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Medical women in academia: silenced by the system

Anita Palepu and Carol Herbert are to be commended for their thoughtful analysis of the issues facing women in academic medicine.[1] While there is acknowledgement that domestic responsibilities are a major contributor to the career obstacles many women face, there also exists a gender issue at the systems level. Because the academic structure developed at a time when men were its only members, it tends to value stereotypically male characteristics such as autonomy, assertiveness and decisiveness.[2,3] In such a structure, "women are perceived as having less leadership ability and less competence, and when women exercise assertiveness or try to assume leadership they have to work harder to get attention and they receive more negative reactions."[2]

Perhaps women could develop a different type of organizational structure. A survey of faculty at a single US academic institution found that, relative to their male counterparts, women faculty placed less value on accomplishments such as leadership, scholarship and national recognition and more value on recognition of their work by patients, students and local peers.[4]

This analysis by no means presumes that men intentionally perpetuate the system, nor does it imply that all men benefit from the current structure.[3] New strategies must address ways of changing the academic system to best accommodate the strengths of both women and men, rather than trying to mould women to fit an organizational structure that was never designed for them. This goal can be accomplished by a willingness on the part of academia to understand and root out the cultural biases that lead to discrimination. We would all be well served by institutional approaches that address "discrimination by fixing the organization, not the women who work for it."[3]

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Early in my career I was blessed with 4 children. Needless to say, this forced me to make major decisions about how I would conduct my medical practice. Although my doctor-husband became involved in hospital and committee work, teaching and a full range of family medicine activities, I decided that I wanted to spend more time with my children while they were young; therefore, I had an exclusively office-based practice.

Now all 4 children are off to university. I have no regrets about how my career evolved. I continued to practise medicine while many of my female colleagues fell by the wayside because they could not balance career and family. My only regrets echo those expressed in the article by Anita Palepu and Carol Herbert[1] — I "regret the time [I] did not have for [my family] rather than the time that [I] did not have for work."

There are some things that I would have done differently, but in the end I think things turned out well for all of us. Proof of this was a recent family discussion during which we talked about which was our favourite weekday. My eldest, without hesitation, declared Thursday to be his favourite weekday because, as a little guy growing up, he knew that I was always home on Thursdays and we would spend time together and do things. The tears in my eyes confirmed that I made the right decisions.

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I commend Anita Palepu and Carol Herbert[1] for challenging us to rethink the orthodoxy that characterizes medical academia. It is through the work of pioneers such as these that not only women, but also visible minorities and other previously restricted demographic groups have entered and succeeded in the academic realm.

Perhaps one of the most critical elements in this transition is the social awareness within student populations at Canadian medical schools. At the University of Western Ontario, I witnessed the development and expansion of several initiatives related to gender, culture and socioeconomics, and from my vantage point as a student leader, I observed this trend at other Canadian medical schools as well.

Central to the success of these projects was the support, both moral and financial, of faculty and administrators. Palepu and Herbert recommend mentorship and innovative administrative portfolios as ways to encourage women to advance their academic careers. Such initiatives send a strong message about the priorities and social conscience of an

academic faculty of medicine and create a supportive environment for medical students. Also, the people acting as mentors and promoting this philosophy are often students' most vocal advocates.

With regard to the authors' notion that female academics often take a different career route than "their male counterparts," perhaps we should broaden our definition of academic and professional success to encompass a variety of alternative pathways and thus to ensure that no academic physician is prevented from building his or her career in a nontraditional way. Facilitating such a paradigm shift will allow physicians to attend to family responsibilities, professional projects and personal growth, the common endpoints being the development of diverse skill sets and truly satisfied academic physicians.

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[The authors respond:]

We thank Rose Hatala, Shirley Epstein and Sachin Pendharkar for their letters, as well as our colleagues who were prompted by our commentary[1] to share with us their experiences of being a woman in medicine. We agree with Hatala and Pendharkar that the academic structure needs to evolve and that multiple pathways ought to be available to allow both women and men to be successful as medical school faculty. We also agree that the definition of success needs to be broadened. Curricula that address issues of gender, culture and socioeconomics in health and medicine may help future physicians to better deal with the complex relationships that they will certainly encounter in their training and practice, whether in the community or in academia. We echo Hatala's call for understanding and for rooting out the cultural biases that lead to discrimination. In many cases discrimination has become increasingly subtle, although a number of women physicians shared appalling experiences of outright harassment. We admire their courage, persistence and difficult choices. Finally, Epstein's reflections on her career resonated with us. Of course, there will always be things that could have been done differently, but when faced with difficult choices, we should try to be fair to ourselves.

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Viral genomes

Alison Sinclair's article on the polymerase chain reaction[1] was an excellent, concise review of the topic, but it contained an important error.

Reverse transcriptase polymerase chain reaction is a valuable tool in research, diagnosis and patient management in certain diseases, particularly HIV infection. The article mentions Herpes simplex virus as an example of the RNA viruses that can be detected by this method. However, members of the virus family *Herpesviridae*, which contains Herpes simplex virus 1 and 2 as well as varicella zoster virus and Epstein–Barr virus, all have DNA as their genomic material.[2]

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Corrections

A recent *CMAJ* article on the polymerase chain reaction[1] correctly stated that the method is used to detect RNA viruses, but presented an incorrect example. Herpes simplex virus was mentioned as an example of an RNA virus, but it is a DNA virus.

In addition, the article incorrectly stated that the thermostable DNA polymerase was originally derived from bacteria in deep-ocean thermal vents. In fact, the original polymerase came from thermal springs; a subsequent generation of polymerases was of thermal vent origin.

Reference

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An additional correction to the *CMAJ* supplement containing the 2002 clinical practice guidelines for the diagnosis and management of osteoporosis in Canada[1] should be noted. In the right column of page S1, the list of endorsing organizations includes the Canadian Rheumatology Association. Other corrections appear in *CMAJ* 2003;168(3):400.

Reference

1. Brown JP, Josse RG, for the Scientific Advisory Council of the Osteoporosis Society of Canada. 2002 clinical practice guidelines for the diagnosis and management of osteoporosis in Canada. *CMAJ* 2002;167(10 Suppl):S1-S34.

In the Feb. 4 article on Parkinson's disease, the photo credit is missing from Fig. 1. The credit line should read "Lianne Friessen/Nicholas Woolridge."

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