).

Do let go of needing to do everything perfectly and enjoy what you are able to do is a lesson I can talk about, but I have trouble with myself. The day after my father-in-law’s funeral, it was my visiting granddaughter’s birthday. She wanted an Ariel cake. I made an angel food cake and stuck an Ariel doll down in the middle of it, and I was quite concerned because the cake with its purple/blue icing was supposed to be a skirt for Ariel and instead you could see the tin foil around her bottom parts, and she was

popping up out of the middle. So we called it Ariel coming up out of the ocean. The birthday girl was perfectly happy, and I realized that it really didn't make any difference whether or not the cake was a skirt. If you're an athlete, which I never was, go out and run the triathlon. What difference does it make if you lose? At least you'll feel like you accomplished something by going and doing it. You knit a sweater for your grandson and he doesn't think a whole lot of it, but you can take a sense of accomplishment out of it.

One of the other things you can do about dealing with dichotomy: teach your family to appreciate what's really important. I should also say that involves listening to what *they* think is really important. There are lots of things you can do together that don't take a lot of time but make you all feel good. My town has a Come Pull the Weeds out of Bear Hill Pond day. It might be cleaning up along the roadsides with somebody's Cub Scouts. It might be going to do something your husband wants to do that you hate, like dual kayaking or something.

Do keep a sense of humor. And, most of all, I think you need to learn to laugh at yourself. In the first grade, I was the Spirit of Thanksgiving, which involved being decorated up as an ear of corn. Yellow crepe paper on the top half, green crepe paper on the bottom half, and lots of scotch tape attached by my mother and the first grade teacher. As I walked down onto the stage, I stepped through the bottom of the costume and fell on my face. When I stood up, all the green bottom part had fallen off, or sort of peeled off, and my underwear showed. I can still remember standing there on the stage and starting to cry, and looking out at the audience, and I could see some of the grownups, covering their faces. Some of the children in the other first grade sections were starting to snicker and their teachers quieted them down. I started to laugh and I couldn't stop. I just laughed my head off.

And everybody else laughed, and it was okay. So I was lucky to learn the lesson early on.

I was born with a congenital tremor. My patients would start getting nervous when I went to take a splinter out or something. I'd say "don't worry, don't worry, I do fine embroidery." They'd laugh and we'd all get through it. So go through your life with a smile on your face if you possibly can. We've got lots of good things going for us, or "it ain't all that bad, lady." We may not be quite as well off as an animal that has good looks (slide of a contented cat) plenty of time to rest; people slaves. People bring that cat food, they pat her, and they take care of her. You probably don't get food brought to you, get patted and taken care of.

But, we've got what cats don't have. Brains. I said "brains," but I really meant intelligence. We've got intelligence, or we wouldn't have gotten through medical school. We've had the advantages of getting an education. We've got lots of contact with other humans. My husband is an astrophysicist. If you want to see a group of people who don't have much contact with other human beings, go to an astrophysicist's convention.

And we have a relatively easy lifestyle. Now, that sounds ridiculous, but if you're feeling really stressed out, you can think about what you can compare your lifestyle to. We have a relatively easy lifestyle compared to doctors elsewhere. Can you imagine being in Baghdad, and having to try to take care of a child without the equipment, without the medicines, without any of the things you would need? Believe it or not, you have a relatively easy lifestyle compared to a stay-at-home mom — I know that one for a fact. Trust me, if you've ever tried being a stay-at-home mom, going to medical school seems so easy. Harvard Medical School in my day required you to have a little psychiatric evaluation — everybody in the class — and the guy kept saying, "Do you enjoy medical

school?” I kept saying, “Oh, it’s wonderful! I just love it! I mean, it’s like a vacation.” I sat in a chair and learned something I liked all day long. Nobody was pulling on my skirt, or yelling; the phone wasn’t ringing. He thought I was absolutely crazy, and I thought, he’d probably never been a stay-at-home mom.

We’ve also got to our advantage — an interesting profession. Can you imagine working on an assembly line, screwing some part into something all day long, or cleaning hotel rooms, or even answering the Verizon telephone thing? We have an interesting lifestyle every single day. When you get up, something different may happen in your day at work. And we’ve got opportunities to make a difference — a difference to one individual or to the world — every day. Maybe you’ll help solve the health care crisis. Maybe you’ll establish new cardiac guidelines, maybe you’ll help a mom and a baby through a difficult delivery, or maybe you’ll just hold someone’s hand while they die quietly. But you’ve made a difference every single day of your life. You have that opportunity. And that’s what makes most of us happy most of the time. We can do it, and aren’t we lucky to have had a chance to live life to its fullest, which I really feel we have. That enormous luck is on my license plate — Mom-Doc.

Barbara A. Rockett, M.D.

THANK YOU FOR INVITING ME. IT’S DIFFICULT TO FOLLOW THESE two outstanding people.

A big part of what you can do as physicians, I think, includes involvement. Get involved. There are so many ways to get involved. I know when I was president, there was a note sent out in January to everyone that asked, “Which committee would you like to serve on? What are your interests?” We had a lot of people sign up for committees as a result of that note, and I think that’s so important.

We did have a Women in Medicine Committee at that time. I was a little concerned about it, if you want to know the truth, because I thought women should be involved on all committees, not just one single committee. But many good things have come from the committee. But expand — go into other things, as well. Commitment is important. If you commit to something, then follow through. You have to be able to say, “I’m going to do it!” There are times, naturally, when you can’t follow through. But really try to do that if you can. I know that so many times I’d be asked to do something and I’d think about it for about two minutes and say okay. My husband bought me a book called *When I Say No I Feel Guilty*. And I think this tells you something about me. And you do have to, as Virginia Latham says, balance things.

There’re only so many things you can do. I think to the students I have mentored (and I have mentored many of them) and I went into Tufts Medical School faithfully every week teaching some of these students in problem-base learning. You have to like, or even love what you’re going to do. It’s so important. I’ve told this to my children, that it’s so important to enjoy what you’re doing. Sure, there are times when you’ll hate what you’re doing, but on the other hand, I think the important part of it is really try to like what you’re doing or to find the good things about what you’re doing. I have five children. I have four boys and a girl, and every time I went to the pediatrician I’d say, “Oh, I’d love to have a girl,” and he said, “Look Barbara, there are some people who have no boys. So face it, you might never have a girl.” Well anyway, I did have my girl. She was born on New Year’s Eve, very naturally. I was not induced, despite the fact the doctor wanted to induce me before that because I was so big, but it’s been a wonderful experience being in medicine and raising a family. I tried to get to all the

sports events I could. In fact, I ended up the doctor for the football team at Belmont Hill. They couldn't play unless I got there, but I was getting there because my son was on the team, and that was the important thing for me. There are many rewards, too. I mean when you see your children grow up and become successful, that's so important. I'll never forget when I was going to consider going into plastic surgery. Dr. Webster, who was a plastic surgeon, said to me, "You have to think of three things, Barbara. One, you should be considering yourself first; second, your family; and third, your patients." Well, that wasn't what I was taught in medical school, and you know that's carried over. Because he told me the patients can always get another doctor, but that my family cannot get another mother — and that's important.

I went to Wellesley and things sometimes have just fallen into my lap, believe it or not. No one believes that when I went to Wellesley, I was going to go to law school, especially with all that's happening in legislation right now. Anyway, I had a wonderful teacher in high school, a biology teacher, and I ended up majoring in Zoology. Again, something I loved. And, I thought, why am I avoiding going into science when this is really, really what I like? I was going to go to graduate school. And I have to tell you, at that time I was engaged to someone else, not my husband. So that was my main reason for going to graduate school. I thought, a year or two and I'll be finished, and someone said "Why don't you apply to medical school?" It's the same courses. Okay, I applied to medical school and I went to Tufts Medical School. I was one of five women in the class, and I loved it. They were so wonderful to me, I can't begin to tell you. I mean, I was invited out to play softball with the men. I went to wrestling matches because the dean in our pathology group was a wrestler. I mean, these were the things that really made a wonderful experience for me in medical

school. We've had so many reunions afterwards. I just enjoyed so much of the whole experience. We were told at that time that you could either have a career or a family. I was listening to this whole thing and then I thought, why? Why is that the only thing you can do — make a choice between those two things? I also found that in my rotations, the thing I liked the most was surgery, and everyone thought I was crazy wanting to go into surgery. In fact, I went to City Hospital where I was a student in medicine. I was told by a wonderful man that if I didn't get accepted in a surgical program, he would guarantee he would take me in a medical program. So that's all I needed to do to know that I could go forward. I went to the Tufts Surgical Service, and I was advised to speak to a psychiatrist, a pediatric surgeon, and a gynecologist, and return for an interview. Well, of course I did it. As they say, you have to be committed to these things. Fortunately, I was accepted on the BU Surgical Service. And again, the only woman. The first woman intern in surgery and it was a terrific experience. I'll never forget when I was pregnant with our first baby. They would send me off to rest or they would send me off to the operating room and do what we call the scutt work at the hospital, because they were just very considerate people. We've had reunions every year until the past two years when our chief of surgery became so ill. Recently he died.

You know, I never expected to get involved in organized medicine. There was a very wonderful man by the name of Dr. Robert Tilly. He came up to me and asked if I would be a councilor. At that time we were called councilors, not delegates, and I said, "Fine, yeah, that would be a nice thing to do." I was appointed to various committees — mental health — maybe they thought I needed it, but anyway, that's where I was appointed. Then I got into legislation. I was recruited to become the vice president of the

Massachusetts Medical Society by a group of men. I just have to tell you that maybe some people have experienced negative feelings. But I did not. I just found that they were supportive. I worked for a while with no executive vice president because we lost the person who was executive vice president, so I served as vice president and executive vice president for a short period of time. At this point we were in a terrible malpractice crisis. Malpractice rates were going up 164%, and no one could afford that. It was just beyond reason, and as you know, we're faced with it again right now. Someone said we had buttons that said, "Malpractice Reform Now." They should have said, "Malpractice Reform Forever," because we have our cycles. We're back to it again. As you know, in this state, our reimbursement is very poor — one of the lowest in the country. As a result, we can't meet the rising malpractice premiums. For women this is an especially difficult time, because most women want to become involved, but it's very difficult to become involved when you have to earn a living, take care of your family, be faithful to your career, whatever. So I think those are the things that many are facing.

The greatest joy for me has been working with some of the medical students, working with some of the residents, and trying to help them along in their careers. I was fortunate to get the Medical Student Award one year, and then I got the Young Physicians Award another year. These are the people who are going to take care of us in the future, so we have to be good to them. We have to help them in their futures.

We sent out an e-mail to everyone asking them to call legislators because of this liability reform. I urge everyone who didn't, to please do it. Even if you just call and say how we have to have the type of medicine in this state that we're used to. We have to keep our good doctors. We have to keep them practicing. All you have

to say to them is: we need liability reform now, and we urge you to support House Bill 4702. I think that's so important. The Medical Society is doing its part. They had an ad in the *Globe* today. They had an ad in the *Herald* yesterday, and they had a wonderful WBZ little vignette about why we need to do this. So I think that that's important from the point of view of not only the ones gathered here tonight, but from all of those in medicine in Massachusetts.

There are many rewards. I think Ginger has pointed out some of the rewards that she has experienced. I'm sure Marylou has, too. One of my rewards is having lunch with my husband. I assist him in the operating room. Someone said, who's the boss in your family? I said, I am at home; he is in the operating room. And that's the way we've gone through life. I made a vow when I was an intern at City Hospital that I would not date any of the doctors there. Well, that was broken very quickly when I met my husband. So, we've had a wonderful life together. I know that no two in this room will follow the same path. No two are alike. But I think we're here to help you. That's what we want to be able to do. If you have any questions, or there's anything you want to do, we're here to support you. The other thing is that I'm really happy in my practice. The nicest thing is to have a patient who's grateful. A patient who's satisfied. I tell you my children grew up with hand-made sweaters because all of these patients were so good. I would make house calls, and my mother would ride along with me, and I'd have the children in the car. I would bring the oldest one in sometimes and he got to know the patients. When I did one time, I remember this lady handed him an orange and he said, but what about my brothers? What are you going to give them? Because my mother had said, if you do for one, you do for all, and that sort of stuck with him as well. I am really, as I say, satisfied with my practice, but I'm fighting very hard to keep people who deserve to

be in practice in practice, because as I say, the low reimbursement, the malpractice, let's say premiums that are rising, and the cost of medical practice are making it difficult.

I'm very happy, too, with my children. You have to have a mother there ready to help out and that mother will say the child can go over to her house for the afternoon, and you can pick them up. Two of them turned out to be doctors, one of them is a surgeon, and one's an orthopedic surgeon. My son the orthopedic surgeon is married to a wonderful young women who is a family practitioner. I have two sons who got their MBAs — one of them married a nurse, and one married a nurse practitioner. I have a daughter who majored in ancient Greece, believe it or not, went back and got a teaching degree and now is helping in the office, and said, "I might like to be a physician's assistant." She used to cringe when someone would say, "Are you going to be a doctor like your mother?" She hated that, but now she's going through all the sciences, and we'll see what happens eventually.

*M. D.: Mother Died or
Marvelously Diversified?*

ROBERTA J. APFEL, M.D.

When I was 12, my parents gave me a charm for my birthday. It was a gold doctor's bag that could be opened, and it had a baby inside. This tiny gift came to represent for me the years of encouragement from my parents and grandparents: that I *could* become a doctor and a mother too. As a result of such messages, I felt quite certain when I left home four years later that I could and would have both a career in medicine and a family. I was shocked to realize that the world outside my home did not share this certainty.

I had attended Bronx High School of Science in New York and was a strong science student. Though I had excelled in the first year of pre-med courses at Brandeis University, then a small co-ed college, my advisor told me (in 1955) that girls are not pre-med and that I should find another major. I was appropriately indignant at this categorical and patronizing statement; I went to the dean and requested that my advisor be changed. It was more difficult once I became acculturated to college in the fifties. Only a few women continued in the sciences at all, and I was the only woman in my class who continued as a pre-med student. My friends were male lab buddies, or talented women in other fields who only later in life would go to graduate school and pursue challenging careers. That general liberal education gave me more experience with and appreciation of the arts and humanities and social sciences, all fields that would enrich my whole life.

But, the fifties were also a time of early marriages, and women who were not engaged by graduation became anxious about ending up as old maids. When during junior year, my high school sweetheart and I decided to get married, he proposed that I give up my plans for a career in medicine so that I could finish school sooner and work to support him through medical school. This was, after all, what other friends were doing, and what his sister had done for her husband.

I started to think that made sense, and told my parents that I was considering occupational therapy or teaching after a one-year masters program. My father, encouraged no doubt by my mother and grandmother, fortunately intervened. He took me out to dinner alone, a first I believe, and told me that whatever else I wanted to do with my career, I could do it better and have more options if I went to medical school. Dad reminded me that I had the ability and opportunity and told me he thought I should go for it.

A general practitioner himself who had struggled with poverty and prejudice to attend medical school, Dad loved practicing medicine and enjoyed sharing that love with me and my younger sister and brothers. My parents had met working in a doctor's office, and later my mother worked alongside my father as his nurse, receptionist, bookkeeper, lab technician, and informal therapist. My grandmother had wanted to become a physician in her native land of Hungary, but that path was impossible for women of her time, so she had groomed her oldest and favorite son for this profession, and they in turn had groomed me. Dad's office was in our home and the family and professional activities were intertwined. What I most cherish in retrospect about Dad's intervention was that he never voiced his own disappointment in my wavering, or the loss of his dreams for me; rather, he focused

on what he truly believed would be best for me and my life. The older I get, the more I appreciate his wise counsel at that time, and the more I realize how right he was about medicine as a “marvelously diversified” career.

I took my renewed conviction about medicine back to my fiancé, and we decided to proceed with separate medical schools in the same city. At my interview with Harvard, I was told I was “too marriageable;” at Yale I was told by one of the few women faculty members that women had to find others to rear their children or they would forfeit their careers. Happily, I attended Boston University School of Medicine where I thrived. I was one of only five women in my class, but there was a clubroom, the “Gregory Society” for women students, and a tradition based on BUSM’s origins as a nineteenth century female medical college. After, getting married, however, having a family presented problems. I was sad to see other women students delegating childcare to others so their educations could proceed without interruption. My friends were having children and I wanted to do the same. Emergency surgery for an ovarian cyst in my second year hurried my decision, I feared that I might not be able to have a baby, so I vowed to take time out to have a family, to find part-time medical work, and to be closer to my children’s development. Of course my husband and male classmates, would not take any time off for childbearing or childrearing. I was in a hurry, so I was pregnant when I graduated, and had three children over the next five years.

Another rude awakening occurred when I looked for part-time work. What could one do with an M.D. other than an internship and residency? When I inquired, I got lots of puzzled looks and an offer of a medical secretary’s job for which I was not qualified because I couldn’t type. Fortunately, Dr. Pauline Stitt became

my mentor, and introduced me to folks at Harvard School of Public Health where I did fascinating research part-time on childhood vision screening for several years. I then took courses for an M.P.H. (in maternal and child health) over several years. Mostly, I was home with my children, absorbed in their development, feeling isolated and lacking adult intellectual stimulation, but never bored. For eleven years after receiving my M.D., I followed where my husband's career took us, and managed to find something professionally interesting to do everywhere we lived. I did not always use my training during that time, but I learned a lot about fields related to medicine — public health, well-baby clinics, family-planning clinics, community welfare, grant writing, library research, complementary medicine, delivering and publishing papers. That time helped me to grow as a person, and probably to become more of a maverick than I would have been if had I followed the usual lock-step path of a physician's training.

A major personal/professional conflict occurred around the experience of being a patient. When I was pregnant with my third child, my doctor prescribed DES (diethylstilbestrol) because my second baby had been born a few weeks early. I, on the other hand, had followed the thalidomide disaster and was concerned about teratogenesis. I didn't want to take any medication! My husband and obstetrician told me I was a bad patient and needed to follow doctors' orders. Much to my later regret, after the first trimester, I took the DES. Five years later the FDA issued a warning against its use in pregnancy because it was a transplacental carcinogen. I became more attuned to the dynamics of the doctor-patient relationship, the necessity for trusting my instincts, the importance of working collaboratively with patients, and the intergenerational transmission of trauma.

While working in an under-served area in the South, I realized that I felt guilty about not working full time and not using my professional abilities more fully. I developed a regional women's health program and recruited school dropouts to help me get into the community to find young women in need of care. I became so fascinated by the personal problems of the young women I supervised that I decided to resume clinical training in psychiatry. I was also tired of writing grants constantly to support good works, and realized I would have more time when my children were all in school. Returning to a psychiatry residency full time exposed for me another meaning to M.D. I was on call frequently, stayed at the hospital every third night, was absorbed by my patients, and excited about what I was learning. All of that put a tremendous strain on the family. Although my husband and older two children seemed to adapt readily, my younger daughter was more vocal about her distress. She would page me so that she could share the book she had learned to read that day, and then when I needed to hang up to attend to an emergency, she would proclaim, "Oh, I know, M.D. stands for "Mother Died"!"

It was during that residency that marital troubles became more visible. I was clearly happier at work than with my husband. Though my M.D. was stale, and I could not recognize most of the lab tests after 12 years out of medical school, I felt very satisfied with the choices I had made. Dealing with young children provided an excellent background for work with psychiatric patients. By contrast, my family was experiencing problems, and I went into personal psychotherapy to talk about my dilemmas and conflicts.

My marriage ended at the end of the three-year residency program. There followed a period of tremendous anxiety, sole responsibility for parenting most of the time, being alone for

the first time in many years when the children were with their father, and divorce. I was saved by “marvelous diversification,” my work, then on an academic track, and psychoanalytic training. I still regret the divorce, and I am still pained by my children’s suffering and the long-term consequences for them, even as adults. While for me divorce was a necessary liberation, for young children, it was a central life disruption that continues to affect their lives today.

The liberation for me allowed me to realize how stifled I had felt professionally. I became active in my new profession, both academically and in organizations. I found my clinical work continually interesting and challenging, and very rewarding. I still consider it an enormous privilege to be able to do this work with people who are hurting and willing to share their most private stories, feelings, hopes and fears. However, I began to encounter the academic hierarchy and its bias against women. And sexual harassment, both overt and covert. A prominent medical school administrator told me that women cannot have academic careers because the years between 24 and 35 are the prime time to build such careers and women are busy having babies. I was then 38. When I chaired the Joint Committee on the Status of Women, I realized even more clearly how pervasive the “boys’ club” mentality has been. Reluctantly and begrudgingly, the male-dominated hierarchy “allowed” us to open a daycare facility on campus; it was an idea I had started to work on when I was pregnant with my son and it opened the week he graduated from college! One of the supportive senior faculty members said, “Well, if we had decided to take in one-legged men we would have had to put in elevators; since we’ve decided to admit women, I guess we will have to put in a daycare center.”

When my medical school class celebrated our 25th reunion (1987), I organized a program on women in medicine. Much to my amazement, there was a long and esteemed history of women in medicine in Boston, a medical school, a hospital (the New England Hospital, now Dimock Community Health Center), and a number of older women graduates who could tell their stories. Many of these older women had courageously chosen medicine as their calling at a time when that choice precluded a personal life. There was some concern expressed then that as women became more prevalent in medical training, and they had more choices to work part time, the field could become debased, less prestigious and important.

I now work with medical students and residents, the majority of whom are women. I am inspired by these young people, and their attraction to a medical career, as I was by our older colleagues. They are bright, from varied backgrounds, and want to make a difference in the world by working closely with people's physical and emotional needs. There is so much in the world's health that needs healing; medicine is a great vehicle by which to do one's share.

The greatest good fortune in my adult life came when I met and married my second husband. The quality of this relationship — our ability to talk about everything, the capacity to share the inevitable and unexpected pains and pleasures of life and the fun we have together — have made me realize it *is* possible to have a soul mate and a successful career simultaneously. Also a psychiatrist/psychoanalyst, my husband has a rich full professional and personal life and is an encouraging, supportive, and appreciative spouse. He is my most admiring supporter and my most feared and respected critic. We have collaborated on some projects, most notably work with the children of war. Having a loving partner

really does make an enormous difference in life. Though it seems trite to say, I am daily impressed by the ease of my current partnership. It is hard to believe that we have been together for more than 28 years because our romance is still fresh. Finding the right partner is indeed a blessing.

So, I have come to believe that Freud's wisdom holds true, that having a normal whole life requires love and work. The truth of that teaching lies in its necessity. Love and work are not always distinguishable, but everyone needs different domains to be "marvelously diversified." Work for me has been a creative distraction, a tremendous salve, and a booster of self esteem when I have been personally distressed. The support of loved ones has sustained me through many a professional crisis. We who have received a medical education are blessed to be able to help others ameliorate some of the toughness of life, and in the process we also help ourselves.

The little gold "M.D. bag" charm did not begin to capture the wonder and adventure and complexity of this life, but served as a reminder that you can be a physician without giving up your life.

Becoming a Doctor Later in Life

SOPHIA B. BAMFORD, M.D.

*M*y move to Boston on January 1, 1953, became the turning point of my life and career.

At the close of World War II, my husband, daughter, and I were living in Augusta, Georgia, the home of the Medical College of Georgia. Dr. George N. Papanicolaou had just announced to the world his detection of exfoliated cancer cells in vaginal secretions being studied for hormonal changes. This discovery gave rise to a wonderful laboratory test for the early detection of cancer of the uterine cervix — the “Pap” smear.

Immediately, I recognized an opportunity to use my college training, which included plant pathology and cytology. After a successful interview with the head of the Pathology Department of the Medical College, I joined a team of researchers who were interested in investigating the Papanicolaou method of cancer detection. I entered the field of exfoliative cytology at the very bottom rung of the ladder. My B.S. and M.S. degrees from the University of Georgia ('32, '33) had prepared me for detailed microscopic work. Over the next five years I was able to identify specific cell changes that were consistent with tissue diagnoses of cervical inflammation, cervical dysplasia, and cancer.

Pathologists interested in the new field of cytopathology came to Augusta from a variety of well-known medical schools to attend our seminars. Thus I received offers to go to Boston, Cleveland, Chicago, Seattle, and San Francisco to develop diagnostic

laboratories for cancer screening. I chose Boston and moved there with my family on January 1, 1953.

The newly reorganized cytology laboratory at the Tufts-New England Medical Center was a part of the Department of Obstetrics and Gynecology. I supervised the laboratory and taught technicians and medical students the criteria to diagnose cancer from exfoliated cells. In addition, I was introduced to gynecological research. I felt greatly honored to receive membership in The Society of The Sigma Xi.

In 1955, at age 42, I decided that I needed to broaden the base of funding for my research. I needed another degree, either a Ph.D. or an M.D., to compete with other applicants when requesting grant funds and to facilitate the publishing of my work. While I had continuing support from Tufts University School of Medicine (TUSM), a medical degree would enable me to obtain grants from the American Cancer Society, the National Institutes of Health, and the Medical Foundation of Boston.

After an interview with the Dean of TUSM, I was advised to take the college courses I lacked to qualify for entrance into medical school. I found that I needed only one course, organic chemistry, so I registered at Boston University summer school for the lecture course, and during the next year, I attended the laboratory sessions. To my great surprise I managed to hold my own with the younger students after being out of the college classroom for 23 years. In fact, I added a course in embryology as well.

After passing the Medical Aptitude Test, my next task was to convince the TUSM admissions committee that I deserved a place in the incoming freshman class. Three faculty members interviewed me. Two gave their approval immediately; the third gave me a hard time. He said that he didn't approve of women in medicine, because women doctors soon left the field to marry

and have children, while men could continue practice with no interference, at least for 30 years. I responded that I was married already, that I had completed my family 14 years ago, that I had given 8 years to the paramedical field already, and that I planned to continue my work while I completed the academic courses over a three-year period. I assured him that my health was excellent and that my life expectancy was such that I would be able to serve in my chosen field for at least 25 years after graduation. Finally he gave his approval, and in September 1956, I entered the class of 1960.

I was very pleased that my classmates accepted me as if I were their age, because I wanted no favoritism because of my age or sex. I was determined to make the grade on my own. I was pleasantly surprised to receive the anatomy award at the end of the first year. Complacency is a dangerous thing, so I never allowed myself to become relaxed. I knew the odds were against me, but I could not let down my family and many other supporters. Even though I had a relatively heavy schedule of classes, I put in a full work week in the cytology laboratory. I usually got home around 10:30 p.m., so I had to do most of my studying on weekends. Without the strong support of my husband and daughter, I could not have completed the degree.

I graduated with the class of 1961, as planned. On the advice of my advisor, the dean, and the chair of the Department of Obstetrics and Gynecology, I bypassed internship and residency. After passing the National Boards Parts I and II, I passed the Massachusetts State Boards, received a Massachusetts State License, and joined the full-time staff of the New England Medical Center as a cytologist with M.D. status. This gave me much satisfaction, for now I could apply on my own for research grants, sign my own diagnostic reports, continue to expand the clinical, as well

as research work, continue teaching, and meet my colleagues on an equal footing.

In October 1961, my department head asked me to speak to his colleagues at the Harvard Club about the cytological criteria that I used in diagnosing cancer. I accepted the invitation and was received very cordially. Later that evening it was suggested that I expand my laboratories to include the new field of cytogenetics. I accepted the challenge and opened the door to further research in my field, as well as providing clinicians with another useful test to enrich their understanding of patient problems, that of the human karyotype.

This laboratory proved useful for research as well as clinical studies. I began to publish my findings and to report on them at cytology conferences, both at home and abroad. I obtained support for my research from the American Cancer Society and the National Institutes of Health.

One day while working in the laboratory, I received a phone call from TUSM, asking me to meet with representatives from the Agency for International Development (AID), a component of the U.S. Department of State. The agency was interviewing for a cytologist to go to Jamaica to establish a cytology laboratory as part of the Government Laboratories at Kingston. I was selected, and thus began another rewarding phase of my career.

I traveled twice a year between 1966 and 1971, training and testing laboratory cytotechnicians, touring the island health clinics to teach proper methods for collection of cytology samples, and to reinforce the Family Planning Program, which had been established by the government to encourage population control. I worked closely with the Jamaican pathologist who oversaw the government operation.

In 1968 I was asked to go to Ecuador. For this assignment I asked a Spanish-speaking cytotechnician from my Boston laboratory to accompany me. She stayed in Guayaquil for 15 months and trained the Ecuadorian technicians. I made three trips during that period to test the new technicians and to meet with the doctors. During my final report to AID, I met the Executive Secretary of the Pathology B Study Section of the National Institutes of Health. He asked me to serve on the Pathology B 3 Study Section to review research grant proposals. With approval from my department head at TUSM-NEMCH, I served a four-year term, from 1972 to 1976.

I enjoyed teaching very much. Having advanced from assistant to instructor to assistant professor, I now held the title of associate professor of obstetrics and gynecology (cytology) at TUSM. I also became involved with the newly organized Massachusetts Society of Cytology and served on its first faculty.

As my 60th birthday approached I was completing 20 years in Boston. It was time to reassess my family needs and put my career into perspective for the future. In March 1973, I returned to Georgia to keep a promise I had made to my mother before her death. I joined the Doctor's Clinic in the town of Washington, in Wilkes County, where I developed a medical practice limited primarily to women and adolescent girls. I set up a cytology laboratory in the clinic to process and screen my patients for cancer and hormonal problems. I offered this service to my colleagues, but made no attempt to expand the service beyond the local physicians. I was content to examine and treat my patients, referring all acute medical and surgical problems requiring hospitalization to my colleagues.

I continued my duties with the Pathology B Study Section at NIH and returned repeatedly to Boston to complete my last

research grant from NIH. These Boston visits eased the transition for my family, for they gave us time to adjust to change, and we found the frequent trips to New England very satisfying. We were able to provide an excellent education for our daughter at Wellesley College, and we had enjoyed the best that Boston could offer for many years. Friends wondered why we chose to return to Georgia, but we never regretted the move, for there was another great opportunity to serve.

During the 1970s we began holding free cancer screening clinics. Sponsored by the local Cancer Society, these clinics were a great success. After a single clinic that drew over 1,100 participants we received national recognition from the American Cancer Society. I felt that I had found a way to return, in a very small way, the help that the ACS had given me for research. I served a three-year term as a director of the Georgia Division of the ACS, and I traveled throughout Georgia lecturing on methods of cancer prevention and early detection. Under the auspices of the local Cancer Society, we held many Quit Smoking Clinics and Breast Self-Examination Clinics and public forums. These activities were very rewarding to me.

After I lost my husband to cancer in 1977, I became even more determined to continue this work. For me, medical practice and community work were, quite literally, lifesavers.

In 1979 my daughter and her family returned from a tour of duty in West Germany. Soon thereafter, she decided to seek a degree in dentistry. She attended American University to obtain prerequisite courses, and in 1982, at the age of 41, she entered Georgetown University School of Dentistry. She graduated in 1986 with a doctor of dental surgery degree, having been named the most outstanding woman graduate. I was very proud. Her choice of career, and her decision to seek it after age 40, had given me the

incentive to continue working. In this way I was able to help her financially and to feel a part of the overall effort. Also, I had the pleasure of my grandchildren's visits during their summer vacations. Those memories are irreplaceable.

During the decade of the 1980s, I became involved with the Chamber of Commerce in my county. I served as a director for a three-year term, and as its President during the third year. At the same time I worked on a revitalization project in my hometown of Tignall, Georgia, restoring a historic bank building and converting it into a small library and museum. Through this project, I developed an interest in the history of my region of Georgia. I began an effort, which continues to this day, to preserve that history in the museum's exhibits. With these pursuits and many other interests, I had prepared myself well for retirement. I had often given the same advice to my postmenopausal patients, who were experiencing the empty nest syndrome, or who were terrified at the prospect of "old age." I was gratified that many followed my advice, turned to volunteerism in their communities, and were much healthier mentally and physically.

Retirement in October 1987 allowed me time to join many historical, genealogical, civic, church, and social groups. Soon I found that I was busier than ever, but I still found time to attend medical lectures and other activities associated with the medical community.

In 1990 I was named Georgia's Mother of the Year. This gave me an opportunity to work with mothers of all ages in Georgia and other southeastern states, and I served for several years on the National Board of American Mothers, Inc. During this time I began planning summer programs for children at the local library. Well attended, these are now annual programs in the town of Tignall.

Another community project that has given me great pleasure is the Georgia Humanities Council Adult Lecture Series. Over the past several years, I have obtained GHC grants to provide funding for professors from colleges and universities around the state to come to Tignall to lecture on Georgia history.

My career has taken me to five continents, either to medical meetings, or on work-related projects. Now I am back where I started life, and I can say truthfully that my career and my retirement years have been, and still are, very rewarding. I am enjoying my later years in a rural setting, surrounded by family, friends, and many wonderful memories.

I leave my readers with this thought: "It is never too late to follow your dreams!"

My Story

SELMA DEITCH, M.D.

Upon reflection, I must conclude that much of my early direction was related to naïve assumptions and immaturity. My experiences growing up, I believe, have allowed me to position myself today where my knowledge, skills, and comfort in delivery of health care can be most effective.

I grew up as one of three daughters of a family practitioner and a former operating room nurse. In high school I took the science courses that my friends did not take. My schedule was related to the assumption that I was going to be a doctor. When I was a sophomore, the biology teacher, whose son was a classmate planning to be a doctor, chastised me for responding to a question with an answer different than he had expected. Afterward, classmates clustered around me, attributing his rude response to my “being a girl” and thinking about going to medical school! I had not considered that possibility. Nevertheless, his behavior made me very cautious in class and astutely aware of possible trouble ahead.

When applying to college, I made it clear I was to be a pre-medical student. I was young, age 16, when I began my college studies. My advisor questioned the advisability of a girl being pre-med and insisted that I take scientific German in order to be able to read scientific articles in the original language. My college curriculum was full of pre-med courses with labs. While my friends joined clubs and went to Boston for fun far more often than I, I followed the group of students to City Hospital

to help out after the Coconut Grove fire and, on Saturday mornings, accompanied an upper classman to watch surgical procedures in a glassed-in space above the operating room at Mass General Hospital.

I was young. It was World War II, and a full academic program offered during the summer was recommended, which implied more labs. Most of my classmates were male. I studied with them. One day toward the end of my senior year, I seemed to have a free afternoon when dormitory friends were planning a spontaneous trip to Boston. It wasn't until I was returning to the college that I remembered I had been scheduled to take the medical aptitude test that day. In a moment of responsible panic, I called the testing office the next morning. I was advised, by the man to whom I spoke, that perhaps being a woman with that degree of irresponsibility, I should rethink my intent to be a physician.

I already had a tentative acceptance and was on my way. Tufts had a history of accepting women. I began my medical studies at Tufts the following year.

In medical school, I did not feel a conflict with my male peers, but due to my lack of sophistication, I was aware that I wanted other women to "measure up." I remember in particular my concern over a female classmate who would arrive late to class. That woman later turned out to be the person I most admired. She was a widow with two small children who lived in Cambridge and drove a Ford with a rumble seat. She had to deal with housekeepers, babysitters, school schedules, sickness, and studying without the help of a local support system. My awareness of her situation made me a better person. It helped me to be more cognizant of gender differences in school and beyond and to further define who I was.

There were occasional gender issues, which arose as I moved through residency training and early jobs, but the one incident that most increased my awareness was related to losing an outpatient hospital position I had held for five years. After a new doctor was hired, I was informed by an administrative assistant that the new leader had a problem with women in medicine and asked that I be told “my time was up.” No meeting, no note. I was not comfortable in being forthright to pursue the issue and left. Several years later, the gender conflict issue raised by that physician was confronted by the next generation of female trainees at that institution.

The outcome of that situation was good, however, as I moved from Boston, had a home, a husband with a regular schedule, and an extended family support group (a blended family of children of varying ages). Professionally, I was covering for busy practitioners and at the local ER on the side (where I attended children of working mothers at the end of the day). I was at a decision point in my career. Recognizing my interest in community services, having heard about the stresses of the poor in discussions at the dinner table throughout my youth, the value of teamwork, and my early exposure to the beginnings of Head Start, I applied and was accepted into the M.P.H. program at Harvard. At the time I did not really know where a career in public health would lead, but I followed my interest.

My role as a department head in the New Hampshire Department of Health and Human Services where I had agreed to a four-day week (unheard of) to enable me to be with my children occasionally during the week worked out well for me. I believe that because I was from a moderate two-income family, I felt comfortable articulating what I thought our health programs needed, speaking before social clubs, funding services, and legislative bodies.

In retrospect, when my husband died and I became the female head of household, I realized that my comfort was rooted in my financial stability. I knew that my family's financial support was now my responsibility. I had to think more carefully about a professional support group as I sought to create social change. This was another time in my life that I was made more aware of gender situations that affected behaviors.

In my current capacity as a consultant to various health, school, preschool, and government groups, my experiences have helped make me acutely aware of gender factors that relate to decision making. We all have to be well informed with clear objectives and strategies for carrying out our goal, but I have learned that the camaraderie among female peers can be a great asset. In some situations, success may be attributed to the support received from female peers.

Two-Legged Animal Doctor

CLAUDIA L. KOPPELMAN, M.D.

*L*ife afforded me the opportunity to be anything I wanted to be. At least that was the atmosphere in which I was raised. With hard honest work, you could achieve whatever you set out to accomplish. Starting out with good genes helped.

I attribute the strength of my character, values, and moral being to three life experiences, which influenced me significantly during my formative years.

1. The fundamental teachings of Judaism imparted to me the importance of education, serving others, and living life with respect for the past, enjoyment of the present, and hope for the future.
2. I was the second daughter, and experienced all the trials and tribulations that have been associated with this birth rank. To become an individual I learned the essential need to disregard being compared to my older sister and rejected the title “little me too.” “Why” became a very important word in my vocabulary.
3. Until age eight, I lived in a middle class neighborhood on Long Island where the children my age were all boys. I can honestly say that those early years, playing with friends who happened to be boys and treated me as an equal formed the foundation of my belief that gender is simply a biological difference.

No one would have predicted “medicine” to be my future. No one could have predicted that fourteen years after taking a postponement of admission to Springfield College in Springfield, Massachusetts, to study physical education that I would complete a three-year residency in internal medicine at Baystate Medical Center in that same city and eventually establish a solo practice in neighboring Holyoke, Massachusetts. There were neither doctors in my family nor medical role models in my life. Exposure to the medical world was via periodic office visits to the family doctor and a 10-day stay at the local hospital for treatment of pneumonia at age 14.

I was an athletic, energetic, and inquisitive child. Studies came easily and sports presented me with the challenge of competitiveness along with the experience of teamwork. Studies in ballet transitioned into gymnastics and discipline with piano scales into the rhythm of the drums. Twelve years in the Girl Scouts exposed me to the meaning of volunteering and sharing, taught me to always be prepared and through earning a sash full of badges I explored topics that served to enhance my knowledge base and allowed me to discover hidden talents. Young Judaea brought the opportunity to “learn and see” the complex relationships of countries and diversity of beliefs in the world. Ultimately the ideology of Zionism led me to immigrate to Israel.

I did many things during the six years I resided in Israel, but the most important was that I matured. The carefree days of my youth were replaced with serious responsibilities when close friends lost their lives during the Yom Kippur War in 1973. Life took on new meaning. Three years were to pass before I decided that living in the desert farming vegetables and raising turkeys no longer provided adequate intellectual inspiration for the hippie who had grown up.

I was 24 years young before I embarked on the road that led to a career in medicine.

Returning to the United States to attend college was an easy decision to make. What to study was the question that was to prove more difficult. Although I had been out of high school for six years, an almost straight A average and two parents on the faculty assured me admission in the fall of 1976 to the State University of New York at Stony Brook.

My thought process at this time was relatively straightforward. With self-sufficiency and financial security as “constant factors” in my decision, I asked myself the following questions:

What did I want to do?

Why did I want to do what I would finally decide?

*How did I want to achieve whatever I decided
I wanted to do?*

Where would I do whatever that decision was?

These same questions would surface eight years later when I faced specialty and residency decisions.

We all see opportunities as paths in our lives, which we choose to follow or not. Either action will have its impact upon us by affecting our destiny. The challenge we face is in recognizing the opportunities.

After seriously considering my interests, talents, and realistic expectations, I arrived at a forked path. One led to a career in music and one to a career in veterinary medicine, two very different fields. Music, as an intellectually stimulating means of communicating one’s ideas, was exciting; I enjoyed composing music, writing lyrics, and singing, but I was also very service-oriented

and possessed the inquisitive mind of a scientist. During my life as a farmer, others would often ask my advice regarding their farm animals and pets. I wondered why as my knowledge regarding this was minimal. Did I radiate an aura of authority; a perception of knowledge possessed, or was destiny giving me hints?

My “constant factors” dictated my decision and I enrolled as a freshman pre-vet student graduating three years later with a bachelor of biological sciences and a rejection letter from Cornell University School of Veterinary Medicine. It was a long shot to be accepted before completing all the course requirements, but that did not stop me from applying. I was amongst the select group of 250 students chosen to be interviewed, an experience that initiated the expansion of my perceived options for graduate education from veterinary medicine to medicine.

The following year I remained at Stony Brook University taking a position as a research assistant under the chair of the Department of Anatomical Sciences, a decision that played a significant role in determining my future. First, I was expected as part of my employment to audit the medical microanatomy course as a graduate special student taught by my professor employer. This was a unique opportunity, which allowed me to be a teaching assistant the following year as a first-year medical student. Second, the day I was to mail my central medical school application, three professors from the Medical College of Pennsylvania visited the chair. When they learned that I was applying to medical school one of the professors asked to read my essay and then questioned me as to why I had not considered applying to their school. Another box was checked off and ten dollars was added to the processing check and the rest is history...

A second interview and rejection from Cornell University School of Veterinary Medicine, two medical school acceptances,

one waiting-list position and three more “sorry” letters established my future. My destiny was to be a two-legged animal doctor.

I chose to enter the Medical College of Pennsylvania in Philadelphia over the State University of New York School of Medicine at Syracuse for two important reasons. I knew that I would never be able to survive in a gray rainy overcast city seven hours from my family’s home when given the opportunity to be only three hours away in the friendly sunny city of Philadelphia. However, more important, the average age of entering students at MCP was 26 and the varied student backgrounds appealed to my preference for diversity in life.

Attending MCP turned out to be a very smart choice for me. I was able to learn medicine without pressure to be anything more than a medical student. Although the name of the school had been changed three times since its founding as the Female Medical College of Pennsylvania in 1850, the tradition of professors being women or men who respected women endured. The student body was 70 percent women and the strength of the school was clinical application of knowledge. Female intellectual thought processes helped to solidify the concept that people have diseases or conditions. As a physician, it is our privilege and responsibility to take care of the whole person. Another very feminine attribute was to accept and acknowledge the fundamental fact that we could not “fix” all the bad things that happened to patients, but we could help our patients by caring and showing them respect.

To focus in on the specialty for which I was best suited I asked myself those same soul searching questions that initiated my educational journey. Being cognizant that my internal clock was permanently set at teenage settings supported my rhythm of staying up very late and becoming truly functional when most people were winding down their day; in other words I am a

night person. My aptitude for using my hands and ability for fine motor coordination would never win out over my internal clock, therefore I eliminated all of the surgical specialties. I also recognized that my intuitiveness, capacity for mental challenge and details, along with an ability to listen to more than just the words people spoke, were ideal traits for a pediatrician or internist to possess. Children are wonderful, but after the six-week pediatric rotation during my third year, I decided internal medicine would afford me the most satisfying career.

Selecting a residency program was determined by three factors: location in the Northeast, strong primary care-based program, and close to downhill skiing.

As I stood on the stage of the gorgeous Philadelphia Academy of Music accepting the diploma declaring I had earned my doctorate of medicine I knew I had made the right decision.

I remember feeling amazed at how fast four years had passed. Stage two in my life, to become a physician, was about to begin at my first-choice match, the three-year residency program in internal medicine at Baystate Medical Center in Springfield, Massachusetts.

Sunday July 1, 1984, was a memorable day. It should have been the first day of my residency. It also happened to be the birthday of my boyfriend. How could I miss his birthday? Especially since we had only met in March this would be the first time we could celebrate the day of his birth together. As the saying goes "if you don't ask, you don't get...", of course, it does have something to do with how you ask. I presented a proposal to my assigned resident he could not resist. Instead of spending his entire Sunday at the hospital with two brand spanking new interns teaching them the ropes, he could make quick rounds on the patients and spend the rest of the day with his family, if only he would allow me to

drive to New Jersey to surprise my boyfriend on his birthday. I promised to be at the hospital at eight o'clock sharp on Monday morning. His yes answer also delighted my co-intern. Despite the four-and-a-half-hour drive each way, the surprise was well worth the risk of the request and the reputation of having *chutzpah*.

I learned to be very organized, very efficient and to survive being very exhausted during residency. I also retained my humanity.

I was not afraid to question my superiors' judgment during my evolution from resident to attending. The word "why" was still an important part of my vocabulary. To understand a decisions' rationale was an important learning tool as well as a survival tool. Being a doctor meant acceptance of the responsibility of caring for another human life and the life of our profession. The Hippocratic Oath in all its wisdom would always be the foundation and guide upon which I would practice medicine regardless of dictums or imposed policies.

During my residency, I also learned that support and love from a significant other was an important part of becoming a compassionate balanced physician. On a beautiful blue sky Sunday in September of my third year I married the man I had met skiing just before match day two and a half years earlier. The man for whom I had had the *chutzpah* to request the unthinkable. He was and still is my best friend, my soul mate and the love of my life. He helped me endure through residency by simply being my stabilizing half.

As fate would fall, I was assigned to be on-call in the ICU the very last night of my life as a resident. Par for the course, being as I had started a day late. Only one problem existed. My contractually provided professional liability policy expired at midnight June 30, 1987, and my tour of duty did not end until eight o'clock

the next morning. I apparently was the only resident in the history of all the residency programs at Baystate Medical Center who had ever thought of this detail. I was advised not to worry and that if anything actually happened resulting in a legal action, I would be covered. Rationally this was not an acceptable response as technically my entire resident contract expired at midnight. The only constant factor in this equation was me, therefore, I insisted on the institution purchasing the additional eight hours of coverage. As it was a request they would not pursue I was simply told to switch on-call shifts with someone. Sure, the last night of three years of sleep deprivation, this would be a real easy feat. I stood my ground and returned a polite but insistent response. Either a policy extension was provided, I would sign out at midnight to the ICU attending or they could arrange alternative coverage. I would not work without liability protection. The powers that be chose the last option.

Another lesson learned. Rely on your intuition, protect yourself, and your license because no one else will. I have to this day approached the practice of medicine in much the same manner. My patient's best interests come first. I have retained my ethical principles and I have no reservations being critical of bureaucratic red tape or returning whenever possible the burden of responsibility back to the originator. It is surprising how much extra work the medical community has had bestowed upon it, simply because they did not object or refuse to accept the extra tasks. In these situations "if you don't ask, you get it all."

Stage three in the life of this physician began in an acute care center. Residency had prepared me for the practice of internal medicine in a hospital setting. Now, I needed to learn about the practice of everyday outpatient medicine. I thoroughly enjoyed my stint as a "Doc in a Box." I had time for a private life and

personal pursuits, time for eating and sleeping, and no responsibilities for on-call or hospital rounds. This experience transitioned me from resident to attending physician. This rewarding experience abruptly ended ten months later when I required emergency surgery.

Recognizing a medical emergency requiring a surgical intervention was easy, getting past the denial stage took a few more moments and fortunately I had less than an hour to contemplate my condition and possible consequences thereof. I transitioned from doctor to patient smoothly as I entrusted my life to my own doctor. Trust is the most important factor in the patient-doctor relationship. It allowed me to remain calm in an otherwise extremely scary situation. The experience reinforced my commitment to always remember that a few words of comfort from someone you trust mean more than the words themselves. Patients do appreciate the few extra moments physicians take to convey they care about the person they are treating.

To heal one needs to feel

To feel one needs to listen

To listen one needs time

Time allows one to share

To share is to care...

...and caring heals.

The next three months while recovering afforded me lots of time to reflect on life's fragility and resulted in a decision to live life a bit backwards. Enjoy retirement first while we were still young and flexible. There would be plenty of future to practice medicine.

Once again, I stepped out of the 'box' of the expected without hesitation.

Traveling fifteen thousand miles around the United States and Canadian Rockies in a converted van, my husband and I enjoyed the freedom of deciding each day what to do and where to go. The "Sailing Free" engraved brass plaque on the dash said it all.

Four-and-a-half months later, we faced the reality that unlike retirees who had planned and saved for retirement, we now needed to settle down and rebuild our financial base.

I accepted a part-time position in another walk-in center, which included one night a week on-call and minimal hospital duties in order to allow me enough time to study for my Boards. Nineteen eighty-nine would be the last year for certification without expiration. I have always abhorred the multiple-guess question exams therefore; I had all intentions of passing this last official test affirming my proficiency of knowledge in internal medicine.

After returning from the two days of filling in black dots, I was offered a full-time position with the same employers, but with the intention that I would develop a full time independent internal medicine practice at a satellite office. Together with another associate, I would be responsible for all the in hospital care of patients from our practice as well as from the walk-in center. This was too ideal. Imagine being paid a salary with benefits to establish a private practice including all the decisions for decor and equipment. The day-to-day operation of the office except coding, claims submissions, and reimbursements was my responsibility. I worked diligently and gained experience without worrying about paying overhead. As an employee, I had the opportunity to concentrate on developing a patient following. After eighteen months and two associates who simply did not have the same

work ethics as I did, I announced my desire for independence. If I was to be held accountable for 100 percent of everything pertaining to the practice, I wanted 100 percent control of all decisions. I took a course in CPT and ICD coding, purchased a computer system, and despite a volatile healthcare market, on May 1, 1991, after a fair dollar exchange for the depreciated value of the equipment, I assumed responsibility for the same office space where I had been practicing. I was especially glad to be able to retain the same phone number. Destiny was looking out for me. The last four digits were of particular significance, one-eight, one-eight, or as I saw it, eighteen, which means double life in Judaism, a perfect number for an internist. And so began my life as a self-employed solo internist, devoted to preserving the “Art of Practicing Medicine,” a decision I have not regretted.

Opportunity knocked; I made wise choices and created my own mold.

My success in creating the life I live is also due to a very supportive husband who shares the office practice experience with me. His wonderful personality handles the pressures of the front office with skill and a charming attitude, alleviating a usual source for stress in any medical practice. Taking time off together never is a problem; it simply takes advance planning at which we have become superbly adept. My night and weekend coverage arrangement is with another solo internist. We both practice medicine in a similar style and cross-cover each other as if we were a group practice, but without the inherent stresses of a contractual arrangement. I take at least eight weeks of vacation each year including a four-week block each summer to enjoy sea kayaking, hiking, and RV'ing with my husband. In addition, holidays and days for organized medicine meetings are interspersed throughout the year, allowing additional

time off from the daily intensity of practicing medicine. With good planning, anything is possible. As important, my reliable, loyal, and well-trained staff afford me the ability to pursue diversified interests while still managing a full-time solo internal medicine practice.

One of those interests is actively participating in the voice of medicine through the Massachusetts Medical Society. Protecting the patient-physician relationship and professional status of physicians by limiting third-party intrusion in the practice of medicine is an important issue and the compelling force behind my involvement in organized medicine.

I make the time to participate and I am not timid in addressing controversial topics and issues. By simply stating the obvious and challenging others to run a reality check, I can influence decisions. Through my work in organized medicine, I have helped to move our mission of advocacy for patients and physicians from a reactive to proactive position. Having first-hand experience with and knowledge of the burdens being placed on physicians from third parties positions me to advocate for meaningful health care reform, especially in these turbulent times. To build onto the past a bridge to the future requires perceptive choices in the present. The ability to stimulate others to see and act on those choices defines leadership. I cannot say I was born to be a leader, but rather the sum of my personality, life experiences, and abilities influenced the development of this trait. Acceptance of this attribute and a willingness to help effect changes has earned me respect from colleagues as well as honors, awards and officer positions.

The challenge of recognizing the need to refresh my spirit and energy was a learning process of balancing responsibilities and needs.

I now make time to enjoy my creative side and stimulate inner balance through bead weaving jewelry, sewing original designs, and writing poetry. I make time to enjoy my husband's company. I make it a point to emphasize the 'be' in human being. Most of all I make practicing medicine as enjoyable as I can by remembering nature is balanced. For everything organized something else must be chaotic. Therefore, if my charts are in order, it is okay if my closet at home is a mess.

To be different and not follow the crowd does not take courage, but rather honesty with oneself. To think and act outside the box can lead to exciting new possibilities. Knowing my limitations, being loyal to my ethics, my profession and myself and not being afraid to challenge or change has allowed me all that I have achieved. We each chose a life in medicine for different reasons. Remaining cognizant of that reason empowers each of us to create the professional mold that fits our own personal needs and lifestyle.

In the quiet hours just before dawn

*the world is in balance before we awaken
and disturb the silence*

*capture the meaning of nature's gift,
through harmony of sounds*

*the song of earth's wisdom,
balanced on the edge of silence.*

Climbing Lombard Street

MARY KRAFT, M.D., M.P.A.

I have been searching for inspiration to tell the story of my life in medicine, and I found it on this day before Rosh Hashana. On the last day of the year, one looks back and then forward, and so I begin my story in my childhood synagogue at Rosh Hashana.

The leaves have fallen. Yellow, orange, red, and brown, they make a majestic carpet on the steps of the synagogue. The sun casts a mystical light on the simple wooden pews. The men sitting in front are wrapped in their prayer shawls and rapt in the chanting of the ancient Hebrew prayers. I sit in the back with my mother and the other women, dressed in new clothes for the New Year, itchy labels and all. The women gossip and I find it distracting. I want to pray in my childish way, enveloped as I was in the sounds, the sights, the smells, and the awe and mystery of the idea that G-d starts to review the lives of His people on this day. The Book of Life will be open for the next 10 days. On Yom Kippur He will close it, and those names omitted from inscription will not live out the year.

My appreciation for awe and mystery in life and religion would return in the spring at our family's Passover Seder, where every year we retell the story of G-d's freeing us from slavery in Egypt. An integral part of the story ceremony is the exhortation to tell your children and your children's children of our miraculous release from bondage. I can still feel my father's eyes upon me as he intoned these words in his sonorous bass voice.

In between these two occasions I led a very secular life. One summer, when I was 11 or 12, I read the biography of Sir Frederick Grant Banting, one of the discoverers of insulin. He was inspired to become a physician/researcher by the death of a childhood friend from diabetes. I was inspired by his story to pursue medicine as a career. I didn't realize it then, but this call to service came from a child's desire to save lives; to help G-d inscribe more names in that Book.

At the end of my sophomore year of high school, I read an article in the *Milford Daily News* about Katherine Cocchiarella, M.D., who had just graduated in the first class of Boston University's six-year program in liberal arts and medicine. I immediately sent away for information from the university and found a path to my dream. The tragic irony is that shortly after I was accepted to the program, Dr. Cocchiarella died from meningococcal meningitis, and I never had the chance to thank her for the inspiration.

In my third year of medical school I developed a love for orthopedic surgery. There had never been a woman resident in the Boston University (BU) orthopedic residency (at the time, 1973, there may have been only one female orthopedic surgeon in Boston). So, in December of my senior year of medical school, I packed my bags and spent the month in Springfield doing a pediatric orthopedic elective at Shriner's Hospital for Crippled Children. I loved pediatric orthopedics! Some of the awe and mystery I experienced as a child returned. I remembered Tiny Tim's words (to mix a religious metaphor) about remembering who made "lame beggars walk and blind men see." I thought it would be wonderful to be G-d's agent in such an undertaking.

I applied and was accepted to BU's orthopedic residency. As a long shot, I also applied to the orthopedic residency program at the Massachusetts General Hospital (MGH). When I went to the

MGH for an interview (and back then it was a whole day of interviews with orthopedic surgeons at several Harvard hospitals), I was told that they never had a woman resident. I was accepted!

Orthopedic residency first requires two years of general surgery. I ranked BU's program first in the match. The great attraction at BU was Boston City Hospital (BCH), where the social condition of the patients may have been down and out, but appreciation for medical care (even by the lowliest medical student) was over the top. Opening the envelope on Match Day, I was delighted to find that I had indeed matched at BU, and I thought my life was programmed for the next seven years.

A little anxious about starting my internship in the BCH Emergency Department, I had a conversation with a wise friend and surgeon who told me he also started his internship in the ED. He gave me sage advice. He told me I should listen to the nurses' opinions — "they've been there longer than you have."

BCH was a great place to train. The teamwork among house officers, attending, and nurses was spectacular. One of my chief residents, Baltej Maini, M.D., was respected for his surgical expertise and kindness to patients. At least once every day on rounds he would ask each of us, "Have you loved your patients today?" He taught us to be as compulsive in the niceties of medicine as in the technical components. He was ferocious about attending to the daily details of medical management and about treating patients with kindness and respect. (On more than one occasion after Baltej went home, the senior resident and I would scream to each other for 15 minutes out of frustration. We thought we had done our best, but we felt Baltej thought otherwise.)

This teamwork applied to our daily lives as well as our physician personae. Thanksgiving 1975 was one of my most memorable. As the holiday approached, a number of us interns

realized it was the first holiday that we would be away from our families. The cuisine at BCH was less than notable, and the ward kitchens in the Dowling Building were still functional, though unused. We developed the idea of making Thanksgiving in the ward kitchen — a feast for all of the surgical house officers on call that day. We divided the labors of menu planning, shopping, and cooking, and then covered each other's tasks while the meal was prepared. I had turkey duty. Stuffing the turkey at home but finding myself with no string with which to truss it, I sewed the cavity shut with the zero silk suture I found in the pocket of my white coat. Tying knots was never so pleasurable! The meal was a great success, and in the brief moments of peace while we were eating, feelings of thankfulness washed through me, and made the holiday a very special one.

By March of my internship year I was starting to get a little weary. Eight months of every other night, every other weekend on call was getting to me. One Saturday afternoon in March when the service I was covering was very slow, the senior resident offered to cover me for two hours so I “could go out and play.” I went to visit a friend who lived a few miles away, and I found myself squinting in the sunlight, trying to figure out why it was so bright. I realized that for the better part of a year I had been a gnome, and suddenly decided that the beauty of the day and the joys of visiting a friend were more important to me than working up one more fever. I had to change my life.

I also recognized that the surgeons I admired most were in the hospital almost as much as I was. Did their families remember who they were? Did one of the most dedicated surgeons, who had many children, just make them and leave? When did they play with their children? When did they talk to their wives? (There were no women attendings then.) I wanted my family and children to

know me. How, I thought, was this lifestyle compatible with that part of my dream?

Then one day in the operating room a very kind and patient surgeon was teaching me to do a cholecystectomy. I had done about a dozen at that point, and I was still fumbling. He was elegant, operating upside down and backwards, and like a rock falling on my head, the epiphany happened. As much as I loved surgical patients and the operating room environment, I just did not have the three dimensional perception it takes to do surgery. I had studied atlases, and I could tell you the process of the operation and which thing to cut when, but confronted with a real patient with real anatomy, I couldn't make the pieces go together without a huge struggle. Just maybe it was time to change specialties.

Change to what? I vowed I would never repeat an internship. I started to explore the possibilities. According to my research, the only two specialties that would not require another internship were anesthesia and nuclear medicine. In the abstract, neither one excited me.

I also struggled with the idea that because I was the first woman to be accepted into the MGH's orthopedic residency, if I switched specialties I would be letting them down. I still loved orthopedics, but when you're deep in a hip joint, it's important to know the subtleties of positioning. I sat with legos and an instruction book and agonized over how the pieces fit.

Meanwhile, I needed a job and health insurance, so I started my surgical junior residency July 1, 1976. My first rotation was anesthesia, and I enjoyed it. I was in an operating room, I didn't have to cut, and the instantaneous feedback of the interplay between physiology and pharmacology was fascinating. Maybe anesthesia was the specialty for me. I thought a lot about it and consulted

a friend and respected anesthesiologist at University Hospital (UH), Marlene Meyer, M.D. Marlene suggested that if I were seriously interested in anesthesia, I should investigate the program at MGH and talk to Dick Kitz, M.D., the chief. (Marlene subsequently joined the MGH staff, and she and I are now colleagues and still friends.)

And so the application process started all over again. Dr. Kitz invited me for an interview. As I sat outside his office, filled with post-call haziness and pre-interview anxiety, a man in scrub clothes came in and danced around the office. After introductions, I discovered that this man was an anesthesia fellow and the brother of one of my favorite radiologists from UH. Dr. Kitz, a kind, avuncular man, made me feel at home, and I thought the interview and the subsequent ones with other members of the staff went well.

Having discovered through my orthopedic interviews that MGH physicians were a little quirky, I was surprised I made it through almost a whole day of interviews without an off-putting remark. It had to happen, of course. Elliott Miller, M.D., was my last interviewer of the day. It was 3:00 p.m., and I hadn't slept in a very long time. He looked at me, and out of the blue — or so it seemed — asked me if I had sight in my left eye. Startled, I realized that my left eye was wandering, which is something it does when I'm sleep-deprived, and I explained it to him.

At the end of a very long day, I returned to Dr. Kitz's office for a wrap-up chat. I told him I had already accepted a position in the orthopedic residency at the MGH, and hoped he would make a decision soon so I could tell MGH. He assured me he would, and I left for some sleep.

True to his word, Dr. Kitz called me a few days later with the good news that I was accepted and could start the following July.

A prominent hospital administrator took the news with aplomb, but never forgot. For years afterwards he reminded me in good humor and always in public that I was the first woman he accepted to be a resident, and then I turned him down.

After two years of every other night, every other weekend on call, the MGH residency, with its every-third-night call seemed like heaven. Not only that, but the ICU patients had arterial lines, which meant I didn't have to assemble the stuff to draw a blood gas, hold pressure on the artery, run halfway through the hospital to the blood gas lab, and try to get back to the ICU before the results were called back — something I did quite regularly at BCH.

I really enjoyed anesthesia. My job was to take care of only one patient at a time, and I could concentrate on the patient in my care without the distraction of beepers.

One day in December 1978, I received a call from one of Dr. Kitz's secretaries. "Dr. Kitz would like to see you. Can we make an appointment?" She wouldn't tell me the nature of the conversation, and my immediate response was, "Uh-oh, what have I done?" I couldn't remember anything awful, so I made the appointment, and when I was ushered into Dr. Kitz's office he was smiling. He wanted to give me an early Christmas present. He asked me if I would be interested in being a chief resident for the next year (there are only two a year in the Anesthesia Department). He told me that if I were to accept the position, I would be making history as the first female chief resident in the Department of Anesthesia.

So I made history. I was not the only history-maker that year at the MGH, for it also saw women as chief residents in the Departments of Surgery, Urology, and Radiology. In my role as chief resident, I scheduled residents for night-call and rotations,

ran interference between the residents and the faculty, and served on several committees. Yet life was sometimes lonely at the top. In my perception, “the boys” who held the job were being groomed for future chiefdoms, while “the girls” did the same job but were not privy to the same kind of education.

In December 1979, one of my favorite attendings announced he was leaving the MGH as of January 1, 1980. I asked Dr. Kitz if he had hired a replacement. He had not, and so I asked if I might have the job for six months. (I had been hired to be a staff anesthesiologist at the then Boston Lying-In Hospital, a position that would start July 1, 1980.) Dr. Kitz thought the idea was a good one, and the deed was done. I didn't know it at the time, but I set a precedent of the chief hiring residents as interim staff until they could begin their next appointments.

One of the attractions to the Boston Lying-In Hospital was its chief of anesthesia, the late Milton Alper, M.D. He was a gifted teacher and a truly genuine man, and I was very much looking forward to working with him and learning from him. I was not the only one who admired him, and in March 1980, he was named chief of anesthesia at Boston's Children's Hospital. Dr. Kitz, knowing my admiration for Dr. Alper, and also knowing the patients served at the Lying-In would soon be moved to the new building combining it with the Peter Bent and Robert Breck Brigham Hospitals, asked me if I wanted to stay at MGH “until the dust settled.” I agreed.

My new plan (it seemed there was a new plan every six months or so) was to stay on staff at the MGH until I passed the oral anesthesia boards and then move to the San Francisco area, where several of my good friends had relocated. With every switchback, life has many surprises. Much to my surprise, Cupid intervened in this plan, and I married a colleague, Donald P. Todd, M.D., on September 10, 1981.

I am Jewish, Don was Episcopalian. By this time, I had mostly stopped practicing Judaism, but still believed that the wonder in the world was created by G-d. Don and I had similar world views, although he practiced his religion on a more regular basis than I had ever practiced mine. I joined him at church, where I once again found that sense of awe and mystery, where men and women sat together, where gossiping during the service was frowned upon, where the services were in English and only lasted an hour, where the music was pleasant and the people were welcoming, and the whole experience was very positive.

At work, I continued to work full time in the operating room. Don and I bought a new house, moved in, invited all of our friends and family to a housewarming party, went to Bermuda to celebrate our second anniversary, and life couldn't have been better. About a week after returning from Bermuda, I woke up one morning so nauseated I could hardly get out of bed to get to the bathroom to throw up. I thought I had "caught something" in my travels. Indeed I had, and nine months later Gordon was born.

Dr. Kitz, coming of age when he did personally and professionally, was a curious mix of an old-fashioned man (motherhood and apple pie) and modern chief (more and more women were being hired as residents and staff). I asked and was granted a year's leave of absence to stay home with my baby. By then I already knew what it was like to have a career, but I didn't know what it would be like to be a mother, and I really wanted to devote my energies to the task.

One of the attractions to the practice of obstetrical anesthesia was that I could be present at the moment of birth. Every time I was in a delivery room, I marveled at the miracle of a lump of blue flesh taking its first breath and letting out a scream. I was no less impressed when my son was born. When I first saw him, he

looked at me with “googly” eyes — his expression seemed to say, “So you’re the lady I’ve been listening to these past months.” I was filled with awe.

After experiencing motherhood for a year, I returned to work — part time. As grateful as I was for the time off, I was also grateful for the opportunity to work with adults and take care of people who could tell me what hurt. There were days and nights when life was a bit overwhelming, and I seriously wondered more than once if those women who wrote about managing careers and children lived in the same universe as I did. No one ever admitted how difficult it was sometimes, or how torn one feels being on call on a holiday.

I thought I knew what overwhelming felt like until 1994, when I really discovered what it means to be overwhelmed. My husband was several years older than I. When we got married, he was already a grandfather. The grandchildren and I became very close. They enjoyed visiting with us, taking care of Gordon, and having us treat them to their favorite foods and special field trips. In March 1994, grandchild Hannah was home for spring break. She called me to ask about physicians. She had just been diagnosed with malignant melanoma.

I was grateful she called me on the telephone rather than telling me this news in person, because I’m quite sure I turned pale at that moment. I felt overwhelming nausea, and yet I managed to stay calm and just answer her questions. All those years of practicing medicine did teach me how to wear a mask when the occasion called for it. My mind returned to medical school, where one of the students a year or two ahead of me had a wife who died of malignant melanoma while we were in school. I wondered if medicine had progressed in the intervening years.

Fast forward to May 1997. A few days before her 24th birthday, Hannah is given the news that there is no more science can do for her. She chooses to spend her remaining life at our house with her parents, her siblings, her friends, and her spiritual advisor making frequent visits and staying with us on an ad hoc basis.

No more science can do! I work in the hospital that represents the cutting edge of medical science. I am a physician, I am a mother, I am a wife, and I am a grandmother, and by definition, I do. But what does one do when there isn't anything to do? I learned to be. I learned to find peace in meditation. By this time, I had wandered back into Judaism (I was so used to praying directly to G-d, I decided I couldn't honestly adapt to a mediator). My rabbi gave me a copy of a Debbie Friedman tape in which she sings the "Mi Shebairach" (the Hebrew prayer for healing). The prayer became my mantra. There are two verses: in the first are the words "help me find the courage to make my life a blessing;" in the second, we ask G-d to help those in need of healing (renewal of body, mind, and spirit). Eventually I understood I had to take care of myself, to pray for courage so I could do my best to be there for the rest of the family. I came to understand the healing powers of love, as the family drew strength from each other at this painful time, and that together we could still laugh, eat together, and savor every moment of Hannah's remaining life.

Hannah died in July 1997. After I returned to work, I found that I had new patience with patients who were going through difficult times in their lives. I remembered the strength and healing I took from the healing services conducted in my living room by Hannah's spiritual advisor, Reverend Thomas Shaw, (Episcopal) Bishop of Massachusetts. If the patients wore religious symbols, I asked them about their faith. These patients seemed happy to talk about what was important to them.

Then I read in the MGH in-house newsletter about an opportunity to apply for a fellowship in clinical pastoral education. This new program, sponsored by the Chaplaincy of the MGH, was an effort to teach health care professionals how to give spiritual care to patients in the course of their individual practices. Fellowship money was being awarded on a competitive basis by the Kenneth B. Schwartz Center to further the Center's mission "to support and advance compassionate health care in which caregivers, patients and their families relate to one another in a way that provides hope to the patient, support to caregivers, and sustenance to the healing process." I applied, and I was the first physician to be a Schwartz Fellow.

When I started my fellowship, my family was still attempting to get back to "normal" following Hannah's death. We thought we were succeeding pretty well until late February 1998, when Don began having unremitting indigestion and was diagnosed with pancreatic cancer. My clinical pastoral education classmates were among the first people I told about this, and they were there with me, supporting me, listening to me rant and rave, and holding me and my tears. They asked me if I would drop out of CPE, and I declined, cutting back work to be with Don, but keeping CPE and its tightly knit community for my own sanity.

The switchbacks on Lombard Street are beautiful, but some of the switchbacks in my life have been quite stark, and the death of my husband was by far the starkest. Don died two weeks before our son started high school. Life was overwhelming at times, but there is a certain dignity and strength that comes from just getting through another day, and my meditation practices were useful. I promised to teach other physicians what I learned in CPE as part of my fellowship agreement. I discovered that as I gradually moved out of the darkness of my grief, speaking about

spirituality in medicine was healing for me. As I applied what I learned to the care of my patients, I found many grateful patients who kept remarking (and still do), “Oh, I feel better now.”

According to Canadian physician Edward Livingston Trudeau, it is the physician’s purpose to “cure sometimes, help often, comfort and console always.” These words have a newer, richer meaning for me now. Every time I speak with a patient, my intention is to comfort and console with my personhood as well as my drugs and medical expertise. I am filled with curiosity about the patients’ lives and they are glad to have a chance to tell their stories, as I am grateful for this opportunity to tell my own. Sometimes I assist them in recognizing the remarkable strength they bring with them, we mutually admire it, and they realize they can make it through the imminent procedure or the operation for which I’m anesthetizing them.

I have also been graced with the good fortune to be the course co-director of “The Healer’s Art” at Harvard Medical School. This course, developed by Rachel Naomi Remen, M.D., has been taught by her at UCSF Medical School for the past 12 years. Among the goals of the course, as stated by Dr. Remen, are the following:

- Identify, strengthen, and cultivate the human dimensions of medicine
- Recognize the commonality of personal concerns among their peers and gain support for personal development from peers and faculty
- Trust the power of listening and presence to heal others
- Recognize that who they are is as important to their patients as what they know

This course was very successful in the past academic year, and my course co-director, HMS Dean of Students Nancy E. Oriol, M.D., the student steering committee, and I are looking forward to presenting it again.

It's time to rest now. It's been a long, hard climb up to this part of Lombard Street in the warm San Francisco sun and the cold San Francisco fog. I finish my story where I began, at Rosh Hashanah. I went to a very special "alternative" service this year. Led by Rabbi Donald Pollock, the theme of this service was "Who's Listening?" As various people stood and told their stories, I experienced a sense of healing — in the words, the light, the smell of the wood in the room, and the prayers.

Here in Boston, the sun rises over the water. Every day I am grateful for what I have and I experience joy in seeing the sun rise. When I make it to the top of Lombard Street, I'll be able to see the sun set over the water, and I imagine that experience will also fill me with awe, mystery, and inspiration.

Pregnancy During Fellowship

KWAN KEW LAI, D.M.D., M.D.

Approximately 20 years ago, I arrived at my fellowship program when I was in my second trimester of pregnancy. I avoided starting a family during my internship and residency precisely because I did not want to encroach upon already overworked colleagues for coverage. My grand scheme was to take a year off after my residency and work part-time. If I contemplated starting a family, a short-term commitment would not disrupt the schedule of all concerned.

As fate would have it, during my third year of residency, I was asked to consider starting my fellowship program right after my residency and not the following year as originally planned. This early start would certainly disrupt my carefully crafted plan. After consultation with my chief of medicine, not telling him of my desire to begin a family, I was advised to accept the early position because there was no guarantee that such a position would appear again the following year.

At that point, I decided to proceed with my plan of starting a family as well as to embark on my fellowship program. Thus it came about that I started my fellowship program during my second trimester of pregnancy. My due date was in December and I realized that I was scheduled to take night calls throughout that month. The senior fellow who made up the schedule did not anticipate this “problem” and left it up to me to swap with other fellows. My main concern was how to request a maternity leave. My consultation with the hospital legal representative brought to

light that I could take up to two months of unpaid leave, but that I would not be guaranteed a job when I returned.

I gathered enough courage to discuss the duration of my leave. My chief of infectious disease was puffing on his pipe with a beaker of Coca Cola right next to him. He stopped puffing and there was a pregnant silence. Finally he peered through the haze and told me that he had never been confronted with this problem before. The woman fellow ahead of me did not get pregnant, and therefore he did not know the answer to my request.

After weeks of mulling this over, I decided that I would give myself a two-week leave. A fellow's wife who had a child told me that was unrealistically short. I was allowed a four-week vacation for the year. I finally settled on taking my vacation in lieu of maternity leave as the best solution to the problem of not disrupting anyone's schedule.

One-and-a-half months before my due date, my chief assigned me a project for an article. I religiously analyzed the data and researched the topic, knowing that despite the impending arrival of the baby, I would be expected to complete the project on time. My due date finally arrived. Two days after leaving the hospital, I was already taking night calls in between nursing the baby, as I did not swap my schedule with any of the fellows. I also used the night feeding time to read articles for my project and begin writing. Despite fatigue, the exhilaration of a new baby spurred me on to prove to my program chief that I could produce against all odds.

I returned to work after my four-week leave. I cannot describe the despair that I felt in leaving my tiny newborn to a sitter. The fact that she was a kindly lady and an experienced sitter eased the pain a little. I met with my chief when I returned. The first matter of concern to him was the assigned project. He was obviously

pleased that I wrote the first draft during my leave. It was not until I stood up to leave the office when he asked about the baby. I was disappointed. Nevertheless, I hoped that his first encounter with a pregnant fellow would not be his last and that I had afforded him the opportunity to prepare himself for the next woman fellow who became pregnant.

I was determined to continue to breast-feed for as long as I could. As the fellows' room was shared by my male colleagues, there was never a private area to breast pump. I had to resort to pumping in the ladies' room. Relief from breast congestion and the desire to keep up milk production necessitated pumping after morning work rounds and just before afternoon attending rounds. I was able to breast-feed for over a year. Being the only new mother among the trainees, I could not share my struggles or how I maintained my sanity between a busy fellowship training and motherhood. The joy and reward of having a baby was the only sustaining force throughout that difficult period.

Over the next few years of my medical career, I had two more occasions when I had to announce my pregnancy and arrange with a male superior for time off. It remained awkward, embarrassing, and difficult.

Nowadays, it is not unusual to see pregnant students, interns, residents, and fellows on the wards. Programs are becoming more flexible in arranging time off and time-sharing opportunities in order to accommodate child rearing. I often encourage new mothers to keep up with their breast-feeding for as long as they can. As the number of women in medicine is increasing, it will become more and more acceptable to raise a family during training. Hopefully, the difficulties that I faced will be a thing of the past.

Achieving Balance

CINDY B. LEVINE, M.D.

I'll never forget August 20, 1984. That's the day I got a call from the Admissions Office at George Washington University School of Medicine offering me a position in the class of 1988. It had taken me a while to figure out I wanted to go to medical school. I was always interested in biology, but was afraid I wasn't smart enough to get into med school. Instead, I majored in medical technology. Classes were interesting, but I found the lab work dull and uninspiring. My favorite part of the day was the patient interaction that came while I was drawing blood. By the time I graduated, one thing was clear to me: I had to go to medical school. The pre-med advisor at my university, an older unsympathetic gentleman, told me, "Your application won't get past the secretary's desk." My GPA was only 3.5, and he advised me to choose another path. But nothing would deter me.

After graduating from college, I worked full time in a hospital lab while taking physics, organic chemistry, and studying for the MCATs. I remember my mother asking me, "Who has a gun to your head?" I answered, "Me." I had three interviews and I was on two waiting lists, but I didn't get into med school on my first attempt. I didn't ever consider giving up. I went to graduate school in clinical pathology and managed to get a 4.0, while taking several medical school classes. I applied again — and this time, I was accepted. My life was set. I'd be learning medicine and taking care of patients.

Medical school was tough, but I enjoyed it. My class was 50% female, and I didn't feel any major discrimination because of my gender. I ran into an occasional sexist resident who told me I should be home having babies, but the main discomfort I felt was due to the culture of barbaric Socratic teaching, otherwise known as "pimping." I have always been opposed to this practice, because it leads to an environment of fear and embarrassment, which is not conducive to learning.

I did my internship and residency in primary care because I liked taking care of the "whole patient." I accepted a position in a small group practice on the North Shore of Boston. After a few years, our practice was purchased by a hospital. Although they promised not to intervene with our practice of medicine, they introduced many money-saving schemes such as firing nurse practitioners and increasing the number of patients we each were required to see in a day. Life got progressively more difficult.

Typical day in my life circa 1999: I leave my sleeping husband in bed and rush around frantically to get to the hospital to round on my in-patients. By the time I get to my office, there are two or three patients waiting, and I climb on the treadmill we call office practice. Twenty-five people are scheduled for appointments, but I know I'll end up having to squeeze in four or five emergency visits. I rush from room to room, hoping no one will dare to be sick, which would put me hopelessly behind in my schedule. If someone is depressed and needs to talk or cry (a frequent occurrence), I try to find the right balance between listening to them and getting them out the door. If someone needs to be admitted to the hospital, the whole day is shot. I try to remember that the patient being admitted is having a worse day than I am, but I'm not always so sure!

The day passes, and calls flood in from the hospital, emergency room, patients, and other doctors. None of my notes are finished. I rarely eat lunch. I usually don't even remember to go to the bathroom all day. When all the patients are gone, I go back to the hospital to finish up whatever I didn't do in the morning, and then back to the office to attack mounds of paperwork. On a good day I'm home by 10:00 p.m., though always with paperwork in tow. On a bad day, my husband is already asleep when I get home. Sometimes I accuse him of just staying in bed all day, but he assures me that while I'm gone he indeed gets up, goes to work, comes home, then gives up waiting for me and goes to bed.

I thought about changing practices, but I was afraid it wouldn't be better anywhere else. My friends at other practices all had similar complaints. Should I just put up with it for another 25 years? After all, I was a doctor, I was helping people — it was all I ever wanted. But I was an angry, cynical doctor. I yelled at people. I had headaches all the time. Advil was my constant companion. I didn't eat right and I never exercised, aside from running around the hospital. I knew I had to make a change.

I asked if I could work part-time. I thought setting limits might help me gain some perspective. The response from my less-than-sympathetic male colleagues? "You don't even have children. Why should you work part time?"

I found a position at a company that performed systematic literature reviews for pharmaceutical companies and government agencies. I didn't miss my beeper, but working in industry has its own stresses. The work was very interesting, but not too satisfying. I missed taking care of patients. I tried to keep up my clinical skills by volunteering in free health centers and teaching medical students.

This wasn't enough for me. After three years, I looked for a clinical position, with the following criteria: 1) part-time; 2) out-patient only; 3) computerized medical records; 4) teaching opportunities.

I was pleased to find a practice in the Boston area that met all my requirements. As of this writing, in early 2006, I have been back in practice for more than three years. I have the flexibility to spend ample time with my patients, I do a lot of teaching, and I also am able to see my family and friends. Clinical practice has its drawbacks. I certainly don't enjoy the constant battles with insurance companies who don't want to pay for particular medications or tests. But overall, I'm happy to be taking care of patients again. While my salary is considerably lower than it was when I was in full-time practice, the trade-off of less money for more time and sanity has been well worth it.

You Can't Be a Wife, Mother, and Doctor

ELLIN (LOURIA) LIEBERMAN, M.D.

As I grew up in a distinguished medical family, I frequently heard, “You can’t be a wife, mother, and doctor.” Those words came from the endless stream of professionals (mostly surgeons) with whom my father associated during my early childhood years. This attitude was in stark contrast to his oft-repeated comment: “You can do that operation with one eye blindfolded and one hand tied behind your back.” World War II accentuated the demands on his time, so his workdays were usually 16 hours long. Nonetheless, I have vivid memories of hospital rounds, house calls, and the yearly *pièce de résistance*, beginning when I turned 11, of celebrating my birthdays by watching him operate — usually a thyroidectomy.

I trimmed high school from four to three years despite opposition from the school bureaucracy. I set my eyes on Radcliffe to avoid the family’s well-known reputation at Columbia. When I entered Radcliffe in 1948, half of the class was pre-med, but only four students went on to medical school.

I received much discouragement regarding my plans to go to medical school. My peers thought becoming a physician was a technical assignment not worthy of a Clifflie. Tutors thought medicine was non-intellectual, and that I would waste my history and literature background (my thesis was on Keats). Dates felt that a career was incompatible with their image of a home life.

In 1951, with wide-eyed dreams of becoming the ideal doctor, I met the Dean of the University of Pennsylvania School of Medicine. I was one of four female medical students in a class of 144. I stayed only two years, because I got married in 1954. I transferred to Boston University School of Medicine and then had a standout year as the only woman intern in internal medicine at what was then Massachusetts Memorial Hospital. I became pregnant and was allowed to take six weeks off after the birth of my daughter.

By the middle of my pediatric residency at Boston City Hospital, I knew that my marriage would not succeed. In 1958 I left Boston. I waited with my daughter for six months until the divorce went through and then set out for California.

In June 1959, I resumed training at Children's Hospital Los Angeles, which was affiliated with the University of Southern California School of Medicine. I joined the faculty in 1963, became the head of the newly formed Division of Nephrology in 1971, and was promoted to full professor. From 1963 to 1995, I built the division and developed a career in pediatric nephrology. The years were full of struggles, heartache, conflict, and many, many triumphs. In those years, mentors and networking were nonexistent. Often times, despite being in an academic center, new ideas were suspect, especially if articulated by a woman.

Not long after starting work at Children's, I met my husband-to-be. I sought counseling to stabilize my world and to reassure myself that indeed I could be a wife, mother, and doctor. Fortunately, my husband, who had trained at Harvard and NYU, came from a family where his mother had taught both sons to help with family chores. He had wanted to be a pediatrician for many years. His private dream was to have a large family and a station wagon. Marrying an academic divorcée had not been a part of this picture, but he was seduced by the imagery of a ready-made

family. We got married in 1960, and now have three married children and six grandchildren.

My life inside and outside medicine was feasible because of the stabilizing influences of my husband, family, and friends. My goals were always a bit beyond the achievable so I was always (and still am) on stretch. The family has provided a backdrop of love, support, and humor. The most telling story came after I was a visiting lecturer in Philadelphia. The woman physician who had invited me asked, "How do your children feel about having a famous mother?" I had no idea, returned home, and asked them. The eldest said, "You are my mommy," the next launched in to the importance of being a role model, and the youngest said, "You're not famous — you haven't been on the *Tonight Show!*"

Time spent with colleagues, fellows, residents, and medical students was not universally rewarding nor satisfying. However, my disappointments and frustrations were overshadowed by selected deep and sustained relationships with a handful of marvelous doctors. Teaching and helping them, when needed, as a preamble to their successful careers have been rewarding far beyond my expectations. Today, many years later, these relationships are alive and well.

Icing on my medical cake came in a most unpredictable and overwhelming way. In 1995, I traveled to southern Russia as an exchange professor from USC. I spent eight days teaching, making rounds, and seeing patients. I learned that my Russian counterparts were afflicted with "information hunger." That brief visit set the stage for the current Western–Russian collaborative medical project based in St. Petersburg. For the past nine years, an initiative has evolved to create an up-to-date Nephrology Educational Curriculum and Fellowship Training Program. The effort has attracted first-rate physicians from Canada and the United

States, four of whom have formed a consortium of which I am the director. The effort is increasingly successful. Each day now brings new challenges, new horizons, new friends, and an ever-deepening appreciation of the richness that my life in medicine has provided.

*Doing It My Way,
In My Time*

WINIFRED C. LOUGHLIN, M.D.

*T*he youngest of a large family, I had great freedom as a child. I was given no chores, because there were older siblings already expert at them. I was not a great achiever; therefore nothing much was expected of me. Unfortunately, I contracted rheumatic fever and did not attend school until age seven. Instead, I learned leisurely while at bed-rest from my siblings without acquiring any study habits.

My parents were both Irish immigrants. My father's job involved minor engineering, neither highly paid nor esteemed, but secure and adequate to support us all through college, and three through graduate schools. There were no student loans, and scholarships were based on "merit" not "need." During the Great Depression, we felt neither poor nor rich, had few demands, and had no luxuries. However, because I was the youngest and my father's resources and savings were slimmed down putting my brothers and a sister through schools and colleges before my turn came, it was suggested that I transfer from a prestigious women's college to the tuition-free City University of New York if I was anticipating graduate schooling. There was much less snobbery and boasting about college names then, so I cheerfully switched to Brooklyn College of CUNY, where I was pleased to find the Chemistry Department a better one. I subsequently matriculated from Tufts University Medical School.

All this sounds like a clear-visioned career plan, but like most true stories it was not a well-planned scenario at all. In fact, there were many crossroads, and only one path was chosen at each junction. The following account is what evolved from indifference and pleasantry to purpose and hard work.

After a year's bed rest (standard pre-penicillin therapy), I had a fear and dislike of all doctors as my mother periodically hauled me to a new pediatrician in her anxiety to find or eliminate the possibility of the dreaded complications of rheumatic fever. As I felt perfectly well, and probably was, I reveled in physical activity after a year captivity in bed. I excelled in freewheeling and team sports as well as swimming, tennis, climbing, etc.

I emerged from that brainless, grubby chrysalis stage at age 15 when I fell in love with the perfect order of chemistry and became a real student. Devoted family and high school teachers encouraged me, followed by the highly motivated and ethnically competitive student body at CUNY. I had earned enough "credits" after three-and-one-half years to graduate and fancied myself as a biochemist-invertebratologist. Having eight months before starting a Woods Hole fellowship in September, I rushed out into the real world in December to secure the Nobel Prize and could not get a job. No one recruited newly minted self-styled chemists in a Depression-ridden era.

A local hospital let me volunteer in its clinical laboratory, and there I instituted what is now called the "consilience" of the sciences, i.e., that mathematics, physics, chemistry, and biology really add up to medicine. Since I had taken an MSATS test in my junior year (just because many other science students did and "just for fun"), I applied to a few medical schools. I did not know or care how hard it was to be accepted and then stay the course.

Columbia University said “no” because I was a New Yorker (it preferred one or two students from each state, or so it was said.). Harvard did not yet confer the M.D. degree upon females. Yale did not like the ethnic ilk of my college or of my native city. I was accepted at Tufts.

My parents questioned the endurance factor and discouraged me with my vital statistics: female gender, short stature (only five feet, zero inches), lightweight (then around 100 pounds), and (my mother again) possible rheumatic fever heart problems. I didn’t listen to them, so they gave in.

Was there a quota for women medical students then? There were eight females among 120 to 130 male students in my class at Tufts, and I think this was about the same proportion in the other schools at that time. I think this was less the result of a quota system than the fact that very few undergraduate women majored in the sciences; those without a science background were therefore ill-prepared for the vigorous first two years of “basic science” medical school curriculum. Application forms included required information as to one’s sex, race, religion, and other characteristics now considered discriminatory; so when a class proved out to be one-third Protestant, one-third Catholic, and one-third Jewish, it appeared to be randomized.

Five of the eight female freshmen graduated.

Did we women cohere to form a cohort or group? No, we were all so unlike that there was no reason to form bonds of friendship. There was no feminist activism or forum. Collegiality and friendliness existed among all the students. We were very busy studying and were mostly penniless and unworldly. However, with a pool of young people, it was lots of fun.

Were we picked on or hazed because we were a female minority? I don’t recall specifically that I or the other women

were. We heard of pranks by male students who secreted male organs in women's lab coat pockets, but our anatomy professor interdicted this by placing these stories in its historical context and deplored such immature "jokes" as inhumane to and disrespectful of the cadaver.

Were we singled out by the faculty because of our gender? There were only two individuals on faculty who appeared to treat the women students differently. An elderly pharmacology professor repeatedly assigned women to concoct "aqua rosae" (rose water) and "unquentum reptigerans galeni" (cold cream) in pharmacy laboratory sessions. We didn't complain because we knew he was old and not just unkind. Also, we were aware that such a cottage industry as concocting prescriptions was about to vanish, even in pharmacy shops. We used the rose water and cold cream on ourselves while we said "Shades of Galen." The second exclusion was from male GU clinics. It must be pointed out that it was considered an act of a kindness to the male outpatients, at a time before the advent of antibiotics, when these clinic visits were mainly ordeals of urethral irrigations via hand-held syringes and catheters for acute gonorrhea. I believe the exclusion of women from these clinics was considered the norm in medical schools during those years.

I was elected to the honor society, but have always had an unconfirmed suspicion that I was the token selection as "that year's woman honoree." If so, this was the bright side of discrimination! I had enjoyed Boston for four years and wanted to remain to continue my internship.

I therefore returned to New York City and rotated at a huge metropolitan area medical center, which included ambulance and emergency duty, and became a resident in Internal Medicine the following year. Subsequently, a residency in neuropsychiatry

followed by a post-doctoral fellow in metabolic diseases led me back to biochemistry!

Just as World War II was thrust upon us, I thrust myself into the whirl of private practice in Manhattan as an Internist. I could have gone home again to a safe and certain future, practicing in my family's Brooklyn neighborhood, but I had had a taste of the larger academic world and knew I would become just a GP at home, and so I took the uncertain plunge. Having trained at affiliated hospitals, I had entry to a staff and faculty at a Columbia-affiliated hospital (the now defunct N.Y. Post-Graduate Hospital and Medical School) and started at the lowest rung on Jacob's Ladder: assistant attending and instructor.

It was a strange time, and what was ill luck for male doctors propelled me into advancement and opportunities I might not have had in a time of peace. As the men vanished into the army and navy Medical Corps I was prematurely promoted into a chief position of a prestigious Diabetes Clinic, given lecture assignments, and asked by departing doctors to "take care of" their practices. I didn't have the long wait that is usual when starting a career in a big city.

In addition, many older and famous doctors asked me to perform the somewhat slavish duties that their now vanished but choice assistants used to do: see their emergencies and be available nights and weekends. Of course, I gladly became a substitute without feeling second choice or second class. It wasn't easy physically, but having morning office hours, early afternoon clinics or teaching sessions and late afternoon or evening wartime industrial medical department jobs (mostly placing the now employable 4-F males and lots of females in appropriate slots at drill press, high speed tooling, and forced productivity) gave little pause to think of fatigue, as a gala wartime social life

also burgeoned. I seldom got home before midnight after a day starting at 6 a.m. I don't recall ever being tired or wearying of it for it was very exhilarating and the experience and learning opportunities were greatly appreciated.

Another boon from that era was the influx of Hitler's non-Aryan refugee physicians from Europe, especially some of the "greats" from Berlin, Heidelberg, Frankfurt, and Vienna. Many of these were given positions at the medical schools and centers, and I had the privilege of being taught and mentored by some of them.

Another aspect of that time was that medicine was on a cusp of a new wave of pathophysiologic analysis and a farewell to learning by historic precedents, observations and listening, leading to a passive sort of wisdom and a somewhat ponderous but humane "bedside manner." We were now more inclined to micro-analyze every nitty-gritty event and perhaps for the first time were becoming aggressive and invasive. Influenced by our time, did we become passive-aggressive, harder rather than softened with time, encouraging more bench work and less bedside musings? In other words, were we the instigators and advance guard of the more detached but aggressive and invasive present cohort of doctors? Perhaps most of my generation kept one foot in each era: Some of us remained more patient-oriented while performing what was called "clinical research," "using some of the new ways of thinking and analyzing, while others became more "in vitro" people.

From 1950 onward, another new era in medicine evolved: there was a waning of the part-time practicing physicians ranks as full-time grantees were asked to lecture students, assume patient care as well as doing their bench work. This relieved the busy practicing physician, but the much esteemed and honorific chores are still missed by the veterans of that era. Before that change was fully evident at every medical school and center, I

had reached the rank of associate professor of clinical medicine, had chief positions in two clinics, chairmanship of active school and hospital committees, and had become an officer of the New York Diabetes Association. All those extra-practice activities were time consuming and unpaid, but were then much sought after as an honor and a reward in themselves. They were also enjoyed and we were dependable and punctilious in their execution. They kept a highly structured system going without outside regulatory dictates. They gave us stature among our peers and added "reputation," which in turn increased patient referrals.

All this activity was time consuming and when combined with the exigencies of private life could become too much.

What of the personal and social aspects of being a female physician? They were different and more difficult for us than for our male colleagues. Socially, we had to endure the tiresome exclamations and explanations of the "doctor" title and the sometimes skewed narcissistic behavior resulting there from. There was a spate of cinema and television portrayals of "lady doctors," which didn't assuage these problems.

Courtship and marriage were and are somewhat misshapen and can result in failures. Child-bearing and -rearing presented problems too. Social events then and now, can be in short supply after a day's heavy schedule.

In my own life and profession, an idyllic scenario was not always unreeling, but a medical education somewhat assuaged the slings and arrows of mishaps, misdeeds, miscalculations, and misery. An early failed marriage and a lost pregnancy "liberated" me into a burgeoning open society: in a non-misogynist/non-misandryac ambience of an almost all-male milieu, life was "just a bowl of cherries," as a popular song said, until a later marriage, when I became a surrogate mother to some fine stepchildren.

Meanwhile the “fine print” of daily life can be stressful for a practicing female physician; my solution was to avoid the fluff of entertaining except in restaurants and to depend on relatives for special occasions and holiday celebrations. Shopping, cooking, and cleaning services can be purchased to some extent, and I did so, neglecting the rest. One can avoid chaos with this solution by “never explaining, never apologizing.” Perhaps that sounds cavalier, but it worked for me. I don’t believe one can be skilled at everything in the same twenty-four hours of a day.

Another aspect of being a female minority in medicine was that of coping with the male majority. Does one cope by becoming more masculine? I felt it not necessary unless one was already so inclined. Does higher rank imperil male-female relationships? I feel it does not if not “pulled,” if humility and willingness to learn from the young is not lost. I found that many male patients liked the non-patriarchal personae of female doctors.

Was I “sexually harassed?” I do not recall ever experiencing this — perhaps I was unaware of it, or because I was not a beauty or glamorous I did not attract this sort of interaction.

What were my accomplishments? I attained some recognition as a diabetologist. I earned a good income, published about seven or eight papers of minor clinical importance and spent forty-five years in public and private service, and I enjoyed every moment of them.

What do I think of the future of women in medicine? I believe the future will be unremarkable as our numbers increase because no longer will women need to be exceptional or be pointed out, except when we join the few who indeed are great and famous. I believe women now have every opportunity to excel, exceed, or to be ordinary. Perhaps women will have a softening

effect upon the present business mode of the profession. I hope women will enter “the sacred grove” because it will be a life of continuous learning and joyfulness and not for a better income or for celebrity status.

Are there guidelines for a grand career in medicine? I believe there are and that they are the same as the Girl and Boy Scouts Oath: “trustworthy, loyal, helpful, friendly, courteous, kind, — etc., etc.,” Slogan: “Do a good turn daily” and Motto: “Be prepared.” Anyone, male or female, entering upon a medical career can reach for these high goals in humanity and will have control over who she becomes while preserving the ancient ideals of medicine.

The Uneven Road

IOLANDA E. LOW, M.D.

From as early as I can remember, I always wanted to be a physician. My dolls were my patients, and I carefully took their temperatures, dispensed medicines, and applied bandages. As a third grader, I still remember being fascinated by studying science, especially the digestive system, while my classmates were repulsed. My curiosity about the medical world extended to sneaking into my parents' library for an anatomy text usually kept under lock and key. With it I studied the complexity and beauty of the human body with its bony structure, muscular interplay, blood circulation, and the other organs hidden under the cover of its skin.

Two seminal events had a profound impact on my decision to be a doctor. The first occurred when I was eight or nine years old, during one of my many serious illnesses. At that time, in the pre-antibiotic era, the diagnosis of "double pneumonia" held a poor prognosis. I was only barely conscious with high fever when I heard our pediatrician in Italy tell my mother, "Signora Maria, the child is very sick, and soon we should reach the critical point of lysis with defervescence and recovery or crisis with complications and possible death. We've done everything possible; the only thing left is to pray to the Madonna." My unspoken response was, "There's got to be a better way to deal with illness." The other important event was discovering the book *Microbe-hunters*, by Paul de Kruif. My family had emigrated to the U.S. during World War II by then, and reading it in my teens

“sealed” my determination to become a doctor with a strong focus on microbiology and infectious disease.

During my high school years in New York City and at college, first at Goucher College and then at Stanford University, I had strong and unfailing support for my interest in the sciences. It was only when I started my medical school application that the prejudice for those lacking the Y chromosome hit full force. I was ill-prepared for the virulence of dislike I encountered in an interview with an associate medical school dean at the university that was considered to be a very liberal institution. Not only did he consider it an affront for a woman to consider entering medicine as a profession, but he also deplored that someone with the “wrong” religion (presumably based on my maiden name of Einstein) as well as being foreign-born, not in an accepted English-speaking country, but in Italy, should even have the audacity to apply for admission. In an interview of a few minutes, I felt devastated, humiliated, angry, and powerless. I withdrew my application, and I wanted to protest more formally, but was dissuaded by my adviser and friends who said that it would only hurt my future and not achieve any changes. “This is the real world, and you’d better accept the prejudices in it.”

The positive event that did not destroy my dreams and kept me from withdrawing completely was Harvard Medical School’s notification that I had been placed on the waiting list. By that time, financial issues also became an important concern, and I returned home to the East Coast and worked as a lab technician in the Rockefeller Foundations’ International Health Division in New York City. It was fascinating to be exposed to well-known scientists and challenging research protocols, but I again saw prejudice accepted in everyday life.

During the hiatus between college and medical school, I met my future husband. I had not planned to get married until I was professionally established. However, fate intervened. One evening I agreed to fill in as a fourth in a bridge game and found my partner to be someone with whom I immediately felt I could happily spend the rest of my life. Eight months later, when my acceptance from Harvard Medical School arrived, we were already married and were on our honeymoon. In the immediate postwar years, the expected role for women was the Mrs. with six children in a rose-covered cottage, certainly not the pursuit of an unsuitable M.D. Fortunately the one support, both emotional and financial, that I received came from my husband, who understood the depth of my conviction.

My four years of medical school in a class of seven women and 140 men forms a separate chapter in my development as a physician. Graduation meant another decision affecting my professional and family life. The prudent choice would have been to accept an internship, mostly limited to pediatrics and psychiatry for women in the Boston area, to assure a medical license to practice. However, the on-call schedule of every other night and weekends would have placed a heavy burden on our marriage. In 1953, internships for the most part did not offer a salary. Another choice was to accept the Harold C. Ernst fellowship with a \$3,000 tax-free stipend to continue the honors research I had done in virology at medical school with the Eaton agent (*Mycoplasma pneumonia*) and influenza. Also there was the concern for the ever-present ticking of the biological clock. A prominent medical school administrator suggested that an attractive young lady should not worry about choices, but should go home to a husband and have her babies.

In the end I decided to accept the Fellowship in the Department of Bacteriology that at least allowed me to fulfill one career aim:

that of research in microbiology plus teaching, as well as starting a family. The plan was that once the children were in school, I would start a residency program and then continue my dreams of patient care with clinical research, as many of my male classmates were already doing. Again fate interfered; each of my three children had serious illnesses, and my infant son came close to death, causing me to adapt my plans to fit my family's needs.

I continued research and teaching over 20 years, mostly as a research associate, in the so-called "equal but separate" promotional ladder at Harvard Medical School. Then I decided to close my laboratory and seek a clinical internship. Many considered this to be a "crazy" choice, and possibly a result of the hormonal changes accompanying a midlife crisis. In fact, I based my clear-headed decision on several facts. This was chronologically my last chance to fulfill my childhood dreams of patient care. The continued pressure of raising money as a single investigator required more time on grant writing than on the research I enjoyed. Harvard and Tufts' associations with City Hospital were terminated, meaning that I would have had to move my laboratory. To be absolutely sure that entering clinical medicine was not an irresponsible plan, I attended a six-week re-training course in Philadelphia. My prior work record and accomplishments allowed me to enter a rotating internship program at Newton-Wellesley Hospital, actually my first choice and close to home. Despite my lack of more up-to-date medical knowledge, my age actually proved to be an asset in the clinical arena. I found that my perspective as a teacher, wife, mother, and daughter of aging parents helped me to survive grueling hours in the hospital, often up to 130 hours a week, and sustained my empathy and caring for patients.

With my clinical training completed, I was able to fulfill the last leg of my 50-year-old professional career dream of being a

physician and an infectious disease sub-specialist. For 15 years I was staff physician, essentially a hospitalist, at the Spaulding Rehabilitation Hospital as well as the infectious disease consultant and infection control officer at the hospital. I also was able to do some applied research during that time, while having some control over my personal life.

I am often asked, “Would you do this again if you knew ahead of time of the hurdles you had to face?” This is difficult to answer. When I was young, the future seemed open-ended. I was naive and optimistic, without fears of possible disasters. In today’s climate, women have many more open doors and equal opportunity laws that took over a half a century to achieve. The ground gained should never be taken for granted because history shows that, especially during economic downturns, fortune can reverse itself with a vengeance. I still have some anger at the prejudices I had not anticipated in the United States, as well as regret about how much more I could have accomplished if I had not needed to devote so much energy and time to overcome barriers of my sex.

However, I have achieved my childhood dreams of caring for patients as well as being involved in infectious diseases and microbiological research. Most importantly, I was blessed with the private happiness of a marriage that lasted over 50 years and a loving family of three children and four grandchildren. Also, despite my childhood illnesses, I have enjoyed good health. This allows me to continue my medical professional life, which includes volunteering to teach medical students and caring for patients at a free clinic in Boston.

Looking back at the uneven road of my life, it often seems unreal. However, in the end, I feel lucky and hope that somehow this path of many decisions will help someone grappling with some of the same problems.

*Do Ask, Do Tell**

JENNIFER E. POTTER, M.D.

*A*s a consequence of bias and ignorance within the medical profession, lesbians and gay men frequently receive suboptimal health care. Knowledge of each patient's sexual orientation and behaviors is critical for the development of a productive therapeutic relationship, accurate risk assessment, and the provision of pertinent preventive counseling. However, clinicians often forget to ask about this information, and many lesbians and gay men are reticent to reveal the truth. I present vignettes from my personal experiences as a lesbian patient and doctor to illustrate the importance of creating an environment in which such disclosure can occur, and to portray the challenges and rewards of coming out as a gay physician.

I juggle many hats in my life: mother, partner, doctor, and educator. Like all my female colleagues, my experiences as a daughter, sister, patient, and student have influenced my approach to each of these roles. But I am also lesbian, and this fact has shaped my life profoundly. It underlies my decision to become a primary care doctor; select women's health as an area of clinical expertise; and commit myself especially to improving the lives of lesbians, gay men, and people from other minority groups.

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It is a challenge to be lesbian in our society. People assume that a young woman is straight, will marry, can get pregnant if she is sexually active, and will have children. This progression is “normal.” Anything else is different and may be perceived as abnormal, wrong, or bad. Historical and continuing records of harassment, assaults, and homicides against lesbians and gay men abound. The medical profession itself has viewed homosexuality as a disorder; aversion techniques, hormone administration, shock treatment, castration, and even lobotomy have been used as purported “treatments.” I feel fortunate that I have never been the target of clearly overt actions because of my sexual orientation.

Insidious effects of prejudice affect my life deeply, however. Imagine how it feels to hear yet another gay joke or to open the paper to confront yet another antigay news story. Examples include the U.S. military’s “don’t ask, don’t tell” policy, repeated referenda that limit the civil rights of lesbians and gay men (even compared with other minority groups), and the opposition of many religious organizations. Many lesbians and gay men find it difficult to avoid internalizing some of these homophobic attitudes. As a consequence, shame and fear are common emotions, and we are more likely to be isolated; engage in risky behaviors; suffer from stress-related health conditions, substance abuse, or depression; and attempt suicide.²

Finding help is not easy. It is hard to trust other people, even health professionals, when one anticipates disapproval. Doctors share the same biases as the rest of society and are frequently ignorant about lesbian and gay health issues. I have often been disappointed with the medical care I have received.

As a teenager, I reacted to the emergence of attraction to other girls with a jumble of conflicting feelings: excitement, fear, fascination, and horror. When I tried to broach the topic cautiously

with my family doctor, he laughed and said, “Don’t worry about that; it’s just a phase a lot of girls go through.” He meant to reassure me, but his comment trivialized and dismissed me instead. An important opportunity was missed to explore and validate my feelings.

By age 15, I was overwhelmed and isolated and made a suicidal gesture that might have had grave consequences. The psychiatrist to whom I was referred believed that same-sex attraction was a sign of stunted psychological development. His attitude perpetuated my notion that something was wrong with me, and I stifled exploration of my identity during two ensuing years of therapy. I eventually found the support I needed when I met a lesbian couple who listened to me, encouraged me to be myself, and demonstrated that it was possible both to be lesbian and to pursue the goals I wanted in life — a committed relationship, a family, diverse friends, and a deeply challenging and rewarding career.

In college, I consulted a physician for evaluation of vaginal symptoms. She asked if I was sexually active (yes), whether I was using contraception (no), and whether I was trying to conceive (no). Before I had a chance to explain, she began to talk about birth control options and the importance of using condoms to prevent sexually transmitted diseases. At that point, I was too embarrassed to reveal my lesbianism. I never did ask the question that was on my mind (“Could I infect my lover?”) and left, uncomfortable, with an absurd prescription for the pill. Her immediate assumption that I was straight and my reticence to reveal the truth prevented the development of a productive doctor–patient relationship and resulted in inappropriate care.

Later in life, when I disclosed my lesbianism to a new internist, she told me that my risk for cervical cancer was so low that I did not need to have regular Papanicolaou smears. This advice was

incorrect. She assumed that my sexual relationships were exclusively lesbian and that the chief cause of cervical cancer, human papillomavirus, cannot be transmitted by woman-to-woman sexual contact. However, sexual identity cannot be equated with sexual behavior. Some lesbians are celibate, many have male partners, and some have partners of both sexes. Moreover, emerging evidence suggests that several genital infections can be acquired during lesbian sexual activity.³ A detailed sexual history is necessary to understand the situation of each patient, ascertain risks for sexually transmitted diseases, and provide pertinent medical counseling.

As a result of my experiences with doctors who did not know how to communicate effectively, I became interested in ways to break down barriers that prevent gay and other minority patients from obtaining good care. I joined a lesbian and gay speaker's bureau and told my story to students at local high schools, colleges, and medical schools. I believe I helped to enlighten others and demolish some stereotypes. Then, after considering teaching, nursing, psychology, and medicine, I decided that my best course of action was to become a physician.

The medical establishment was an inhospitable place for gay trainees in the 1980s. As recommended by my premedical advisor, I concealed my lesbianism during the medical school application process; I question whether I would have received my "Welcome to the Harvard family" letter if I had been more forthright. Once a trainee, I faced all the challenges that every medical student and resident encounters: trying to master a huge body of knowledge, accepting the enormous responsibility of caring for people, learning to function with aplomb in emergency situations, and competing with others for advancement. In addition, I had to cope with tacit and

overt advice that my lesbianism would be tolerated only as long as I kept quiet about it.

Ambivalence about being open is a problem that heterosexual persons can barely comprehend. It arises because of a continuing lack of acceptance of gays by most of the population and the fact that homosexuality is invisible, unlike the minority status of people with different skin color or language. As a consequence, disclosure is a choice left to each gay person.

On the face of it, maintaining silence makes almost everyone happy. I can interact with others without fear of prejudice, and people are spared the discomfort of responding to a sensitive proclamation. But invisibility has many downsides. Self-respect is difficult to preserve when one lies by omission. Silence implies acceptance that, as a member of a minority group, I have nothing valuable to contribute — that I am a “minus.” If I selectively omit mention of involvement in activities that could identify me as gay, I cannot highlight all of my accomplishments. If I attend professional social gatherings alone, I miss the opportunity to introduce my partner of 23 years, show our example of a long-term relationship, and provide everyone with a chance to build acceptance.

Secrecy leads to isolation. Whenever I encounter new and unfamiliar situations, I am tempted to watch, wait, and figure out the lay of the land before revealing my lesbianism. Although this strategy feels safe, it produces loneliness. A subculture of lesbians and gay men exists through which clandestine identification takes place. But when secrecy is the paramount mode of operation, people are reluctant to gather together because of guilt by association. Silence limits opportunities for friendship, support, and professional collaboration not only with other lesbians and gay men, but also

with sympathetic people from the mainstream who share my values and goals.

Secrecy also requires an enormous expenditure of energy. Staying “in the closet” is not a passive process; constant vigilance is required to steer conversations away from personal issues. Of course, people sometimes ask directly whether I am in a relationship. If I deny that I am involved, I enter a vicious cycle of deception. If I admit to having a partner but try to conceal her sex, I have to take great care to avoid the pronouns “she” and “her” in subsequent discussion. Such behavior wastes a great deal of energy that could be channeled productively.

When I remain silent, people make assumptions about me that can be very awkward, especially if they later realize that their beliefs were wrong. When I started to practice medicine, many of my colleagues assumed that I was single because I did not talk about a boyfriend or husband or wear a wedding ring. Some concluded that I was an “old maid by choice” — a woman who had subjugated family to career. Others assumed that I was available, so I had to decline advances. When I became pregnant, nearly everyone assumed that I was married. In a particularly embarrassing moment, the chief of a major service told me in a public forum that he thought he knew my husband!

I have gradually learned that it is advantageous to be open about my sexual orientation. Disclosure is empowering: it allows me to be myself, integrate my public and private lives, voice my opinions, celebrate all of my achievements, and work passionately to increase tolerance and acceptance. I know that I deserve respect and recognize that I serve as an important role model.

Coming out is a process that never ends. Every time I meet someone new, I must decide if, how, and when I will reveal my sexual orientation. I find it simplest to be candid with colleagues

from the start, but this approach can be awkward with patients, because it is considered inappropriate to mention intimate personal details in the context of a professional relationship. However, every doctor–patient interaction is built on trust, and I believe strongly that I have an obligation to be honest. Patients often ask me personal questions about my family and how I balance home life and career. Up-front disclosure of my sexual orientation avoids embarrassing people who might otherwise assume that I am straight and ask about my “marriage” or “husband” and allows patients who feel uncomfortable having a lesbian as their physician to choose a different doctor.

In general, I try to communicate who I am nonverbally, by displaying pictures of my family and having gay-friendly posters and health literature in my office. I developed and use an intake form that is inclusive of alternative lifestyles and avoids the designations “single,” “married,” “divorced,” and “widowed.” My name is listed in a lesbian and gay health guide, I give talks to lay audiences on lesbian and gay health issues, and I volunteer free health screening for lesbians and other minority groups in the community. I have also developed and teach a curriculum on lesbian and gay health to medical students and residents as well as to peers at continuing medical education conferences. When I am asked directly about my private life, I answer truthfully.

Reactions to my openness have been mixed, but my experiences coming out as a lesbian health professional have been rewarding overall. When I decided to coordinate a lesbian and gay student group in medical school, I had to identify myself to the administration in order to apply for funding and take the risk of being seen posting notices about group activities. Some flyers were defaced, presumably by other medical students, and I once saw one being removed by a dean. I tried to channel my anger into eloquence

and gave a talk to my classmates. Although a few ignored me subsequently and one student began to pray for me every morning before class began, the posters were no longer disturbed and attendance at group-sponsored educational events increased.

Later, as a resident in the early AIDS era, I encountered numerous examples of homophobia in the hospital. There were many antigay jokes; some implied that gay men were getting what they deserved. Some of my peers refused to shake hands with gay patients or put on gowns and gloves before entering their rooms. My coming out stopped the jokes, at least in my presence, and seemed to result in more humane behavior toward people with AIDS-related illnesses.

Over the years, I have received a few lectures on the ills of homosexuality and even a letter stating that people like me should not be permitted to become doctors. However, several gay patients have told me that my visibility enabled them to find me and finally receive the understanding and support they craved. My openness has also allowed gay medical students and residents to identify me as a role model and mentor, and many of my straight colleagues and patients have thanked me for the opportunity to examine their assumptions and biases about gay people.

Somewhat to my surprise, my openness has not harmed my clinical practice. On the contrary, I have many referrals from medical colleagues and hospital administrators who want me to care for their wives and daughters, and I was recognized by *Boston Magazine* as a top internist for women in the February 2001 issue. Coming out has also afforded me some novel professional opportunities. I believe that my openness during an era of emphasis on cultural competence was a factor in my appointment to the Beth Israel Deaconess Hospital Board of Trustees. Likewise, my willingness to speak out has resulted in invitations to participate

in a panel discussion on lesbian and gay health at the Massachusetts Department of Public Health and to serve on an advisory board to the American Cancer Society.

Despite these successes, much work still needs to be done. In recent years, Harvard Medical School has taken steps to diversify the racial and ethnic composition of its student body and increase tolerance and acceptance of its gay community by sponsoring town meeting discussions. However, few minority faculty members have been promoted to leadership positions, and consequently, many of my values and those of minority colleagues remain poorly represented. I strive to promote further institutional change by being visible and voicing my questions and concerns.

A professor at my institution once warned that it is a mistake to “ghetto-ize” one’s career in women’s health. I take issue with this statement. I believe that my work is not only legitimate but of critical value. My talents include an instinctive ability to understand and empower patients from highly diverse backgrounds and a gift for changing the attitudes and behaviors of medical students and doctors. My work requires courage and resilience, and I believe that the outcomes are as important as the results of basic science research and clinical trials. Challenging clinicians’ stereotypes and increasing the sensitivity with which they communicate with people from different cultures will benefit all of their present and future patients. I am proud to be a lesbian physician and educator.

¹ Miller N. *Out of the Past: Gay and Lesbian History from 1869 to the Present*. New York: Vintage Books; 1995.

² Dean L, Meyer IH, Robinson K, Sell RL, Sember R, Silenzio VMB, et al. Lesbian, gay, bisexual, and transgender health: findings and concerns. *Journal of the Gay and Lesbian Medical Association*, 2000;4:101-51.

³ Diamant AL, Lever J, Schuster M. Lesbians’ sexual activities and efforts to reduce risks for sexually transmitted diseases. *Journal of the Gay and Lesbian Medical Association*. 2000;4:41-8.

New Molds

KAREN L. REUTER, M.D., F.A.C.R.

The “mold” that I made for my ultimate career in the 1970s was quite different from what would be most likely today. I had been intrigued by medicine, understanding how the human body functions, and how to make it function well, from my early years in high school. It was made clear to me both in public school and by my mother that a girl should be prepared to be self-supporting; that she should learn to be a high school educator or a nurse. I was even shown an article that said that most women physicians remained single. Thus I matriculated at a college, Bucknell University, as an education major, first in elementary education, then in biology. I received my practical teaching experience at Yale University in the MAT program. While studying there and working in one of its medical school laboratories, I realized that high school teaching was not my true goal. Since I was unable to change into a broader course of study at the master’s level at that time, I did teach high school chemistry and biology for one year.

Unfulfilled during the year of teaching, I began a Ph.D. program at the University of Pennsylvania in biology/genetics. In selecting a project for research and doing a lot of soul searching, I faced the realization that my actual goal was to become a physician, to work to help people directly. Laboratory research would not provide the depth of human health involvement, which had always really been my interest.

Entering medical school at Tufts University I was four years older than most of my classmates. However, as a group we got along very well, forming a camaraderie I had not experienced in my earlier schooling. There were quite a few other students in my class who had been in other careers: a priest, nun, nurses, researchers, and a paramedic from the Vietnam War.

Even within the field of medicine, “molds” can change. I had considered the specialty of obstetrics and gynecology, endocrinology, or radiology and decided on the latter. However, during a major part of my professional life I subspecialized in gynecological imaging and worked closely with infertility patients. This fulfilled my other two interests from medical school. I received an academic degree from the Department of Obstetrics and Gynecology at the University of Massachusetts Medical School, which significantly strengthened my position.

I often tell young adults not to feel rushed to make a career decision, that different paths can lead to a positive goal. My tortuous path was interesting and energizing. Several lifelong friends have been the result. I met my husband, Dr. John Krolikowski, in medical school. Looking back, I love my career in medicine; I am so glad I pursued my longstanding passion.

With more encouragement for women to pursue their passion for science and medicine at an early age, paths will probably be straighter for many of them. However, I do predict that many different “molds” will be made by women within a field as they work through their specialty goals to construct one path that is right for them.

Balancing Act: Parenting and Medical Training

ELIZABETH A. RIDER, M.S.W., M.D.

*M*y path to medical school was different than most of my classmates. I came to medicine after an eight-year professional career as a senior clinical social worker, training program director, therapist, clinical supervisor, researcher, and graduate faculty member. I had my own office, secretary, parking place, and paycheck. Despite a successful first career, I desired more, and I chose to risk a new career path. I decided to go to medical school.

My first year of medical school was challenging. Not only was I ten years older than most of my classmates, I was one of three married women. I had responsibilities and life experiences different than my peers. My science background was nascent, and my last graduate school experience was nine years before. I found it difficult being held captive in the classroom eight hours each day. Nonetheless, I survived the first year of medical school.

I discovered I was pregnant the day before second-year classes began. The pregnancy was planned, and my husband and I were excited and happy. Starting medical school in my early 30s, I did not have the option of waiting until I completed my training to start a family. Friends with children told us our lives would change, but I didn't *really* believe them. The disruptions started earlier than expected. At 22 weeks and again at 24 weeks of pregnancy, I was admitted to the hospital with premature contractions. Twelve weeks of bed-rest followed. The summer before, I

had studied outcomes of significantly premature infants, so I had a vivid picture of the difficulties that can occur when a baby is born too soon.

My sense of adventure in taking calculated risks regarding life and career decisions was lost. This time, I felt the risks were controlling me. We could only wait to see the outcome for both the baby and my own health. Friends and colleagues were supportive; my husband was consistently helpful and available. We were fortunate: our delightful son was born on his due date.

Since then, I have discovered parenting to be an enriching, joyful, and unpredictable experience. It is also exhausting, like being on call every night. I worked hard at a professional career; I work much harder now as a parent. Balancing medical school with home and child rearing was challenging. I felt part of two worlds: the world of childhood, with its lyrical and slow sense of time, and the fast-paced, controlled world of medical school.

As a former child therapist with knowledge of child development, I worried about the effect of day care on my child, about whether his emotional needs were being met *well*. I missed seeing my son during the day, although I was lucky and could go to the day-care center to nurse him at noon. My husband and I juggled schedules when he was sick. I missed the lecture on ear infections when he was sent home with one. There were times during finals week when he was up most of the night before my exams. He came to classes with me several times, and spent time at work with his father.

My life before I had a child was much less complex. I came home after a long day at school and relaxed for several hours before studying. As a parent, I came home to a delightful child who needed to be changed, fed, bathed, and put to bed, all at his own pace. I spent evenings playing with my son. His devel-

opment was a joy to watch. By the time I put him to bed, I was exhausted. Then it was time to study. I looked forward to weekends when we could spend time together as a family, yet I was torn between that and studying.

Several years later, after an uneventful second pregnancy, our daughter was born. When considering residency options, I chose pediatrics, a specialty devoted to promoting the well-being of children and their families. I realized a full-time residency would have high costs for my family. Given my knowledge of child development, I felt that the hours of work in a traditional training program would be difficult, both for my children and for me as a parent. With the time commitments required for both good parenting and good doctoring, a part-time or shared residency made the most sense.

I set out to create the opportunity to do a shared residency. My first goal was to find a partner. With the support of the dean for medical education at Harvard Medical School, I wrote to 80 medical school deans, M.D./Ph.D. program directors, and fourth-year students at several medical schools. I also spoke with residents sharing a position or on reduced schedules, and with training program directors who offered flexible training opportunities.

Several opportunities became available for part-time and shared residency positions, and I pursued one at Children's Hospital in Boston with a Harvard Medical School classmate who is a father. He and his wife, who was starting a part-time internal medicine residency at Brigham and Women's Hospital, alternated child-care responsibilities each month for their small infant. In my determination to find a residency partner, I created a national clearinghouse called Pediatric Residency Partners (no longer in operation) to match individuals inter-

ested in sharing a residency and to serve as a resource to help people arrange flexible training schedules. There was interest nationwide; I heard from medical students from as far away as Hawaii, Texas, Wisconsin, Arkansas, and California. Many, but not all, were parents seeking residency arrangements that would allow them to spend more time with their families. Others wanted time for research or other pursuits.

I began my pediatric internship at Children's Hospital in Boston along with 27 other somewhat nervous but enthusiastic interns. My daughter was then 18 months old, and my son was five years old.

After five days of orientation lectures, demonstrations, and even a canoe trip, my fellow interns began their work on the wards. I went home and did not start my internship until a month later. My residency partner and I initially shared one position, alternating four weeks of work with four weeks off, fitting into the rotation schedule that all interns at Children's Hospital follow. After two years, I found that a more consistent part-time arrangement worked better. Some month-long rotations required a full-time schedule including overnight call. Other rotations could be part-time, i.e., without overnight call, so that during "on" months the resident was home nights and weekends; overnight call was taken during "off" months. Emergency room shifts were spread out or shared. By the time I was a junior resident, four residents worked part-time at Children's, each with a schedule individually arranged.

During my first month of internship, one of my patients, who was the same age as my youngest child, died unexpectedly. I was in touch with the pain and loss a parent feels in such a situation. Because of my previous professional experience, I could help the mother deal with her shock, anger, and grief at the loss of

her small child. I felt a familiarity in working with children and parents that made being a pediatric resident easier.

When not formally scheduled, I continued to see patients in my continuity clinic one-half day each week and attended teaching conferences almost every day. In contrast to the months when I worked a full-time rotation, I was rested and learned more easily from the material presented. I had time to read, write several papers, attend meetings of Harvard Medical School committees, manage Pediatric Residency Partners and, most importantly, spend time with my family.

I could reconnect with my husband and children, spending extra time with my son as he began school, and with my daughter as she made the transition into the toddler class at her day-care center. As I played with my daughter and rocked her to sleep at night, spent time talking with my son about friendships and life, or had long talks with my husband, I realized how fortunate I was not to miss these intimate and important moments.

On some rotations, I left home each morning before my children awoke and returned at night after they had gone to bed, sometimes not seeing them for several days at a time. It helped to know that this schedule was time-limited and that I would be able to parent my children on a more consistent basis when my current rotation ended.

My experience as a parent enabled me to be sensitive to the needs of my patients and their families. In my former career, I had created and directed a fellowship program in child and family therapy, directed emergency services for an outpatient child psychiatric clinic, provided therapy for children and their families, and trained clinicians. These experiences provided a framework for working with patients, colleagues, and students as a physician.

Sharing a residency had some disadvantages. My paycheck was half that of my colleagues — not quite enough to cover my daughter's day-care expenses. Training took longer. My residency lasted five years instead of three. After four years, I decided to complete my final year of residency full-time. It was a hard year for my family, and I missed my children's development, but I finished sooner.

Was it worth it? Yes. Temporarily, I was on a different track than most of my colleagues. A flexible residency allowed richness in my life and energy and enthusiasm for my patients and family. I am grateful that I had a flexible training program; I could be the kind of parent I desired to be while learning to become a good doctor.

I love being a parent. I also love having a medical career. Having both is not easy, but I cannot imagine a life without children, family, and career. It would seem empty. We must aim for both love and work in our lives. One without the other is only half a life.

Epilogue: Dr. Rider and her husband continue to be busy and fulfilled. Their son is now a student at Yale University, and their daughter is in high school at Milton Academy.

*From Physician to Soldier:
My Experience in Iraq*

SHAKTI S. SABHARWAL, M.D.

When I joined the U.S. Army National Guard in August 2001, September 11th (and the changed world that followed) was still far away. A weekend every month at the local Guard unit less than an hour's drive from my home, did not pose an excessive burden. I wanted to give something back to the country that had offered me a full-tuition International Peace Scholarship to go to medical school in the name of a fallen U.S. soldier from the 1983 Grenada invasion. Born and raised in a family of army personnel in India, I was not unfamiliar with the harsh realities of war. But growing up as a young woman, I had never imagined myself in a war zone. Yet here I was — deployed in Iraq, far removed from the secure routine of home and family. The repeated sounds of mortar attacks were much too close for comfort!

How did I get here? I, along with many others, was glued to the television on March 20, 2003, seeing the reports and night-vision images of U.S. air attacks and missile strikes that were the beginning of the war in Iraq. However, as the war went on, it became clear that this would not be a quick and easy conflict. By November 2003, a large number of reservists were being notified that they would be deployed to serve in this war. One of the National Guard units notified at that time was the 118th Medical Battalion, to which I was attached. Our mission: to provide medical support to troops in Operation Iraqi Freedom.

The period between this notification and actual deployment was busy and stressful. There was much to be done in those few weeks, including pre-deployment health assessment and processing, trying to get myself and the family ready for the months ahead, planning for childcare needs, financial planning, completing wills and power of attorney forms, getting vaccines (including anthrax because of potential risk of exposure as part of a biological attack). I also spent some time in a high-volume trauma center to brush up on some of the ER-related skills that I would be required to draw upon during deployment. Uncertainty and the potential for changes in deployment dates and locations also contributed to the stress in this period. I finally got the written deployment orders about two weeks before my actual mobilization date.

My memories of leaving home on a cold morning before dawn in January 2004, and the accompanying feelings of anxiety and anticipation, are still quite vivid. I hugged my son and husband, who were both bleary-eyed and still in pajamas in the wee hours of the morning, and embarked on my journey. Along with a few other members of the unit, we drove from Boston to Fort Drum, in northern New York State close to the Canadian border, for initial mobilization and pre-deployment training.

The time at the mobilization station in Fort Drum was hard work, physically and emotionally. The goal was to practice soldier skills and combat training to complete our transformation from reservists to soldiers! We learnt how to put on gas masks, specialized protective clothing, and follow MOPP (Military Oriented Protected Posture) procedures correctly, a skill that could save our lives someday in the event of a chemical attack. We practiced shooting till our instructors were convinced that it was adequate training. I can tell you that trying to learn to shoot straight with your fingers getting numb in 30-degrees-below-zero wind chill

on a bitterly cold January day is no small feat. In fact, on one of the days I was there, we were told that Fort Drum had the dubious distinction of being the coldest spot in the nation for that day!

Finally the day came when the training ended and we left the U.S., taking a flight to Kuwait City airport. The flight was uneventful although thoughts of the challenges that lay ahead gave way to anxiety and reflux. We arrived late at night at Camp Virginia in Kuwait, which was our initial transit stop. It didn't take much time to realize how far behind I had left the comfort and security of home. Still, I counted my blessings every day. At least we had enough to eat and a roof over our heads, even though it was just a tent. Surrounded by uniformed soldiers in such large numbers that I had not seen before at one time, I felt quite secure but still lonesome. I was jet lagged, covered with dust, loaded with heavy gear, but determined to succeed in our mission. We got used to the weather and practiced some more combat tactics. At the end of the two weeks at Camp Virginia, our unit split up to continue our journeys to our respective assigned destinations.

I was part of a convoy that traveled into Iraq from Kuwait. That was a stressful journey fraught with dangers that required continuous vigilance for insurgent attacks and road bombs. At every stop, we were on high alert: soldiers took watch with their fire-arms drawn and ready to fire at any hint of danger. The inability to see lurking dangers through a sandstorms and reduced visibility meant that we had to halt our travel early in the evening and resume at daybreak the next morning.

Our destination was Camp Taji, about 12 miles north of Baghdad. When we reached there, I initially felt secure being inside the perimeter of the camp after the harrowing journey in the convoy — but this sense of security was very short-lasting. There were frequent mortar attacks and sounds of explosions

nearby. Every nearby explosion left me wondering if it had hurt someone and if we would be seeing some of the casualties. We often saw these casualties, and the uncomfortably close mortar attacks made me very aware of my own mortality. Although the attacks initially kept me awake at night and I had occasional nightmares, I did learn gradually to suppress the fear and block it out. But, there were times when that was harder to do; for instance, on April 24th there was a mortar attack in our camp at about 4 a.m. while we were asleep. A few soldiers in our camp were killed and several others were wounded.

Camp Taji had not been fully developed when we first got there. There were still areas where personnel and equipment were housed in tents, and there was a lot of debris around and some buildings in ruins. However, there was ongoing construction, and after the first few weeks we were able to move our treatment facility to an actual building. We called it the “Boston Treatment Center,” although even without that name the Red Sox Nation posters on the walls were tell-tale signs of our origins.

I was part of a medical team assigned to a camp of over 10,000 soldiers — the team consisting of physician, physician assistants, and medics. I was really amazed by the Army medics, some of whom, unlike me and the Physician Assistants, had held nonmedical jobs before being deployed, so they weren't used to this — but they did well. We were the second level of care after initial first aid and stabilization in the field where an injury took place; we provided continuing emergency treatment, resuscitation, and stabilization of the wounded, and prepared them for transport to the next level of care as needed, often to the nearest Combat Support Hospital.

Casualties were transported on the ground by Humvee ambulances and, by air ambulance through a military Medevac unit.

On occasion, I went along in Blackhawk helicopters with the Medevac team to collect and transport patients from the location of injury. As far as combat injuries go, we would have extended periods of relative quiet interspersed with periods of intense activity when multiple casualties were brought in. We saw a fair number of blast injuries caused by Improvised Explosive Devices (IEDs) such as roadside bombs and car bombs. Although I had spent time in major trauma centers during medical training, the high-velocity and high-explosive trauma associated with rocket-propelled grenades (RPGs) and IEDs were unlike anything I had encountered in civilian practice. Kevlar helmets and Flak vests, which were very heavy and not necessarily suited for small frames such as mine (as I soon found out from my aches and pains after wearing one), were standard equipment for soldiers in Iraq. Although the vests did protect troops from injuries to the torso and viscera, there were still severe limb, head, and facial injuries.

Of course, we also treated more routine ailments since soldiers also get twisted ankles and skin rashes! There were lots of backaches, muscle sprains, diarrhea and GI upset, and dental problems (since keeping up with dental hygiene is often not high priority in this setting). Also, with higher numbers of reservists and National Guard troops, who are often older, we encountered a fair amount of ailments common to middle-aged groups, such as chest pain and heart disease. Malaria was another concern. Due to the dangers of insect and bug bites, soldiers were strongly advised to use Permethrin-treated uniforms and insect repellants containing DEET on all exposed skin, although that in itself can cause skin irritation and rash, as I can relate from personal experience! I also had to practice my psychiatric skills in dealing with some of the behavioral and adjustment problems and combat stress-related disorders.

Although we primarily provided medical support to the U.S. soldiers stationed at Camp Taji, we also treated civilians and enemy combatants, a situation which sometimes led to challenging ethical and logistic dilemmas. There are some ethical issues that come up in the role of the physician serving in a combat zone. Was my primary responsibility to the patient or to the military mission? In most cases there was no conflict, and good patient care was also in the best interest of the military. But there were occasional situations with the potential for conflict. I was lucky that I had a company commander who made it clear that he fully supported the guiding principles that I followed. These were to always keep medical ethics in mind when treating a patient, and to be familiar with the rights and duties accorded to medical personnel by the Geneva conventions. However, I didn't really think too much about such situations till I actually encountered them and my knowledge of these was relatively superficial initially; more in-depth familiarization with some of the specific details might have been beneficial.

Personally, it was a physically and emotionally challenging time for me. The occasional phone calls home were much too brief although greatly cherished; there was often a line to use the phone or to access the computer for email communication. It was hard to be away from home and family, and even more so on occasions such as Mother's Day. Our medical team gave those of us who were mothers on the team a surprise party that night and arranged for a cake.

In spite of the challenges, I found my experience in Iraq rewarding overall. I learned first-hand the personal, professional, and financial challenges and dilemmas facing physicians who are called to duty in war zones, and believe that I matured both personally and professionally during this time. I did return

with physical aches and ailments and emotional scars that may not have been apparent to others, as did many others who have witnessed first-hand the ravages of war. However, I was lucky to have a loving family, understanding friends and a very supportive supervisor, Dr. Thomas Dickinson, which helped ease me back into a supportive home and work environment.

The camaraderie and support of fellow soldiers, sense of purpose, and pride in fulfilling this duty all helped immensely during my service in Iraq. One of my treasured possessions is a letter from an elementary school girl that I received in Iraq that said —

Dear Major Sabharwal (MD),

My name is Rebecca and I am a second grade student in Billerica, Massachusetts. I wanted to write to you and say thank you for helping other people, being so brave, and keeping us safe. I hope you stay safe, you get to your family soon, and take care of yourself, and go home soon.

Sincerely,

Rebecca

*Generation to Generation:
Mother-Daughter Physicians*

DIANE K. SHRIER, M.D.

I graduated from medical school in 1964 in the era shortly prior to the feminist revolution. Gender discrimination and sexual harassment were the norm, especially in the conservative, male-dominated bastion of academic and clinical medicine. A popular pamphlet recommended for women contemplating medicine at that time was entitled, “Why Would a Nice Girl Like You Want to Go into Medicine?” This title was a variation on a question commonly asked in medical school admission interviews. Women, but not men, were routinely asked if they were planning to marry and, if so, if they were planning to have children. The implication was that they wouldn’t be able to be both mothers and doctors. Such questions are now against the law, but are still occasionally asked of women applicants.

A myth at the time was that women who entered medical school were more likely to drop out and not ever practice than were their male colleagues. In fact, research has found that women physicians practice an average of seven years longer than their male colleagues, in part because women tend to live longer. It was true — and remains true — that women physicians on average practice fewer hours per week than do men, especially married women with children. But that is generally because most women physicians continue to bear 75% of the responsibility for family and household, working a second shift at home.

I learned about Yale's quota of 6% women in their class of 80 students when I transferred to Yale Medical School during my second year. I was a first-year medical student at Washington University Medical School in St. Louis, Missouri, where I was one of 12 women — a large number for 1960. At Washington University, I was in the same class as Carolyn Robinowitz, M.D., who recently became dean at Georgetown Medical School. Dr. Robinowitz is the first woman psychiatrist dean and one of only nine women deans in the United States. Women in those days had to be twice as good to go half as far as our male colleagues. Most of the women in my generation of physicians felt lucky to be among the chosen few, and we rarely complained about the discrimination we faced. I almost wasn't accepted at Yale because I was breaking their quota on women and because my undergraduate degree was from a public college rather than an Ivy League school. When I gave birth to my first child in my last semester of medical school, the Dean threatened to withhold my medical degree, despite the fact that I fulfilled all the requirements to graduate.

In my generation, 95% of the population married, and only 65% of my children's generation marries today. However, women physicians in my generation, and even more so in the generations that preceded me, were much less likely to marry at all, and, if married, were much less likely to have children than other women in their cohort and certainly than their male colleagues. Couples living together outside of marriage or having and raising children as single parents were almost unheard of. So many choices exist today: to marry or stay single; to live with someone or not; to have children or not; to raise children as a single mother or as a couple; to have a full-time career, a part-time career, or stay at home. Having so many choices can make life much more difficult

as you agonize over which choice is the right one, even though these choices open up options unavailable to generations past.

Women, or girls as we were called then, were also cautioned that no one would marry us if we were too smart or too capable. And, if we wanted to have careers and leave our children in the care of others, we were told that we would be terrible mothers who would do lasting damage to our children. By the 1970s, the feminist revolution was in full swing and it was very pleasant and amusing to suddenly no longer be viewed as deviant, but to now be admired as a role model.

I was determined to prove the myths wrong and to somehow have it all. I was extremely fortunate to have a husband who was ahead of his time in wanting to be a full participant in a dual-career partnership and who wanted a wife who was a professional and a physician. My husband and I were young and foolish enough to think we could do anything we wanted to do. We married when I was 20 years old and entering my second year of medical school, and he was 23 and working toward his doctoral degree in chemical engineering — typical ages for people in our generation to marry, but very different from people of my children's generation, who likely marry in their late 20s, their 30s, or sometimes not at all. My husband originally wanted to have 12 children, but because I was going to become a physician, we compromised. We planned to have six children, one every two years, with the goal of them all being born before I was 30 — an indication of how naïve we were. In those days, 30 was considered elderly for childbearing, another fact that has changed. We had our first child, Jonathan, during my fourth year of medical school. Maternity leave was, of course, nonexistent in medical school, and paternity leave not even imagined. However, Yale expected their fourth-year

medical students to work on their senior thesis for half the year and that is what I did, in between changing diapers and feeding who turned out to be a very good-natured and flexible baby son. Five months after our son's birth, during my internship in pediatrics at New York University/Bellevue Hospital in New York City, my husband took primary responsibility for the baby, including arranging for and supervising live-out child care. His role was crucial since I was chronically sleep deprived from being on call every other night and every other weekend, and from commuting an hour each way by train from our apartment in New Jersey to New York City. We were both so exhausted after my internship that we spent the next year in Cambridge, England, where my husband did a post-doctoral fellowship in chemical engineering. In England, our second child, Lydia, was born, two years after her brother. When we returned I started my residency in psychiatry at Albert Einstein/Bronx Municipal Hospital Center. It was four months after Lydia's birth, and I had another lengthy commute from New Jersey since we elected to live midway between our two workplaces. This time we decided to hire live-in child care. Our third child, Catherine, was carefully timed to be born two years later, in between my psychiatry residency and my child psychiatry fellowship. I took only two weeks off. With a four-year-old, a two-year-old, and a newborn at home, it was a relief to go back to work. My husband and I began to rethink our original plan. Two years later we got a large English setter — a serious mistake. Five years later we completed our family with the birth of our fourth child, David, and by giving away the English setter — after he bit the mailman. Somehow in the interim my husband, attending school at night after work for four years, managed to get his law degree. We certainly had a lot of energy in our 20s and

30s! I have no idea how we did it all, but my only major regret is not having the time and energy to manage more children and not being able to find and keep better childcare. After David's birth, which had been a complicated one, I worked half-time (25 to 35 hours per week) and found time to learn tennis, aerobic exercise, and get to know women who didn't work outside the home.

Despite the background of gender discrimination and harassment, I have had a very satisfying professional career as a psychiatrist and a child and adolescent psychiatrist. I have gone as far — or further — than many of my male colleagues. I started my full-time academic career at 37 years old at New Jersey Medical School in Newark after my youngest child turned five. I had the exciting, though stressful adventure of building and running, with a team of colleagues, a large clinical and training Division of Child and Adolescent Psychiatry for more than 10 years. I learned to do clinical research and to publish in professional journals and climbed the faculty academic ladder. Ultimately, I became a professor of psychiatry and pediatrics, a rank only 10% of women academics achieve, which is still the case today.

After 14 years at Newark and launching our youngest child off to college, my husband and I left the New Jersey suburbs and moved to Washington, D.C. There I became vice-chair and director of Clinical Services at Children's Hospital and a member of the faculty at George Washington University Medical Center (GWUMC). After two years of dealing with the impact of managed care on an academic medical center, I left my paid academic position for a part-time solo private practice, while establishing myself as an "academic without walls." I write, do research, teach and supervise faculty and attending staff, and I am an active volunteer in professional organizations.

I have been fortunate in having a loving and supportive husband who has been an equal partner. We raised four accomplished and high-achieving children, one of whom followed me into medicine. For 10 of my years at Newark, two of my child psychiatry and psychology colleagues and I co-taught a lunch-time elective for medical students called "Parenting and Professionalism: Combining Career and Family" (Shrier, Brodtkin, and Sondheimer, 1993). We all learned a lot about the different ways to strive to have it all without turning off our children to careers in medicine. My daughter, Lydia A. Shrier, M.D., M.P.H., and I have now embarked on a long-term study called "Generation to Generation: Mother-Daughter Physicians."

LYDIA A. SHRIER, M.D., M.P.H.

*W*henever I hear my mother recount her experiences, the same thought always comes to mind, *I have it easy!* I feel as if I have always known I wanted to go into medicine. I honestly don't know if having a doctor for a mother influenced my initial interest in a career as a physician. I suspect that many of the same traits that attracted my mother to medicine were operating in me. I, too, am a nurturer and like to be in charge. However, once I decided to go into medicine, having a trail-blazer for a mother was very important to me. My mother never pressured me to be a doctor, nor did she ever try to dissuade me, but the way she has led her life has allowed me to focus on the positives of being a physician.

Following is the opening paragraph of my personal statement for my medical school applications, which I wrote at the age of 20, the same age my mother was when she transferred into her second year at Yale Medical School.

When I was four years old, I announced that I wanted to be a nurse. My mother, a practicing physician, asked me, 'Why not a doctor?' I replied matter-of-factly, 'Women can't be doctors!' Needless to say, my perspective on the capabilities of women has changed somewhat, not without a little help from my mother! Indeed, my mother has been instrumental in fostering my interest in medicine. Through her I have seen that one may have a successful career in this field and a large family. Having raised three of her four children while still in training, my mother certainly serves as an appropriate role model. Furthermore, she has exposed me to not only her personal satisfactions derived from a medical career, but also opportunities to develop my own perspectives on such a profession. Throughout high school I worked in my mother's office (a psychiatric practice in our home) and regularly visited the hospital where she was chief of the division of child and adolescent psychiatry.

Do you think I was just a little proud of her?

As a girl going through junior high and high school, there was nothing unusual about wanting to be a doctor. As an undergraduate at Yale from 1983 to 1987, I knew many women in my class who were planning a medical career. I chose to major in applied mathematics with chemical engineering, in part to be a nonconformist, in part because I hated biology, and in part because my father received his doctorate in chemical engineering from Yale. I am the daughter of *both* my parents and I enjoyed the metaphor of completing my premed requirements *and* an engineering major.

At Albany Medical College approximately 40 percent of my medical school class were women. I never felt academically different from the men in my class because I was a woman. However, in reflecting with my classmates on what led up to us entering medicine, it became increasingly clear that I had a unique set of experiences by virtue of being the daughter of a woman doctor. We all had to jump through the same academic hoops to get into medical school, but each of us had his or her own personal barriers. I began to realize how extremely fortunate I had been to never be plagued with doubts that I could be a doctor because I was a woman. My mother's history made the path I was traveling seem perfectly reasonable. Sure, it was a heck of a lot of training, but I wasn't also up to my elbows in diapers! Being a woman certainly never seemed to be an issue.

One of my most wonderful and cherished experiences in life was my graduation from medical school. I was really a doctor! The day was made all the more special by being hooded by my mother. I was the only person, male or female, whose physician mother participated in the ceremony and the only daughter of a woman physician.

After pediatric residency at Yale, I came to Children's Hospital Boston for a fellowship in the Division of Adolescent/Young Adult Medicine and continued on as faculty. The division is more than 90 percent female, and is headed by a woman chief. One of my colleagues is also the daughter of a woman doctor; another has a physician father. While no longer quite as unique in my heritage, I still feel very fortunate to be able to reflect with my mother on her career and mine. She is both my mentor and role model, but I, too, have been able to teach her a thing or two about medicine and about research. As I am also pursuing an academic track, I have been able to discuss with my mother how to balance the

multiple demands of the job, develop effective negotiating strategies, and climb the academic ladder, while still remembering the patient care aspects that drew me to medicine in the first place.

Despite the many differences in our experiences being women in medicine, my mother and I share some unfortunate similarities. Throughout my education and training, I have been confronted several times with sexual harassment. It is always shocking to me. I have been in educational and work environments with boys and men my entire life, and I have never felt that either my gender or theirs needed to enter into the equation. Situations I've encountered in which a male superior has sexualized an interaction with me serve as potent reminders that as far as women have come in medicine, bias still exists in the profession. Much as I feel empowered by having a physician for a mother, and one who has written on the subject of sexual harassment (Shrier 1996), it is amazing to me how emotionally debilitating sexual harassment can be.

The personal and professional commonalities I share with my mother have allowed us to become closer. We had our moments when I was in high school, college, and even medical school when we didn't get along so well, probably because our temperaments are so similar. But let's face it — it is unavoidable — I am becoming my mother! I, who had declared my intention to be a pediatrician (not a child and adolescent psychiatrist like my mother) at the age of 12, won the Best Student in Psychiatry Award in medical school. I subspecialized in adolescent medicine in part because of the mental health aspects of the field. My mother and I discuss dilemmas in the management of our eating disorder cases and refer cases to one another. Both my mother and I have done research on the topic of child sexual abuse, and I have cited my mother's research in articles I have written. My primary research advisor

is the chair of psychiatry at Children's Hospital Boston and, while my primary appointment is in pediatrics, my secondary appointment is in psychiatry. My mother's primary academic appointment is in psychiatry and her secondary appointment is in pediatrics. I confess: I *like* our similarities.

Being the daughter of a woman physician has enriched my medical career in so many wonderful ways. I feel I have been very fortunate.

Four Generations of Women in Medicine

MARGARET E. TOMPSETT, MB, BCHIR

*M*y grandmother, Ethilda, was a pioneer. Born in England in 1872, she was the fourth child of a British merchant who worked in India for many years. The family was very religious and Ethilda's mother was often distraught when her husband gave his last penny to the poor instead of saving some for the family. Ethilda knew from an early age that she wanted to be a doctor. This may have been partly because of the suffering she saw all around her in India, but also because she had deeply held values of service and caring for those less fortunate than herself. In addition, she was close to and admired tremendously her brother, Harold, two years her senior, who became a doctor.

By the age of 12 she had had little formal schooling, but her older sister Mary who was studying music in Goettingen, Germany, invited her to attend high school there and share her home. Ethilda spent two years there before returning to her family, then in Morocco, where her father had transferred because of poor health and started the *Morocco Times*, in which he wrote about the poverty and the appalling manner in which indigenous people were treated. When the family returned to England, he was thrown into jail for his seditious writing.

In 1888 Ethilda attended the North London Collegiate School for Girls, the only place in London where she could get an education in the sciences, which she needed to go to medical school.

She distinguished herself there by becoming Captain of Sports and persuading Miss Buss to hold a sports day of Olympic games and competitions. When she completed her education, her parents tried to discourage her from becoming a doctor and sent her to work in the Gorbels in Glasgow, a port city on the west coast of Scotland that had terrible slums. There were as many as four families living in each room, and sanitation consisted of a hole in the ground in the courtyard.

This experience only strengthened Ethilda's resolve to become a doctor, and she was accepted at the London School of Medicine for Women at the Royal Free Hospital in 1893. She was one of a class of eight women, and qualified as a doctor in 1898. By the end of the 19th century there were 200 women doctors in Great Britain.

After four years in England, Ethilda set out for India. She first worked in Bombay, and later was appointed physician-in-charge of the Victoria Hospital for Women and Children in Calcutta. Her description of her work in gynecology and obstetrics makes fascinating reading. Many of the patients were seriously ill. She operated on a woman who had been in labor for three days. The uterus was firmly contracted on the child, and a copious offensive discharge was present. The pelvic outlet barely admitted two fingers. The operation took 35 minutes, and both mother and child did well. Through her experiences in India, she concluded that often the will to survive was more important to recovery than severity of illness.

In 1908 Ethilda married my grandfather, Oscar, a Calcutta businessman. She had met him hiking in the Himalayas and got to know him playing chess. According to my mother she walked down the aisle of Calcutta Cathedral on an incredibly hot humid day saying to herself, "Why am I doing this? I am much too old to have children." They had a stormy marriage, as my grandfather

was a fairly conservative well-organized businessman and my grandmother was an imaginative woman who was filled with enthusiasm for various causes. Once she thought something should be done, she left no stone unturned until she made it happen, and did not always realize how much she put other people out.

Their first child, Harold, was born in India in 1909. Their second, Martin, was born in Geneva in 1911. My grandmother stopped off on her way home from India to hear Sigmund Freud speak, while her sister Ellen helped her look after the two boys. During 1910 and 1911 my grandmother published three gynecological papers based on her work at various European clinics. In 1912 my mother, Sylvia, was born in England. My grandfather was furious at my grandmother for getting pregnant again, as she was well acquainted with Marie Stopes' pioneering work in contraception. However, when the baby turned out to be a girl, his heart melted.

In late 1913 she set out for India once again, leaving the two boys in the care of a nursery. This was not an unusual thing for British people working in the colonies to do, as the Indian climate and diseases took a tremendous toll on the health of children. War broke out, and my grandparents were not able to get back to England until late 1917. By this time they had a fourth child, George, born in Darjeeling.

The family settled in Reading, just west of London. My grandfather had been forced to retire early because he spoke out about his firm's mistreatment of their Indian employees. My grandmother made good childcare arrangements for the family, as she always had an intelligent educated woman living in to look after them and help run the household. By this time, my grandmother was becoming more and more interested in psychoanalysis, and obtained work in a psychiatric clinic in London. In 1922 she made

arrangements for care of the children during the Easter holidays (they were all in boarding school by then), and went to Budapest to be analyzed by Ferenczi, while my grandfather studied violin at the Conservatory there.

My grandmother's last paper, entitled "The Infantile Mind and its Relations to Social Problems and Mental Hygiene," was published in 1928. At that time she was an associate member of the British Psychoanalytic Society. She traveled up to London and participated in most of their meetings, and was delighted when finally she was made a full member in 1934. During her later years, she worked in private practice as a psychoanalyst.

My mother remembers wanting to be a doctor at a very young age. She enjoyed looking after and helping people. She looked up to her mother, and internalized her values of family loyalty and respect. She was less religious than my grandmother, regarding herself as an agnostic, but was a firm believer in humanitarian values.

My grandmother made sure that my mother, Sylvia, had the same educational opportunities as her brothers. When my mother was only two weeks old, my grandmother met Penelope Lawrence, founder of Roedean, a boarding school for girls, and put Sylvia's name down for it. When Sylvia was thirteen she went to Roedean. There she distinguished herself by being a prefect (in charge of discipline of the younger girls) and captain of the lacrosse team. She received a good education so that she was able to follow in her mother's footsteps to the London School of Medicine for Women.

Sylvia qualified as a doctor in 1935, and went to Bristol to work as a house officer. She shared an apartment with her brothers: Martin, who was studying medicine, and George, who was in business. George left to train as a fighter pilot, but in 1937 was

drowned in a sailing accident. This was devastating to the whole family. Harold came back from India, where he ran a sugar plantation, to be with his parents. Sylvia was heartbroken, as she had been very close to George.

Sylvia returned to London to pursue an interest in psychiatry and applied for a job at St. Bernard's Hospital, a large mental hospital outside London. She was in analysis with Marjorie Brierly at the time. My father, Ted Hatfield, was working at St. Bernard's Hospital. When he heard that Sylvia was coming to the hospital and that she was in analysis, he thought "this is the girl for me," as he was also in analysis and interested in pursuing psychoanalytic training. They met shortly before war broke out and their lives were totally disrupted. My father joined the Navy and went to sea as a ship's doctor. By June 1940 France had fallen. My father got 48 hours leave, came home and married my mother, as then at least they would have some chance of seeing one another again.

My mother did various hospital jobs during the war while my father worked first on a destroyer and then in the psychiatric service. My older sister, Jess, was born in 1941 and I followed her in 1942. My father's mother was so incensed that my parents were so irresponsible as to produce children while Britain was at war that she refused to see us, and sadly died on VE (Victory Europe) day, before reconciliation was possible.

Near the end of the war, my father bought a practice in Chipping Ongar, a small town 23 miles northeast of London. Conditions were very hard at first as they had no money, no furniture, and nothing to heat the big drafty house. He used to drive 50 miles a day making house calls to agricultural workers who could barely afford to pay him, while my mother answered the phone and took care of people who came to the house when my father was not there. Financially, it was a tremendous relief when the

National Health Service came in, and they were paid a certain amount for each person on their list. My parents' office was in the house, and there was also a small cottage hospital, where they could do minor surgery and deliver babies. We often had a chicken or goose at Christmas given by a grateful patient.

In the early days my mother did not do much medical work except on the telephone. My brother, Edward, was born in 1945, and my sister, Anne, in 1946. Richard followed in 1950. My father was an only child and determined that each child should have a brother and a sister. Mother was happy with this but said six was her maximum. An older friend, Mrs. Chapman, came to live with us when she was grieving for her son killed in the war and for the loss of her house which was bombed. She stayed with us until I was 14 and taught us until I was 10 and went away to boarding school. Mrs. Chapman had a rather authoritarian manner, and my mother was glad that she brought order into a chaotic household. We also had a cook, Mrs. Hale, who ruled the kitchen.

My parents always held up medicine to us as the most fulfilling profession, as they were interested in people and in the psychological aspects of illness. They attended groups at the Tavistock Clinic run by Balint for general practitioners, and at the dinner table there would often be medical discussions. My parents were also convinced that their way of organizing their work life was the best. As the practice grew they took in first one and then another married couple as partners. The women could practice less when they had young children and more as the children got older, with the men picking up the slack. Overall I think this worked out well, although we still felt that we did not see enough of our mother. She was a very kind person, thoughtful and caring, but somewhat distant. I determined to have a smaller family as

I thought she was overburdened with five children. I only have four; two boys and two girls.

My parents were much loved in their practice as they always spent time listening to their patients and knew many families for several generations. They continued to live in the home in which I grew up for many years, and when my mother went shopping she would be greeted warmly by local people whom she looked after as patients.

As a young child I did not want to be a doctor. I hated patients, viewing them as strange people who dragged my mother away from me by calling on the phone or by coming to the door. In my teenage years I became deeply religious and planned to become a missionary. My parents were dismayed and gave me books on medical missionaries, such as Albert Schweitzer, to read. When I was 16, my mother sat me down and talked to me about doing medicine, so that at least I would be doing something useful instead of just converting people to Christianity! I thought about both medicine and teaching as professions and opted for medicine as I prefer working with people one-on-one, and I could not imagine keeping order in a class of naughty children.

I did well in school, spending the last two years at the North London Collegiate School, where my grandmother had been a pupil. I was accepted at Cambridge, where men outnumbered women ten to one. They were happy years in idyllic surroundings with an incredible level of intellectual stimulation. I met my future husband, Mike Tompsett, a physics major, during my first year. My parents were afraid that if I did not marry a doctor I would give up medicine. However, I proved them wrong.

I spent my clinical years at St. Mary's Hospital in London, where my father had trained. I did not want to go to the Royal Free Hospital, where my mother and grandmother had been, as

it was for women only. My brother, Richard, later went to the Royal Free to continue the family tradition. By then it was co-ed. At St. Mary's there were many more women than at Cambridge, because in our generation bright men were encouraged to go into physical sciences. At Cambridge medical students were regarded as "thick medics" and looked down on. My first clinical rotation was on the allergy unit where there were many asthmatics. I soon found that I was far more interested in their personal lives than their diseases, and in the stresses which led to their asthmatic episodes. In addition, I wanted to have a family and felt that it would be easier to keep up with one small branch of medicine than with the whole of medicine. I therefore decided to go into psychiatry. I entered an essay competition, run by the Mental Health Research Fund, on the topic of advances in the treatment of mental disorders in the last 30 years. I was awarded a prize and on the basis of an interview I was also awarded a fellowship to do one year of my psychiatric training abroad.

When I graduated medical school in 1967 Mike and I married, and while I was doing my year of medicine and surgery we looked for suitable work in the United States. In 1969, after I had six months' experience in psychiatry, we came here on immigrant visas, I to work for a year at Montefiore Hospital in New York and Mike to work at Bell Labs. At the end of the year he was so involved in exciting new work on charge-coupled devices that he did not want to go home. Now we have been here 37 years and have four American children. I did a child fellowship after my residency training at Montefiore and have been in private practice as a child psychiatrist ever since.

I was determined to strike a better balance between work and family than my mother had and so did not start a family until I finished my training. Then I took time off and for several years

only worked 10 hours a week. I did not increase to 20 hours until my youngest was in first grade. As time has gone on I have increased my work load and have also taught child psychiatry and psychotherapy at New Jersey Medical School. More recently I have been very involved in disaster psychiatry, helping out after 9/11 by running a group for children who lost their fathers, and after Hurricanes Katrina and Rita by working in Louisiana for two weeks. I never thought of myself as having a career but as doing useful and interesting work. Despite my attempts to balance work and family, my oldest daughter, Karen, is angry at me for not being sufficiently available to her.

Karen was born in 1973, a much loved and desired child, after Mike and I had known each other for 12 years. She was very bright and showed tremendous determination from a young age. She excelled at lacrosse as well as creative writing and sciences at school. She went to Dartmouth to major in government. One summer she went to Ghana to do volunteer work, which turned out to be poorly organized, and some of the volunteers got seriously ill. She phoned us from there to tell us that she had decided to become a doctor. She switched to premed at Dartmouth, and after a year of travel in which she visited India and Nepal, she started medical school at the University of Pennsylvania. She has been honored by being made a 21st Century Fellow, and being inducted into the Alpha Omega Alpha Honor Society. She married Dave, who trained in emergency medicine, and she became a dermatologist. They hope that by choosing these two specialties they will be able to balance work and family. They now have one child, Emma, a lively little girl dear to all our hearts.

Karen will have the distinction of being the only fourth generation woman doctor as far as I know. I do not think any of us have felt any conflict about medicine as an appropriate profession for

a woman, since my grandmother blazed the trail. Our conflict is more about how to balance work and family. Let's hope that Karen is more successful than I have been.

*Art and Science in Medicine:
A 40-Year Experience
in Medical Practice*

INGEBORG VAN PELT, M.D.

I grew up in a family where medicine was a tradition. My grandfather had practiced medicine in a small town where my father later became the general practitioner. Would any of us six children continue in the same field? I did not feel particularly drawn to medicine during my school years, but was pushed in that direction at the end of my high school years because of political circumstances in Communist East Germany. When I refused to join the Communist youth organization, I was barred from any profession other than pure science. What about medicine? Was it pure science? Would I qualify? Here the positive aspect of Communism came to my rescue: equal rights for women. Female students were sought after in East Germany, and since I had been an excellent student in high school, in 1951 I was allowed to enter medical school without Party membership.

At the beginning of my medical training, I wanted primarily to learn about the causes of disease. I wanted to be taught how to treat patients and to guarantee cure. I soon discovered, however, that the human body is not a machine known and manageable in all respects; instead, it is a complex organism with only partially predictable physiological and biochemical functions and interactions. I remember the first time my science-oriented mind was challenged to think about the art in medicine. The professor in

pediatrics in a West German Medical School presented a toddler who was admitted to the university hospital because of fever of unknown origin. We discussed in detail the differential diagnosis and we learned at the end of this discussion that the child's fever was caused not by an infection or by another serious disease, but instead by stress. The family farm had recently burned down, devastating the whole family and contributing to the illness of the youngest child. I wondered how fever could be caused by stress.

What impressed me even more was the treatment the child received in the hospital. While organic illness was being ruled out, the child was provided with a small children's chair during his hospital stay. He was presented in the lecture hall sitting in this chair. Since the family had nothing saved of their own, the child was to be discharged from the hospital with this chair. The professor emphasized the importance of security for this child, and for any child, in order to assure health and wellness. This gift of the chair not only helped the child, but it also served as an enticement for the family to rebuild with hope. This example of caring, of concern for the well-being of the child and the family, has stayed with me throughout my medical career. It was the first stimulus to lead me to specialize in pediatrics.

My pediatric training began in the early 1950s in a hospital in Germany. Because it had only limited laboratory facilities, I needed to quickly acquire the skill of observing my patients closely and of listening to any changes in body function, like respiration, or to a vigorous or feeble cry. During this time, I learned the most from the nurses who worked 12-hour shifts, spending most of their time with the children. The skills I developed then have benefited me throughout my medical career.

My further training in Canada and the United States taught me the importance of a close working relationship with the child's

mother or guardian. I learned to recognize when it was sufficient to provide the mother with a prescription and adequate instructions, and when I needed to get help for the mother and introduce her to a social worker. This step needed to be approached in such a way that the mother could accept it as a positive step, and not perceive it as a defeat. I learned how to comfort mothers of children who were physically or mentally challenged. I discovered the importance of not bombarding the mother with bad news. If the child had diagnosis of mental retardation, learning disability, or a seizure disorder, the mother already knew that. Instead, I tried to convince her that she could contribute to the child's development. I, the physician of her child, was dependent on her keen observation of the child's developmental progress as well as her observation of the seizure control.

I was reminded of the success of this approach last year, when a headache patient of mine commented: "You will not remember me, but you saw me with my daughter 35 years ago when she suffered from seizures. I never forgot your words: 'We will get the seizures under control. In regard to her mental development — she will be doing well, as long as there is a steady gain, even if she is still below the desired percentile.' My daughter has outgrown her seizures; she is well, and a happy mother herself."

When my three children were young, I decided to drastically reduce the hours of my professional medical practice because I wanted to be part of my children's development. As an unexpected side-effect, spending time with my children also enhanced my professional expertise. I learned from my children how to interpret a complaint, when to look for an organic cause, and when it was necessary to explore other reasons. For instance, when my oldest son was a first grader, he started to complain of daily stomach-aches before going to school. I functioned

initially as a pediatrician. He looked ill and stayed at home. He then recuperated surprisingly fast each day. I soon found out that it was not an illness that caused his pain, but the fear of a rigid teacher and a confining class setting. I changed overnight from a dedicated physician into an ardent school reform advocate. As I became involved in the school, my son's physical symptoms started to disappear. My children also taught me that severity of pain was not necessarily in keeping with the seriousness of the illness or injury. Their perception and expression of pain paralleled rather their emotional status, their need for comfort, or their fear that something terrible had happened to them, to their body. My medical knowledge served me well and helped me decide whether to act as a professional medical doctor or whether to act as a wise mother and distract my child with pleasurable activities or little surprises.

When I returned to professional medical practice, I certainly had to refresh my scientific knowledge. On the other hand, I brought back to my profession what I had learned as a mother: how to establish trust, how to give comfort, how and when to be firm, and when to insist on compliance with my instructions. All these skills I now used successfully with the adolescent patients in my new college student health profession.

I started my part-time job in student health because the women of the newly formed coeducational program demanded a woman physician, knowledgeable in gynecology and women's concerns. During the following years, my role as the "gynecologist" on campus changed to that of an uncommon general practitioner, who became several times an honorary member of the graduating class. Why? I became aware of the numerous influences on the students' health, issues of gender, of cultural background, of sexual orientation, or issues of excessive physical, academic,

or other demands. The students requested medical treatment for chest pain, abdominal pain, headache, insomnia, fatigue, and depression, and hoped for a quick cure.

Here again, I was challenged with making a medical diagnosis, and with interpreting the complaint as a possible symptom of underlying distress. It soon became known on campus that I was interested not only in disease and illness, but about each individual. I was visited because I was able to “sort things out,” to explain the connection of body, mind, psyche, and the environment. But how would I explain to the college administration that my approach was professionally sound? Since I had witnessed an unexpected “cure” of a patient with a 14-day history of daily headache, I decided to enhance my knowledge by participating in the Headache Clinic of the Faulkner Hospital in Boston. Here I learned the art of engaging a patient in a personal dialogue, and I improved my skills in obtaining the necessary medical information while being aware of emotional, cultural, social, and interpersonal concerns. I also learned the importance of interrupting the medical inquiry by moving the questioning to a “neutral zone,” by asking about hobbies, pleasurable events, or skills, so that the patients would realize that their life was not just pain. I found that an initial one-hour interview is time well spent. It provides the opportunity to establish a mutual trust between physician and patient, which is so crucial in caring for patients with chronic illness.

After eight years as a part-time physician I accepted the directorship of the Amherst College Student Health Services, not because I was hungry for power and prestige; I wanted the college to understand the importance of health and health care, the importance of giving the students responsibility for taking care of themselves, particularly, at this time, when fear of an AIDS

epidemic had gripped the entire nation. I also wanted to demonstrate that mental health and physical health need to be seen as interdependent. Therefore, I was particularly interested in establishing a working relationship between the center of psychoanalytic therapy and our medical health service. How could I and my staff justify our bio-psycho-social approach in medicine when the counseling center insisted on the concept of isolation and non-communication? The dichotomy between the two departments' understanding of health care made me continue in my efforts to educate the entire campus about this issue until improvement took place.

During the following years, I kept up my search for scientific answers to my questions about healing. I enhanced my knowledge in the bio-psycho-social field by familiarizing myself with biofeedback and other stress reduction techniques. I became interested in insight and awareness meditation and yoga. I found both of these methods to be beneficial for those patients who needed to calm their hyperactive minds and their stressed bodies. However, it did not solve the problems for those who struggled with self-doubts, who felt depressed about chronic illnesses, and who suffered from anxiety and fear about frequent headache attacks. I needed to find a psychology/philosophy that stressed the importance of activating inner strength and the importance of hope and meaning in life. I rediscovered Viktor Frankl's logotherapy. Its premise is that we have a body and a psyche, but that we are human because of our healthy human spirit, with an innate freedom for choice, a will to meaning, and a capacity for transcendence. By applying Frankl's clinical techniques, I meet my patients as human beings who are endowed with inner strength, although they are concerned about disease and physical or emotional pain. Our personal encounter

guarantees a trusting relationship, it enhances the patients' willingness to share the necessary information for a diagnosis, and it also energizes them to take the lead in their treatment plan. As a result we witness improvement of their condition and amelioration of pain.

My new insight about self-healing, not through miracles, or external measures but through positive thought and action has humbled me as a physician. At the same time, it excites me because it points to new possibilities for studying the positive placebo effect.

My 40 years in medicine reflect my professional journey toward an understanding of illness and healing. Now, almost at the end of my medical career, I evaluate the growth in my professional development. I began as an enthusiastic student of pure scientific medicine, which I assumed would disclose all secrets of disease and dysfunction of the patient and would provide a blueprint for cure. I soon learned that because of the many variants of each individual, science alone will not cure a patient from disease and dysfunction. As I went along in my training and practice, I was introduced to the art in medicine: to become a good listener, a keen observer, and a patient advocate. My instructors, my patients, and my children helped me to discover the interrelationship of the physical, psychological, and social spheres. Finally, I learned to understand my role as facilitator for healing and health by empowering my patients, by sharing the responsibility and the joy in the healing process.

When You Don't Fit the Mold, Make a New One

ASHA P. WALLACE, M.D.

*L*ike many other women physicians my age, I met with a lot of resistance on my path to becoming a doctor. But I've always been a very determined person. Looking back, I don't think I even noticed some of the obstacles. I was fixed on my goal.

I knew when I was five years old that I wanted to become a doctor. I loved school and I enjoyed challenges. I grew up in Malaysia, a fairly westernized multi-racial Southeast Asian country. My father was a physician; my maternal grandfather a veterinarian. Nobody I knew thought medicine was a suitable career for a woman.

As I grew older, I enjoyed studying science and I knew I wanted a career that would be rigorous and rewarding. I was a good student, and early on I aimed for medical school. My father resisted at first; his plan was for me to be a teacher or a nurse, enter into an arranged marriage, then supervise a household and raise a family. I had different ideas. When I won a scholarship at age 15 from the United States Information Service to go to medical school in the United States, he realized I was serious about becoming a doctor. He did not let me use that scholarship, but he allowed me to apply to medical school, including Adelaide University in South Australia, where I was admitted.

I was 16 when I left home in 1956 and entered a six-year program in Australia. It was a totally new environment with a different climate, culture, and lifestyle. My fluency in English

was only slightly helpful in comprehending Aussie English, but once I mastered it I really began to enjoy the company of my women residential college-mates, many of whom I stayed in touch with. From them I learned important skills such as how to toast crumpets on the portable radiators we bought for our dormitory rooms.

My medical school class of 105 had 10 women in it. All of us were regarded by our male colleagues as somewhat peculiar. All of us heard, "What's a pretty girl like you doing in medicine?" We were all highly individualistic, and we did not participate in the social culture of the university to the same extent our non-medical counterparts did, partly because of our heavier schedules.

Some women married straight after graduating from medical school and did not return to medicine, which I saw as a waste of their training. A brave few pursued their profession and remained single, enduring remarks about their "old-maid" lifestyles and the silent disapproval of both men and women.

I looked for a way to have both a family and a career. I did not want to work full time, because it would not have allowed sufficient time for me to be with my children.

Part-time work at that time was not well paid, and it was often a dead end. Besides, it did not eliminate the need for childcare. It did, however, keep one in touch with medicine. So I decided to go that route. My decision to work part time was strengthened after I heard the story of a very successful woman physician who worked full time. Her husband was also a very successful physician. They had several children who had a very close relationship with their live-in housekeeper, but a somewhat distant and formal relationship with their parents. When the children grew to be young adults, their mother, unfortunately, became very ill. She retired from practice and asked her children to accompany

her on a cruise before she died. One child refused the invitation, saying that there was an important career opportunity that could not be missed.

I made one other break with tradition: I decided to marry an Australian despite all the advice to the contrary from well-meaning relatives and friends. I met my husband at university when he was an engineering student, and he was perfectly comfortable with the idea of me pursuing my profession after marriage and completing residency training. He was not at all threatened by having an educated wife with career ambitions, and he supported me in reaching my goals.

Our decision that I would work displeased my husband's parents, because they felt it reflected poorly on his ability to support me. I tried to explain that we truly needed his income as an engineer because I was being paid a pittance as a resident, but they thought my explanation made very little sense because I was putting in long hours and unable to be home each night to greet my husband with a three-course dinner, which had been the custom in his parents' home.

My new husband and I decided on my choice of specialty together. I toyed with the idea of plastic surgery, but the training period was daunting. We decided that general practice offered the greatest flexibility for part-time work. After my son, and 19 months later, my daughter arrived, I began working part time in an office practice. I was paid four guineas per four-hour session, a fee set by the local medical society. I also hired a babysitter.

My mother-in-law lived too far away to provide childcare, which she would have been willing to do; regardless, she thought I should stop working and stay at home with the children. She would not have objected to me hiring a babysitter for the purpose

of playing bridge or tennis regularly, though, because that did not reflect negatively on my husband's abilities as a provider.

Like most women, I accepted primary responsibility for the children and household management, so part-time work was enough to keep me very busy.

Four years later we traveled from Australia to Massachusetts "just to have a look" — very much to the dismay of our parents. We found that my husband was easily employable as an engineer because of the accelerated space research program. We liked the United States, and soon made many friends.

I was still pursuing my goal of working part time in medicine and was fortunate to be admitted to a half-time residency in ambulatory pediatrics at Children's Hospital in Boston. The other half of the residency had previously been negotiated by a woman I did not know.

I heard many derogatory remarks about women doctors in Australia, and I heard them in Boston, too, as well as remarks about foreign medical graduates and heavy accents. We simply had to work harder to prove ourselves. On the bright side, I became an active member of the American Medical Women's Association, where I made many lifelong friends.

After completing my residency at Children's Hospital I continued working part time, mainly at Student Health Services at Wellesley College. I also became involved in the Massachusetts Medical Society. At the time, most of the Society's members were middle-aged white men, but they got used to the presence of the "gals" and "ladies," and eventually we found ourselves in leadership positions in the Society, particularly when women began applying to medical school in greater numbers.

After my children began high school and my husband settled in his business career, I started a full-time solo practice. It was

challenging and demanding, but I really enjoyed it. Having some life experience and maturity helped me understand my patients. I became so busy that I was glad I had taken the time to be at home when my family was young.

I am fortunate to have had people in my life who helped me grow as a doctor and enjoy being a physician. My husband supported me, and I supported him when he went to MIT's Sloan School for his M.B.A. I also had a wonderful mentor at the MMS, Grant Rodkey, M.D., who encouraged me to achieve goals I thought were beyond my ability, and who was pleased when I did achieve them. Dr. Rodkey told me that my duty as a mature physician was to mentor others and encourage them to set high goals for themselves. He said that would be the most satisfying thing I could do for myself, and it has proved to be true.

I'm glad I was blissfully ignorant when I set out on the path to becoming a doctor — that I did not know how many obstacles would face me. Young women in the 1970s and 80s believed they could have it all. They made huge sacrifices at home or at work in trying. They were told they could spend small amounts of “quality time” with their children, and that that would be enough. It was very hard for them; they were trying something that had not been tried before.

These days, many young women choose to put their careers on hold while they raise their children. It seems as if we have come full circle, back to the 1950s and 1960s, when my women classmates and I were struggling to choose between family and career.

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