

SELAM *News*

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Pamela Zarkowski, MPH, JD
SELAM President 2007-08

FROM THE PRESIDENTS-----

Greetings!

This year SELAM celebrates its 10th anniversary. As we approach that landmark and reflect on the first decade, we bask in the reflection of the increased numbers of women in executive positions. Tremendous strides have been made in the numbers of women at the top and in the development of women who will lead in the future. In order to protect these achievements and make further progress, SELAM needs to develop services to sustain women in these positions and assist as they make additional transitions. In order to prosper in the next decade and serve the changing needs of its members, SELAM needs to change and grow. To that end, the SELAM Board of Directors has taken on a number of major initiatives. Two-day retreats in July and October 2006 allowed us to make substantial progress on these goals.

Change in structure of the SELAM Board of Directors: In order to sustain growth in the organization, changes have been adopted that will enhance continuity of planning for programs that enhance their quality.

1. In lieu of three vice-presidents, a president-elect will be elected. In preparation for serving as president, this individual will serve as Chair of Chairs for committees, work closely with the president to facilitate continuity of initiatives, and identify goals for the next year.
2. Committees have been strengthened to include terms and succession planning.
3. Regional chairs will be selected to increase bi-directional communication and develop regional programming.
4. A one-year transition plan will facilitate implementation of the new structure.

Documents are being completed that describe these changes in detail. They will be included in future communications.

By-laws revision: A change in the structure of the Board of Directors requires a revision to the by-laws. These changes that are under way will simplify the document. It is expected that this process of updating will be completed by April 2007.

Strategic Plan: The Board of Directors adopted a revised mission statement [included in this newsletter and available at our website (www.selaminternational.org)]. Clear articulation of our mission formed the basis for a strategic plan. A first

Regular Features

[From the Presidents](#)

[Event Reports](#)

- [ELAM Class report](#)
- [The SELAM BOD Retreat](#)

[Editor's Corner](#)

[Communications Committee](#)

[Board of Directors](#)

[Book Reviews:](#) *The Girl's Guide to Being a Boss (Without Being a Bitch)*

[Issues in the Workplace](#)

- [Renewing Trust in Regular \(Allopathic\) Medicine and Research](#)
- [More Medical Schools Mean More Leadership Positions](#)

[Notable](#)- The New SELAM Mission Statement

[Quotable](#)

[Membership Information](#)

[How Can I Support SELAM?](#)

Due date for inclusion in next newsletter: July 31st, 2007

draft of a strategic plan has been proposed.

Two task forces have been established. One task force will evaluate our entire program of activities and make recommendations that will become detailed directives within the strategic plan. The second task force is charged with establishing a development plan to support those programs to ensure their success. Our goal is to accept a formal plan by April 2007.

Committees: Under the leadership of Mary Lou Voytko, the Membership Committee is working to strengthen the benefits of membership and identify new ways to engage institutions. New member services are an important part of the strategic plan. Please let me know if you have suggestions for new programs or would like to get involved (cabrass@u.washington.edu).

Programs: At the Annual Meeting of the American Association of Medical Colleges in November 2006, the SELAM program, "Making your work *work* for you," defined ways to translate leadership into scholarship, as well as other forms of activities. Many thanks to Roberta Sonnino, MD, who took a lead role in developing this program.

Mark your calendars for the annual SELAM Spring Continuing Education program "**Academic Leadership: Lessons and Lesions**," which will be April 20- 21, 2007 in Bryn Mawr PA. This program will focus on skill building for improved navigation in the changing environments of academic health centers. Seasoned leaders will provide insights into unexpected challenges. Legal experts will provide cogent solutions to everyday gnatty problems.

I challenge each of you to get involved in SELAM to make the next decade even better!

*Chris
Christine K. Abrass, MD
President, SELAM International, 2006-2007
cabrass@u.washington.edu*

SELAM PAST PRESIDENTS REFLECT

As we enter the 10th year of SELAM International, we asked Past Presidents to describe the impact and value of being President on their career lives. We asked the questions:

- Describe your career roles, skills, plans, goals, and long-term dreams – as you contemplated becoming President of SELAM, while you were President, and where you are now.
- How did the SELAM membership and leadership role help or hinder your career development?
- What were your goals for SELAM while being President? What plans and resources helped you achieve your goals?
- As you look back, what was your most significant achievement(s) during your Presidency?
- At this point in time, what experience as President do you value most?
- Was there a humorous incident that occurred (even if it did not seem so funny

- at the time)?
- Anything you would like to say?

Here is the second and final installment.

PonJola Coney, MD, FACOG, 1997-1999

SELAM Co-founder, 1997

AKA “Founding Mother” of SELAM International

Current position: Professor of Obstetrics & Gynecology, Meharry Medical College School of Medicine, Nashville TN

Reflections

When I entered the inaugural class of ELAM (Executive Leadership in Academic Medicine) (1995-96), I met some wonderful academic professional women who also were excited about building leadership skills and learning ways to break through the glass ceiling of academic medicine. After graduating from ELAM, many of us realized that we needed a medium in which to continue the key activities of social and professional networking and development, a particular emphasis of executive training. Furthermore, many of us had minimal opportunity to do so in the culture and environments of small numbers of women colleagues and lack of interest in the promotion of women in our home institutions. After many conversations among the first class members, surveys, and helpful directions from Page Morahan and Rosalyn Richman, I volunteered to spearhead the creation of an organization of ELAM alumnae. I sought legal advice as well as support from my then Dean, Carl Getto.

The first organizational meeting was held during the 1997 AAMC annual meeting in Washington, along with the organization’s inaugural continuing education program. I personally funded this first program. The faculty, Carl Getto, Sue Cejka, Marvin Dunn and Jeffrey Houpt, donated their time and *virtual* honoraria. Page graciously blessed the name, SELAM, after our concerns that it could be confused with ELAM. Nancy Hardt was elected founding president (in absentia) and, lo and behold, she accepted. Shortly thereafter, Nancy, Debbie German and Suanne Daves were conscripted to serve as founding board members. The four of us convened in Atlanta and hammered out the details of putting the organization together. Thereafter, having gone through the painstaking legal and financial steps of developing Bylaws and other criteria necessary for obtaining 501 (c) (3) non-profit status with the Federal and state bodies, the Society was incorporated in Springfield IL.

Thus, SELAM International was born. SELAM continues to pollinate a very special group of professional women in academic medicine and related fields who share their own culture and institutions in a network of some of the most accomplished individuals in leadership circles and academic healthcare. Outside the social and professional impact of SELAM for the members, implicit in the meaning of SELAM is that its mission, vision and members share the mutual concern and interest in recognizing the value of empowering and advancing women and supporting with commitment, dedication and resources the funding of initiatives of ELAM and other similar programs as they might emerge, hence the need for the 501 (c) (3), non-profit, IRS designation.

From that auspicious beginning, the interim years have witnessed SELAM become a distinct self-perpetuating group with members who are committed to the advancement of women in academic medicine and to growing personally and professionally.

While the time, energy and dollars that the other founding members and I invested in establishing this society brought challenges, I can say unequivocally today that I am personally and professionally gratified and immensely proud of SELAM.

SALUTE!

Nancy S. Hardt, MD, 1998-1999

Current position: Robert Woods Johnson Health Policy Fellow; Clinical Professor of Pathology and Obstetrics and Gynecology, University of Florida, Gainesville FL

Reflections

Although I was the first "named" President of ELAM, the true founder of the organization was PJ Coney, MD. Shortly after the second ELAM class finished in 1998, PJ thought that we should have an alumni association to network across classes. She was really prescient in this because, at the time, there were very few ELUMs. Even with every eligible person joining, a SELAM treasury would not have enough money to do much. Of course now, so many years after my ELAM Fellowship, the many relationships I made through SELAM are difficult if not impossible to distinguish from the rich relationships I made through ELAM.

PJ planned the first meeting of SELAM, which I could not attend, but we talked about it before the event. She asked me if I would be an officer of this newly formed and named organization. I said sure, as long as it was not President or Treasurer. Of course, we all know what happens when we miss a meeting. After that meeting, PJ phoned me and, with that characteristic warm laugh of hers, congratulated me on being appointed President! I felt too guilty about missing the meeting to tell her I wouldn't do it.

Her disarming words and laugh made it very hard to say no.

At the AAMC annual meeting I wracked my brain to find others who could help. I felt really grateful to Kris Lohr and Roberta Sonnino, who were willing to pitch in and help as Secretary/Newsletter Editor and Treasurer, respectively. All of us were acting on faith, since the organization had just been born. Time would only tell if SELAM would grow and blossom into something.

Once when we were discussing a logo for SELAM, we got caught up in choosing its color. We were too poor to create a multicolor logo, so we had to agree on one color. I really opposed having a pink or purple logo, thinking these colors were stereotypically too "girly". I hoped for green, the color of money, which we needed to raise through memberships and donations to carry on. Well, I guess the others won out, but they did modify the pink-purple to make it a bit closer to burgundy. I'm sure this was just to pacify me.

Then one day some of us met in the Barnes and Noble bookstore located on Philadelphia's Rittenhouse Square. Roberta and Kris wore the same attractive black raincoat from TravelSmith. I thought it would make a nice "uniform" so I went home and ordered one. To this day, this raincoat is my favorite, and has traveled with me all over Europe and the British Isles. For fun, I would love to have a photo of the three of us wearing that coat.

The SELAM/ELAM network helped shape some of my career skills to move boldly forward in my career path. This led to positions of VP Finance (U FL), Endowed Professor of Women's Health and Professor of Preventive Medicine at UT Health

Science Center, and currently a Robert Woods Johnson Health Policy Fellow. So much credit goes to so many people, to name just a few: PJ, Deb German, Roberta, Kris, and of course, Suanne Daves who put together a great SELAM meeting the following year.

Alice J. Speer, MD, 2002-2003

Current position: Consultant in faculty development; Adjunct Associate Professor of Medicine, The University of Texas Medical Branch - Galveston
Reflections

When I became President of SELAM International, I was excited about building upon the foundation of the previous Presidents. SELAM leaders previously had extended membership to deans at all levels in medical and dental schools and had created the opportunity for institutional membership. During the previous two years, under Joanne Conroy's leadership, a SELAM Award for Excellence for the advancement and promotion of women in academic health was established.

I realized that the movement of SELAM members into higher executive positions now encompassed academic health centers and major healthcare, pharmaceutical, and policy-making institutions. That network carried the benefit of diversity for the SELAM network. The diversity of ideas and the perspectives of SELAM members from around the country and across national borders could enrich the growth of SELAM. I saw my contribution of leadership to be strengthening the infrastructure of SELAM and pulling more members into active roles. My focus included broadening the membership; developing marketing, advancement strategies, and membership benefits; solidifying the Bylaws; setting up policies and procedures; and centralizing the SELAM office. Many people worked with the SELAM Board of Directors to accomplish these tasks.

SELAM Bylaws

The Board of Directors worked diligently to revise the Bylaws. The resulting Bylaws define more clearly the structure, terms of office, and roles of the Board of Directors and Committees:

1. The **Finance Committee**, providing oversight of the budget and advising the President and Board of Directors regarding investment accounts and endowment funds.
2. The **Development Committee**, responsible for fundraising activities to support programs, activities, and the operations that enhance the mission of SELAM.
3. The **Program Committee**, charged with organizing and coordinating activities of the Annual SELAM Meeting that features the Continuing Education (CEU/CME) Program.
4. The **Membership Committee**, charged with developing and implementing recruiting efforts.
5. The **Nominating Committee**, charged with providing a slate of candidates for vacant officer or Board of Director positions, committee positions, and the SELAM Award of Excellence.
6. The **Publications Committee**, charged with the oversight of marketing and other advertisement and the development and distribution of all SELAM publications including the newsletter.

Policies and Procedures Guide

The Board of Directors developed a Policies and Procedures Guide to codify

operating procedures, committee structures and functions, and other activities of SELAM. This included formally constituting the above committees and charging them with their duties.

SELAM Award of Excellence

The 2002 SELAM Award of Excellence went to Janet Bickel, MA, then Associate Vice President for Medical School Affairs and Director of the Women in Medicine Program at the Association of American Medical Colleges (AAMC). As a national leader in academic medicine for 25 years, Janet Bickel championed academic women physicians. She established the AAMC Office of Women in Medicine with its national network of representatives from US medical schools. She co-developed the series of professional development seminars for academic women physicians and scientists that contributed to the increase in women in higher academic positions.

Continuing Education Program

The annual Continuing Education (CE) Program, chaired by Victoria E. "Vicki" Judd, MD, and co-chaired by Linda R. Atkinson, PhD, featured the theme "Courage: The Key to a Successful Career." Keynote speaker, Karen A. Holbrook, PhD, President of Ohio State University, addressed "Women of Courage: Succeeding as Leaders." She emphasized that competence and authenticity were critical to academic leadership.

A special regional plenary session was designed to reach out to women faculty in the Pennsylvania area. The CE tradition of including ELAM Fellows for one day continued.

Other Accomplishments

- The receptions at the AAMC and ADEA national meetings were successful public relations activities, thanks to Karen P. West, DMD, MPH.
- Joanne M. Conroy, MD, completed SELAM documentation for Internal Revenue Services.
- New SELAM officers and leaders began terms: Kathy B. Porter, MD, as Treasurer; Christine K. Abrass, MD, as 3rd Vice President; Wendy Weinstock Brown, MD, MPH, as Board Member-at-Large; Helen K. Li, MD, as Secretary-Elect; and Linda R. Atkinson, PhD as CE Director (- year term).

During my term as President of SELAM International, I gained the sense of moving from a fledgling organization to a professional society of executive leaders with a strong mission and far reaching scope. Enhancing each other's professional development and careers and reaching out to others to expand the network, we are building great skills and moving health practice and academic health closer toward excellence.

Vivian Reznik, MD, MPH, 2003-2004

Current position: Professor of Pediatrics, Division of Nephrology, University of California, San Diego, School of Medicine

Reflections

At the AAMC Meeting I heard the keynote speaker Jim Collins, author of *From Good to Great*, a business text that really has applications to any organization. This session made me reflect on my time on the SELAM Board. The first tenet of Collin's book is that those who build great organizations make sure they have the right people on the bus before they figure out where to drive the bus. As we started SELAM, although we did not have any guiding text, we really were focused on finding the right people to sustain the leadership training many of us had earlier in our careers.

My leadership team could not have been a better example of people I wanted on our bus:

- *Finance Committee*: Chair, Kathy Porter, MD, Treasurer
- *Development Committee*: Chair, Karen P. West, DMD, MPH, 1st Vice-President
- *Membership Committee*: Chair, Roberta E. Sonnino, MD, 2nd Vice-President
- *Nominations Committee*: Chair, Alice J. Speer, MD, MPH, Past President
- *Publications Committee*: Chair, Christine K. Abrass, MD, 3rd Vice-President
- *Program (Continuing Education) Committee*: Chair, Linda Adkison, PhD
- *Secretary*: Theresa F. Lura, MD
- *Secretary-Elect*: Helen Li, MD
- *Members-at-Large*: Wendy Weinstock Brown, MD, MPH, Bonnie J. Dattel, MD, Leilani Doty, PhD, and, of course, Rosalyn C. Richman, MA.

We were preoccupied with ideas of how our future could be secured – how to increase membership, secure financing and focus our activities to keep them in line with our founding mission. Collin’s rules include one that talks about adherence to core values, combined with a willingness to challenge and change everything except those core values—keeping clear the distinction between “what we stand for” (which should never change) and “how we do things” (which should never stop changing). Doesn’t that sound like a SELAM Board Meeting? Vigorous debate about how to do things, but never any wavering from who we are and what we stand for. And we moved forward during my time on the Board from a “start up” to a mature organization that now has status within the Association of American Medical Colleges (AAMC) and shares ownership of many of the AAMC premier sessions on leadership.

And finally Collins talks about a Level 5 leadership – a culture that values substance over style, integrity over personality, and results over intentions. That is the hardest of his rules to follow and assures that the organization survives over time. For SELAM, this might have been written as our guiding principal. From my now distant vantage point, SELAM has come of age, understands its core values and is primed to become a great institution.

Roberta E. Sonnino, MD, 2005-2006

Current position: Associate Dean for Academic & Faculty Affairs, Creighton University School of Medicine, Omaha NB

Reflections

During the year immediately before becoming SELAM’s President, my professional life took a very good turn. I moved to a new position that finally had the elements I had been seeking for many years, and that allowed me to put into practice many of the things I had learned both during my ELAM year, and in my years of participation in SELAM in various capacities. Therefore, my Presidency happened at a time in my life when I was as content as I had ever been. This has continued into this year as Immediate Past-President.

From a personal perspective, my long-term dreams had pretty much come to fruition. Now what was left was to do the best I could, both in my job and as SELAM President, to continue honing my skills, improving my own capabilities and performance, and filling in the many gaps. Hopefully at the same time I would be able to pass along some of the lessons learned to my colleagues and the younger generations, and finally become the advocate and mentor I hoped to be. For too many years, other concerns had inevitably put my own career in the forefront. Now it was

finally time for my career to take a back seat, and to start looking out for those around me who could benefit from my school of hard knocks. As the movie says, now is the time to “Pay it forward”.

I have been an active SELAM member almost from the organization’s birth, and a passionate fan of this crazy bunch of women who set out to change the face and culture of academic medicine. My SELAM membership always helped my career, never hindered it. In fact, it is through my SELAM connections that I landed the position (Associate Dean for Academic and Faculty Affairs) that I currently hold and enjoy. My leadership role in SELAM also helped, albeit in a different way that one would think. Presidency of SELAM is a much less visible position than leading other bigger and better known organizations, so I cannot say that it brought me any substantial “fame and glory”. But it did help me to pull out of some mental drawers a few skills that had started to collect cobwebs, such as bringing together people with very different personalities, crisis management as a way of life, answering to a large group of critical individuals yet trying to keep a smile on my face, and learning to delegate (after all, I am a surgeon... we are not very good at that). I was fortunate to have an extraordinary Board of Directors that made that task so much easier.

I had many goals for SELAM (too many?) during my Presidency. The ones that actually were achieved were a result of planning (yes, I will take some of the credit), an energetic Board of Directors, and good timing. I think SELAM was ready to “come of age”, and I happened to be the one leading it there. Among my goals were

- Establishment of regional leadership programs, according to local needs, providing our experience in developing such programs to regional Women in Medicine or leadership groups.
- Establishment of a “President’s Advisory Committee”, so that the wealth of experience and passion from Past Presidents would not be wasted. Their priceless input into SELAM decisions was extremely helpful to me during my Presidency.
- Enhancement of the interaction with current ELAM Fellows. The move of our annual CE meeting to the Gregg Conference Center helped create connections to ELAM and resulted in recruitment of more new members from their ranks.
- Increasing SELAM’s visibility, including new strategies to encourage non-ELUM’s and men to join our ranks and become active members. Hopefully this will dispel the common notion that one must have completed ELAM to become a SELAM member.
- Increased, more formalized collaboration with AAMC’s Division of Women's Programs/Faculty Affairs
- Preparation of an “Orientation to the Board of Directors” book for new BOD members. The first step in this direction was a ½-day mini-retreat before the Annual CE Meeting, so the Board could finally spend more time catching up on issues that were long overdue, and for which we never had time. Reinventing the wheel had become routine. Little did I know that the group would be so energized, that it chose to continue the discussions at a weekend-long Board retreat in Chicago. More about that later.
- Organization and distribution of our Policies & Procedures document, as a user-friendly written compilation of the Board’s cumulative institutional memory as well as a revision of the Bylaws, and the posting of both documents on the website.

Looking back, my most significant achievements during my Presidency were

- Planning of the 1st pilot regional CE conference in Aspen CO. While the success of this project will take years and will depend on many variables, I believe it was a very important step to make SELAM more known, and bring it closer to many who would like to get involved, but cannot or prefer not to travel to PA every year.
- Appointing Leilani Doty as the Assistant Editor of our Newsletter. Between her and Kris Lohr, our Editor-in-Chief, the quality of our publications has continued to climb. The newsletter, now entirely electronic, comes out more frequently and is of superior quality.
- The first weekend-long BOD retreat – the entire board gave up a July weekend to work in a cramped hotel room at O’Hare Airport to plan the year ahead.
- Increased time commitment by Tori Odhner, our SELAM Administrator, now spending 40% of her time on SELAM business
- Tighter working relationships with ELAM and AAMC, now a partner in several of our functions, with more to come.
- Increased presence at dental functions, including ADEA
- Our first formal Annual report, compiled by our dedicated Secretary, Helen Li

Working with a BOD and membership that proved to me every day that SELAM does indeed attract the best that academic medicine has to offer is probably the best part of the experience. I felt particularly honored to be serving as President during the 10th Anniversary year of ELAM. The ELAM team had an intense year of celebrations and plans for growth. SELAM was honored to partner with them.

It was a great thrill for me to be the one giving awards to pillars of our organization and ELAM, such as Page Morahan, Walter Cohen, Deborah Powell, Roz Richman, and Kris Lohr. It read like a “who’s who” of ELAM and SELAM. I had the privilege of being the one to present the Awards.

And finally the fact that we ran out of space for two events, in rooms that in the past would have seemed so large, was for me the best indicator of our success!

Regarding a humorous incident during my Presidency, I recall the registration table at the 2005 SELAM Workshop at AAMC. Tori had diligently prepared everything, including the registration packets, our first ever give-aways (in neat little bags, each with a ribbon), etc. Everything seemed so perfectly ready... until the anticipated “20 on-site-registrants-if-we-are-lucky” turned into 60. We ran out of everything – seats, packets, give-aways. Most BOD members gave back theirs to hand out to the crowd that seemed never-ending. We ran to make extra copies, we emergently drafted our treasurer to help keep track of the registration money, we grabbed chairs wherever we could find them... Perfect organization had turned to chaos, but for the best reason of all: success! In reality, it was organized chaos, and all went well, but our sense of humor was tested for a while. That session was followed immediately by a reception so crowded that one had to be careful not to get knocked over ... I am sure we all went to bed exhausted and relieved that the day was over!

My experience as SELAM President was the high point of my career. Regardless of what will be said about it, the year was fun, hectic, invigorating, and exhausting, one that I enjoyed a great deal, and will cherish for years to come.

Christine K. Abrass, MD, 2006-2007

Current position: Professor of Medicine, Department of Medicine, University of Washington School of Medicine, Seattle WA

Reflections

When I ponder why I got involved in SELAM, the answer is easy...the people. My first exposure to SELAM was through Nancy Hardt...drawn in not because of her pitch to my ELAM class to join SELAM, but because of her astounding grasp of finance...the ability to make it clear and relevant. Later I came to learn of her charm, wisdom and love of horses. Next came Debbie German with her infectious smile and positive attitude...she made me believe that all things are possible. Kris Lohr is a dynamic mix of boundless energy and no-nonsense attitude with a surgical precision for seeing it like it is. Joanne Conroy created and enlivened a network of senior women....a role model of leadership with an unending commitment to excellence, but always being supportive to gently guide you to be the best possible. Vivian Reznik combined many of these same qualities, but added a raucous laugh to remind me not to take things or myself too seriously.

SELAM is a network of wise and capable women who share their talents without selfish motives or expectations.

Working with the SELAM Board of Directors this year has broadened that network further. These busy women devote that 25th hour each day to enhance the future environment for women in the academic health professions. They bring a diversity of opinions and approaches to the tasks at hand. They have accomplished tasks with an efficiency that I have not experienced previously. Working with the Board has offered me a chance to grow and learn from their talents, build friendships that will endure, and become a part of a growing network dedicated to the future. While SELAM works to grow its mission, reach out to more members, and achieve financial stability, its primary asset remains its network of women leaders. Participation is an ongoing opportunity to grow that network, learn from the skills of its members, and utilize those resources to enhance women's roles in the academic health professions. I can't think of another opportunity that costs so little, has so few demands and provides so much.

My words for others...invest in yourself and your future...join SELAM!

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Event Reports

- [Note from ELAM Fall Sessions](#)
 - [SELAM Board of Directors Retreat](#)
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Note from ELAM Fall Sessions

ELAM is definitely an experience like no other. Never had any of us had so much attention focused on us as individuals – personally and professionally – all with the intention of helping us stretch (including the yoga classes!). We began by interviewing each other in a free-floating group (3 interviews, 3 questions, and “don’t give the same answer twice”) and writing the results on the individual sheets kept on the walls. These brief bullets of self-disclosure were very revealing. They told of professional accomplishments, recent births of babies who were left at home for the first time, enjoyment of empty nesting, and hobbies as diverse as flying and ballroom dancing. We would return to these pages of “bullets” many times over the next few days.

We were inducted into the cult of *Myers Briggs Indicator Type* personality typing, which proved prophetic in some of the group exercises. For example, we all laughed when we were told that the ENTJs do a medley every single year when asked to write a single song about their group! We came to respect that talented, successful people see and process information differently, and that allowing each person space to exercise personal strengths results in a more creative, sturdier, and enduring product – witness the exercise of building a hospital with newspaper and string!

For most of us, this was the first time we had been in a forum where all the leaders were women, all of them accomplished women with leadership positions in academic health centers all over the US and Canada. What a unique and transformative experience! This pivotal event will stand in our professional lives, defining us as pre- and post-ELAMers. We learned the value of appreciative, positive inquiry in effecting institutional change and new concepts like “fanning positive deviance.” We vacillated between being annoyed that we were told to “dress up” for dinner (“*Can you imagine them telling men to do that!*”) to being wholeheartedly grateful for the professional coaches who guided us in identifying benchmarks of our strengths and weaknesses and strategizing plans to capitalize on both for professional and personal growth. We were also grateful for the personal advice and encouragement offered by the ELAM faculty, Page Morahan, Roz Richman, Nadine Kaslow, Judith Katz and others, to help us navigate the minefields of academic career advancement in medical, dental, and public health schools.

The exercise, *Ann Preston School of Medicine*, was a unique experience. This opportunity proved to us that we had the knowledge and skills to assess quickly the basis for financial failure, to create potential remedies for a hypothetical academic health center, and to present to a hostile board cogent recommendations for re-direction. In addition, this exercise revealed our own personal strengths and weaknesses in functioning within an ad hoc work group laboring under time pressure with inadequate information to complete a complex task.

There were so many highlights of that week at the Gregg Center:

- *Learning Communities* composed of participants from our geographic area – quickly connecting with this diverse group in a rich and personal way
- *Organizational exercise* with assigned roles as rank and file workers or top or middle managers to understand the pressures and frustrations of workers that result from their place in the organization, and how to instigate positive change for individuals in all three positions
- *Action-oriented exercises* for effective meetings, generation of ideas, and ad hoc presentations
- Rich list of *references* beyond traditional academic medicine/dentistry/public health
- *Interactions with women leaders* from the panel and within the ELAM class.

After our first meeting we re-connected with our Learning Communities by conference call and WebCT discussion. We found in these connections a safe space to voice our insecurities, seek emotional support, validate our ideas, and receive sincere praise for our accomplishments. We returned as a group in conjunction with the Association of American Medical Colleges (AAMC) meeting in Seattle WA in October 2006. The ELAM sessions were intense and long, going well beyond the 20 minutes, attention-span rule. Still, an enormous amount of good information covered conflict management and other issues that can derail a career – practical examples for everyday real life were plentiful. We will all remember to say, “You said that with a smile, but it sounded like a dig. Did you mean it that way?” (Cathy Siders)

As the ELAM sessions segued into the AAMC meeting, Virginia Valian and Jim Collins were clearly the star attractions. Valian’s take-home message was that we need to move beyond “fixing the women” if we want to attain the ELAM goal of promoting and sustaining more women leaders in academic medicine, dentistry, and public health. We need to change the institutions so that men and women – both from diverse cultures – have the opportunity to reach their full academic potential. We can see that the current state of academic medicine is analogous to having all of one Myers Briggs type leading – we are not fielding our best teams to meet the challenges we face in the broad areas of health and healthcare in this country.

Collins’ main take-home point addressed the same theme from a different angle: the success of any organization or undertaking needs the right people “on the bus” at the outset. Then these people may decide collectively how to drive the bus to accomplish the goal.

The AAMC meeting had some additional highlights – and Seattle was a terrific location. Dinners with the Learning Community topped the list. The deans’ reception had the feel of a debutante ball. Although it provided the opportunity for some to hear public praise from their dean, for those whose deans elected to be elsewhere, it re-affirmed that events targeting the promotion and advancement of women are not seen as the “real” work of medical school deans.

As we enter the New Year, we are reminded how little time we have to complete our ELAM assignments. However, we look forward to our interviews with institutional leaders, completing our benchmarks assignment, and continuing our dialogues on WebCT and with our learning communities. Finding opportunities to learn from one another and to receive advice and recommendations from our ELAM colleagues reminds us of the value of the present and future network that ELAM helped us forge. As Page and Roz said, ELAM fellows and ELUMS form a community of practice and we, the class of 2006-07, are grateful to be its newest members.

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SELAM Board Retreat – October 26-27, 2006

Optimal global health will be possible when women are fully engaged as leaders in the academic health professions.

This is the new vision statement for SELAM. The statement was drafted at the Board Retreat during the AAMC meeting in Seattle WA. Retreat participants included: Chris Abrass, Phyllis Beemsterboer, Kathy Kim, Elizabeth Kunkel, Joan Lakoski, Karen Novielli, Tori Odhner, Roz Richman, and Roberta Sonnino. In addition to the vision statement, the retreat participants revised the mission statement. The values of SELAM were articulated as follows:

- **Equal opportunity.** All individuals in academic health professions shall have equal opportunities for advancement to and success in leadership positions
- **Excellence.** Women advancing to leadership positions shall achieve excellence through professional development opportunities that enhance their success
- **Community.** Women leaders will be members of a global community that fosters their success
- **Advocacy.** All individuals will develop and promote women into leadership positions

The final mission and vision statement will be presented to the membership at our annual meeting in April 2007.

In order to enhance continuity, expand involvement of members, and enhance services to members, the retreat participants approved a new structure for the Board. The Board of Directors will be comprised of:

- **Five Officers:** President (1-year term); President-Elect (1-year term); Immediate Past-President (1-year term); Secretary (2-year term), and Treasurer (2-year term)
- **Six Committee Chairs:** Program (1-year term); Communications (1-year term); Development (1-year term); Membership (1-year term); Finance (chaired by the Treasurer), and Nominating (chaired by the Immediate Past-President).
- **Four Regional Chairs:** Northeast (2-year term), South (2-year term), Midwest (2-year term), and West (2-year term).

The new Board would have a total of 13 members. The new structure will be presented to the membership in April 2007 and implemented in April 2008.

The group then discussed establishing a Development Plan and Task Force. The development plan would be linked to the strategic plan. It would review internal sources of revenue (membership, pins and scarves, auctions), and consider an endowment drive and other sources of external support. As part of our development efforts, Karen Novielli and Mary Lou Voytko attended the AAMC Development Course in San Diego in January 2007.

Remember the SELAM Annual Meeting will be held April 20–22, 2007. Starting in April 2007, each SELAM Committee will be expected to meet at the Annual meeting.

Kathleen Kim, MD

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EDITOR'S CORNER

Some things never change, some things do. Today (April 4, 2007) news reports feature the University of Tennessee Lady Vols and coach Pat Summitt as NCAA champions. But what do I wake up to? The local DJ references the ESPN story, "She has won more games than any coach in college basketball history, and more NCAA titles than any women's coach, period... Summitt's 880th victory surpassed former North Carolina men's coach Dean Smith for most Division I career wins." And he says (the infamous, unnamed) "they" are questioning if she would do as well coaching a *men's* basketball team. I say, give her the chance, but then she'd be under the magnifying glass as any woman in a "first" situation would be. But, no doubt, up to the task.

SELAM International is evolving as it celebrates its 10th anniversary. See President Chris Abrass's letter describing the change in Board structure, bylaws, and strategic plan. These are further described in the Board Retreat Summary and Mission Statement. I'm excited to be a part of "Creating the belief that you can...so that you will."

Our Associate Editor, Leilani Doty, describes the impact of more medical schools – more opportunities for the under-represented in academic medicine. In another article, she talks about how we can renew trust in regular (allopathic) medicine and research, as she describes a sad chapter in medical history. Leilani also reminds us of Maya Angelou's wisdom.

Molly Carnes spearheaded this year's report of the first session of the current ELAM Class. Alice Speer is creating more time to read, and shares her thoughts on *The Girl's Guide to Being a Boss (Without Being a Bitch): Valuable Lessons, Smart Suggestions, and True Stories For Succeeding as the Chick-in-Charge*. I reminded Alice and Leilani of one definition of bitch that I heard on a CD by Saffire: The Uppity Blues Women:

**Being
In
Total
Control of
Herself**

Although, being in the midst of change myself, I work to control myself. The next issue of *SELAM International News* will be born as I assume a new position in the Department of Medicine/Rheumatology at the University of Kentucky in Lexington, effective June 1, 2007. I look forward to being in Dean Sharon Turner Land (and soon-to-be former Associate Dean for Academic Affairs Karen West, as she heads off to Nevada to be Dean). And with that issue, Alice will join us as Associate Editor. So let's toast the change of growth! (BTW, I will work on the newsletter as I gaze eastward over my six-acre lot where, as soon as the storage building is adapted and fencing installed, my horse will graze on "blue grass.")

In Change We Trust
Kris Lohr
Editor

Communications Committee
SELAM International
April 17, 2007

Members: Wendy Weinstock Brown (Chair), Leilani Doty (Associate Editor), Kris Lohr (Chair & Editor), Roz Richman

Newsletter:

- Transition to fully web-based publication accomplished
- Three issues per academic year, maintained on the SELAM website
- Addition of Alice Speer as Associate Editor for the upcoming academic year
- Issues to be addressed: investigate alternative way to publish the newsletter online, since the current process takes a significant amount of Tori Odhner's time. Conference call TBA (Editor is in the process of moving from one state university to another).

Finances:

- Cost is that of "labor" and included in Tori Odhner's salary component for SELAM International work.
- No publication costs since the newsletter is 100% web-based and maintained on the SELAM website

Kristine M. Lohr, M.D.

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BOOK REVIEWS

Book Review

The Girl's Guide to Being a Boss (Without Being a Bitch): Valuable Lessons, Smart Suggestions, and True Stories for Succeeding as the Chick-in-Charge by Caitlin Friedman and Kimberly Yorio; © 2006; Morgan Road Books Publisher

Caitlin Friedman and Kimberly Yorio are two women who described starting their own business in *The Girl's Guide to Starting Your Own Business: Candid Advice, Frank Talk, and True Stories for the Successful Entrepreneur* (©2003). In this new work they use their own experiences, research and interactions with other businesswomen leaders to provide useful information for the new, and experienced, woman manager.

This is a well written, incredibly easy read. They use bullet points to provide key points, and intersperse them with personal case reports and interesting interviews with women leaders in business. The authors illustrate each of their key points with cases and then cement the points with the interviews; thus, readers come away with a game plan that encourages them that they can succeed.

The first two chapters outline the definition and basic responsibilities of managers. Though some of this material seemed intuitive, having it spelled out sets up new managers with the tools to build the kind of team that will lead to success. In the succeeding chapters, the authors expand on the basic concepts, such as how to motivate the team. They use their research, such as women being uncomfortable with delegating work, to write a chapter on just this topic. As they do in most of their chapters, they explain what the issue is, e.g., why managers have problems with delegating. Next, they explain why learning this skill is important, not just for the new manager but also to the individual team member and the company (or institution) as a whole. Finally, they provide clear guidance on how to gain this skill, how to avoid pitfalls, and how to do it “right” so that the manager and team members win.

They are not afraid to tackle difficult questions, such as evaluations and firing. There is even a chapter on “office politics” and how to use office politics instead of seeing it as a dreadful fact of life. Interspersed in the chapters, they also address common mistakes that women make and how to avoid or deal with them. For instance, women are often seen as emotional. They make the case that being a manager is emotional (e.g., firing an employee is an emotional task). But then they shift the perspective and remind the reader that to be a manager is to be in control, and controlling one's emotions is just another role that good managers must take on. (For further information on emotions in the workplace, Daniel Goleman's *Emotional Intelligence* is a good source).

Each chapter can be read as a stand-alone chapter; however, throughout the book, the authors consistently describe a method for being a manager that builds a collegial, collaborative culture. They make it clear that new managers should understand what kind of team they want to build. Then the authors go about showing them how to do it. They also spell out the necessity of having a concrete vision, with short and long term goals and a plan for how to reach those goals. The plan and goals should be integrated with the mission of the department and the company. This higher-level function of manager sets the stage for the next steps in her evolution, i.e., from manager to leader.

All in all, this is the best guide I have read on the subject of how to be a good manager. The book clearly outlines how to be a good manager, what the pitfalls are, and how to take the next steps to leadership. I recommend this book for new managers, as an excellent guide to starting out on the right foot, and to experienced managers in mentoring both junior faculty and “junior” managers. I believe that the advice provided is not only good for women, but also for men. As a matter of fact, my husband is going to read it next. I’ve challenged him to read it at work. I wonder what kind of response he will get?

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ISSUES IN THE WORKPLACE

- [Renewing Trust in Regular \(Allopathic\) Medicine and Research](#)
- [More Medical Schools Mean More Leadership Positions](#)

Renewing Trust in Regular (Allopathic) Medicine and Research

In US academic health centers, inequality reigns at many levels. At the physician level after one and a half centuries of trying, females are entering medical schools at comparable or higher percentages than males. However, males still predominate in academic health center positions of upper administration and as senior faculty. At the patient level, inequities exist in the recipients of services. Some racial and ethnic groups are highly underrepresented in the patient population, not only as recipients of health services but also as the focus of research. The purpose of this article is to uncover some of the history leading to racial inequities in patient populations, to extend the discussion to inequities in advancement opportunities for women in academic health and to provide suggestions for improvement.

Dr. Martin Luther King, Jr, remarked, "...of all forms of inequality, injustice in health is the most shocking and inhumane."1

While the remarks of Dr. Martin Luther King, Jr testified to his dismay over the racial inequity in health care services, the remarks apply aptly to other injustices, such as the inequity of leadership opportunities and career advancement for female faculty in academic health institutions.

The chasm that separates privileged males from their female colleagues in academic medicine is similar to the chasm that has separated marginalized populations from receiving quality health services from trustworthy health providers. Some of the underrepresented, marginalized populations in the US mistrust, even fear, regular (allopathic) medicine. Even today African Americans and Native Peoples (Native Americans) are often reluctant to go to a regular doctor until the entire repertoire of home, family and neighborhood remedies has failed. Despite being severely ill, some of these people refuse, at great cost to their health, to visit a "teaching hospital", especially one that is part of an academic health science center at which research occurs.2

Tracking down the roots of such apprehension of health services may provide a history that is parallel to the challenges of women to develop professionally and move to the highest levels in academic health careers. The path into the past uncovers interesting details in the history of medical education, research and practice in the US. For example, Elizabeth Blackwell, using ingenuity and an "E." on her

application, was assumed to be a male, and finally gained entry into Geneva College NY for medical training. She graduated as a physician in 1849.³ In the past, a number of teaching hospitals in the South used only African Americans to demonstrate differential diagnoses, treatment plans, and new surgical techniques under development.²

The building of health centers contributed to this interesting history and growing distrust of health services. When neighborhoods with concentrations of African Americans or other minorities were torn down to allow for expansion of the nearby urban teaching hospital or academic health science center, feelings of subservience, mistrust and paranoia festered. Keeping a physical distance between themselves and the invading nearby health care institutions evolved from the resultant displacement and a mistrust of those institutions' goals and services. Embedded in the physical distance was a growing emotional distance between the majority and minority groups.²

The history of women becoming physicians is a stormy one. In the mid and late 1800s, among the few African American physicians who weathered the storms that imposed multiple barriers were some indefatigable women. The traveling National Library of Medicine/National Institutes of Health exhibit, *Changing the Face of Medicine*, reveals stories of many of these women.² Some of these notable women physicians included Rebecca Lee Crumpler (graduate of New England Female Medical College), Rebecca J. Cole and Halle Tanner Dillon (both graduates of Women's Medical College of Pennsylvania), and Susan Smith McKinney Steward (graduate of NY Medical College and Hospital for Women).^{1,3} Typically, in academic health education, the professionals and administrators were (and today continue to be) White (usually male), while the support personnel (e.g., people in laundry, food and custodial services) were (and continue to be) minorities.² Not until 1970, as a result of the complaints and action of the Women's Equity Action League against every US medical school, was there an increase in the previously imposed limit that only 5% of medical school positions in each class could be available for women.² It took over 30 years for the percentages of female medical students to stretch from 5% to today's more balanced ratio. Tracking further into the history of medical education, research and practice reveals a stronger basis for the distancing, fear and antipathy of many minorities toward health care, particularly in the South. In 1989, efforts to revamp a historic site, the first medical school built in Augusta, GA in 1835, led to an amazing discovery. As renovation efforts began, construction equipment unearthed thousands of bones and artifacts from the earthen floor basement of the old medical school building.⁴ Robert L. Blakely's research on these bones and artifacts partially explains the basis of southern African Americans' current fear and dread of allopathic medicine and research. The explanations unfold in a fascinating anthropological-archeological saga, *Bones in the Basement*, edited by Blakely and Judith M. Harrington.⁵

Finding the Bones

In 1989, in the process of digging in the basement to renovate the first medical school established in Augusta GA, now named the Medical College of Georgia (MCG), construction workers unearthed numerous artifacts and bones. They immediately notified the coroner's office. The coroner contacted Dr. Karen Burns, a forensic anthropologist on the staff of the State Crime Laboratory of Georgia, a faculty of the University of Georgia, and a personal friend of mine (she always has the most interesting stories to tell!).

When I learned about this archeological find, I phoned Burns (“Kar” to her friends) about the event. She remembered the incident well. As soon as she received the coroner’s phone call, she drove immediately from her Atlanta office to the site. Her inspection led her to insist that the construction stop for a full investigation. She contacted Blakely, an anthropologist renowned for managing major digs. He happened to be teaching a course in forensic anthropology that summer at Georgia State University in Atlanta. Under his leadership an enormous team excavated almost 10,000 human bones and fragments, about 300 animal bones and about 2,000 artifacts such as old medicine bottles, scalpels and other dissection tools, microscope slides, syringes, remnants of clothing and shoes, pipettes, enamel basins, parts of a large vat, evidence of whiskey to store bodies or body tissue, and scatterings of peanut shell particles. As part of their research, the team explored the history of MCG, including the culture of medical education and practice at that time. They also interviewed elderly residents of Augusta to uncover stories passed down to them by forbears about the nature of MCG and related activities in its early days.^{4,5}

Stepping Back into History

In the early and mid-1800s Augusta was second to Savannah as the busiest river port in the Southeast. The urban area teemed with various people: itinerants, seamen, dockworkers, slave owners (some very wealthy), the free urban poor (Whites and Blacks), indentured servants (Whites) and slaves (Blacks).⁵

Regular vs. Irregular Medicine

At that time, regular medicine or regular therapy by formally trained physicians involved removing poisons from the body. The poisons were thought to emanate from the air, water, decaying matter and other factors in the environment. Typical treatments fell into two basic categories: 1) heroic medicine, i. e., bleeding, blistering, and purging, and 2) regular therapy, i.e., administering cod liver oil, calomel, quinine and assorted liquids with high alcohol contents.^{4,5}

Irregular therapy by root doctors, shamans, women who caught babies (midwives), and other people trained through various methods of apprenticeship involved homeopathic and home remedies. In homeopathic and home remedies, natural herbs, plants and liquids were used sparingly. Root doctors used popular roots and plants such as garlic, chinaberry, comfrey, mustard weed, and peach tree leaves (to soothe a fever). Other concoctions included boiled cockroaches, sheep-dung tea, mullein leaves and 3-4 glasses of wine daily (for rheumatism), and rubbing a bee sting with a chunk of fatty meat. Female and male shamans tried to match chants, drummings, and plants to an illness; some of them worked to move energies and light to heal the body and/or spirit. Though sometimes not curative, these irregular therapies of root doctors, shamans, and others probably did not lead to death as often as those of heroic and regular medicine.⁵⁻¹⁰

Location of Care

The urban wealthy received medical treatment at home. When they did not heal, they died at home and were buried on family-owned land. Others who remained ill despite home remedies were taken for medical care (usually free) to the city hospital or teaching hospitals where iatrogenic infections raged. When hospitalized ill patients died and/or no one claimed the body, the deceased often provided tissues

or bodies for medical study, experimental therapies, and autopsy (usually without the patient's or family's permission).¹¹

Dissection

Before 1834, the practice of dissection was illegal in the US, but physicians in allopathic training needed direct instruction about systems and structures of the human body in order to address disease. Anatomy classes included dissection. In 1834, Massachusetts became the first state to pass an anatomy act that authorized medical schools to possess and dissect a human cadaver; New York followed suit in 1854. Much later, other states began passing similar acts in the 1870s with Georgia coming on board in 1887.⁴⁻⁶

Procurement

To accommodate medical education at MCG before 1887, cadavers were procured in various ways. Research interviews by Blakely's team in the early 1990s sought out any elderly whose families had dwelled in the Augusta area for generations. Some elderly Black interviewees revealed stories passed down from grandparents about activities of grave robbers, night doctors, and resurrection slaves, including "Resurrection Man." As stories unfolded, it became clear that most of the bones found at MCG in 1989 were probably from the Cedar Grove Cemetery, the local cemetery for African Americans, with some bones probably coming from an adjacent potters' field, a cemetery for the indigent.^{11,12}

Research findings from the bones unearthed at MCG indicated that many of the bones belonged to humans and had cuts suggestive of dissection procedures, e.g., false start kerfs or breakaway edges from incomplete cuts. Population records in the 1850 Census Counts from Richmond County show evidence that a disproportionate number of bones came from adult African American males. Anthropologists categorized 79% of the bones as belonging to adult African Americans vs. 21% from Euro-Americans. Of the African American bones, 79% of the bones probably came from males.¹²

In the early 1800s African Americans in the South were typically slaves. They believed with justification that medical experiments would be performed on them, and that they would be left to die in the hospitals and their bodies taken for autopsy and dissection. Fear of "night doctors," who were usually medical students (or their hires) visiting acutely or severely ill people at night, kept Augusta folks away from hospitals at night for fear they would become victims of dissection.⁶ Despite people who held watch over the dying and the recently buried, bodies were "snatched" for medical education and training. Elderly in the Augusta area described these activities during interviews.¹¹

Resurrection Man

Records from MCG indicated that in 1852 the Dean paid \$700 for a Gullah slave, Grandison Harris. Seven MCG faculty shared ownership of Harris. Though purchased to serve as a porter, essentially Harris' principal task was to obtain recently deceased cadavers for dissection. Sometimes he negotiated for purchases of cadavers from other locales. His reputation as "Resurrection Man" came from his skill at digging a grave, slightly opening the head of the coffin, and lifting out and placing the cadaver into a

bag before loading it onto a wagon. Then he carefully arranged the grave's surface mementos, left by mourners, so that the gravesite looked untouched.¹³

Harris stored the procured bodies in vats of whiskey at MCG, laid them out for dissection, cleaned the labs fastidiously after the classes and discarded used cadavers. Over time, as Harris gained expertise in dissection and anatomy, he became the laboratory teaching assistant, guiding the medical students in correct dissection procedures and the identification of anatomy. Though sometimes his activities were the subjects of jokes, he was highly respected for his skills and was often the preferred resource for medical student questions.¹³

During his 50 years of MCG employment Harris not only played a major role in the gross anatomy labs, he also served at academic social functions, held festive parties, and was a strong political leader in the African American community. During Reconstruction, he moved to Hamburg SC where he served as a judge. After Reconstruction ended, he returned to MCG and held the position of janitor. Though seriously underpaid by MCG, he was wealthy compared to other urban African Americans in the area. Highly literate, Harris was an elite member of the African American community with membership in the prestigious Pythians Masonic Lodge. Harris retired from MCG in 1905; he died in 1911. MCG faculty and students respected Harris while African Americans in the community highly feared him. ¹³

The Marginal Figure

Harris represents a marginal figure from a marginalized population, a population essential to the functioning of society but remaining on the fringes. Carlos Velez-Ibañez (1983) expands the concept of the marginal figure to more than being on the edge of a society. He purports that a marginal figure moves in two worlds, that of the majority and minority cultures. Rather than bridging both worlds, Harris was a marginal figure. He served the leaders, healers and medical academics of the dominant culture, by using the resources of the subordinate culture. In doing so, he magnified the inequality of both groups. His activities helped him and his family not only to survive but also to live a very comfortable lifestyle. At the same time he expanded the chasm between the privileged and the disadvantaged. He helped to keep the subordinate group in a subservient position and contributed markedly to their fear of academic medicine.¹⁴

In many ways, this history is repeated today in academic medicine in a different context. In considering the inequalities of opportunities afforded to males vs. females, females comprise the disadvantaged subordinate group and are often marginalized. Sometimes, a female academic rises to become a member of the power structure, e.g., becoming a chair or dean of a medical school or the provost or president of a university. Sometimes the female bridges the two groups to facilitate the entry of others from the subordinate group into the opportunities in upper administration at medical schools, universities, or corporations. Though few in numbers, these privileged women who bridge disparate groups deserve the highest accolades for their successes, bold efforts, and breakthroughs on behalf of others.

Many times, however, the academic female receives an opportunity to head up a project, to contribute resources and to accomplish goals that strengthen the resources of the dominant group, yet keeps the

subservient group in their less powerful position. In other words, much like Harris' example, women in academia become marginal figures. When they enter into leadership positions to serve the population in power but do not make the population from which they evolve become more powerful, they become marginal figures. For example, a person may accept an invitation to chair a Search Committee for a dean or vice president, yet not invite others who are junior faculty to join the Search Committee (and learn). The president or CEO of the institution may invite the female academic to head up a task force to update the institution's bylaws or manual of policies and procedures. This leader may accept all professional opportunities for publications and presentations without acknowledging the strong contributions of other colleagues; this leader may neglect to invite junior colleagues to present reports to the power players and decision-makers of the institution. Thus the junior colleagues do not receive appropriate exposure and recognition; they miss opportunities to enrich their professional growth.

Other than the grand parties Harris hosted, not much is known about how he shared his good fortune to better others. The anecdotes that have outlived him are devoid of such messages. Not only have the stories of "Resurrection Man" lived through time and generations of people, but also these stories have crossed the borders into other southern states. And the stories carry antipathy, fear of allopathic medicine, and dread of people such as Harris who practice regular (allopathic) medicine, especially in teaching hospitals and academic health centers involved in research.¹¹

Building Trust

Today, African Americans in the Southeast still mistrust regular medicine. *Bones in the Basement* reveals some of the history in the 1800s that contributed to that mistrust. African Americans as far south as Florida know stories of the "Resurrection Man". Fear of medical treatment and research reach beyond the Southeast and permeate African Americans throughout the US because of memories about projects such as the Tuskegee Study. [The Tuskegee Study, funded by the US Public Health Service from 1932 to 1972, withheld treatment (penicillin) for over 400 African American males in order to follow the destructive course of their syphilis.¹⁵]

To unravel mistrust and build trust, physicians must educate themselves about the history of medicine and surgery related to African Americans and other minority populations. Physicians must expand their respect of others. They must deepen their empathy, cultural sensitivity and cultural competence. One approach may be to link to the respected leaders of the diverse cultural groups and partner with such leaders on projects that enhance the community. Another approach is to become involved with African Americans who are colleagues or peers on town-gown projects such as improving or developing educational resources (improving the local library or soliciting businesses to sponsor K-12 classes or classrooms) or recreational projects open to all children in the community; sponsoring arts and music events at multicultural and multigenerational health fairs; partnering with grass roots citizens to provide health education, screenings and mini-med schools in their neighborhoods; training business owners and staff at organizations such as beauty or barber shops to bring health information and educational materials to all their customers; and attending (for visibility) popular gatherings such as religious events and at popular sites such as community or senior centers. Accepting more African Americans into medical schools and upper level administration in academic settings will help to increase the comfort level of grass roots citizens regarding health services and research. By providing health providers, upper

level administrators, and researchers “who look like me and know my family”, African Americans and other diverse populations may feel more connected to the providers and more trusting of services and proposed research.

To build leadership skills, academic health leaders should mentor others and open the doors to privileged information. The junior academics must learn to trust themselves, learn constantly, increase their risk-taking skills, and persevere to achieve and climb the institutional ladder. Women in academic health should be looking ahead to discover opportunities, looking abreast of themselves to assess the current picture to maintain successful growth, and looking back to remember the lessons that provided the strong rationale and foundation for continued growth. Professional seminars, fellowships, professional support groups, email networks, and professional organizations such as SELAM help strengthen strategies and the steps toward academic advancement.

Summary

The chasm that separated people in academic medicine in the 1800s at MCG from the people needing health care is similar to the chasm separating the privileged in academic medicine and the junior professionals trying to advance. Learning from history should help academics today avoid repeating inhumanity against humanity and to strengthen health education, allopathic practices, and research. The fear that arose as a result of activities such as those that occurred at MCG in the mid-1800s continues to fuel the anxiety and reluctance of southern African Americans today to seek allopathic medical treatment and to participate in research. Reading about some of the experiences of African Americans who have received inhumane medical treatment may help a medical provider understand and be more empathic in designing academic health curricula and programs that address diverse people.

Women in academic medicine and other health disciplines in the US have struggled to attain education and training. They have made inroads into health professions and have begun to overcome the barriers into academic health center leadership positions. However, inequities still exist. Leaders and providers of opportunity at all levels of academic health need to educate themselves about the disadvantaged groups, devise strategies to dissolve the chasms, and make academic health opportunities more humane, more open and more advancement-friendly to all.

Leilani Doty, PhD
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More Medical Schools Mean More Leadership Positions

More Medical Schools Needed: Then vs. Now

Reflecting visits to 155 US medical schools, the Flexner Report of 1910 urged high standards for admission and training, and concluded that too many medical schools and physicians existed.¹ By 1930 there were only 76 medical schools, but by 1981 there was an upswing to 127.²

As predictions in the early 1990s grew stronger about the glut of physicians in the US, some medical schools closed. Now predictions are moving in the opposite direction. The baby boomers are aging, and

the aging are living longer. Meanwhile, many baby boomer physicians are entering retirement.

In a 2005 report, the Association of American Medical Colleges (AAMC) urged institutions to expand medical school classes or to build new schools to increase student enrollments 30% by the year 2015. This increase would avoid an estimated 20% shortfall of physicians in 2020.³ If that shortfall occurs, patients, especially the elderly and poor, will have to wait longer, travel farther, make do with fewer medical services, and present with amplified health problems when they finally do access a physician's care.

Start-Ups

In Arizona, California, Florida, Michigan, Pennsylvania, Texas, and Virginia, there are plans for or actual start-ups of allopathic medical schools. In *The Chronicle of Higher Education* Richard A. Cooper, PhD, Professor of Medicine and Senior Fellow in Health Economics at the University of Pennsylvania's Leonard Davis Institute of Health Economics, reported knowing of "...at least 20 allopathic and osteopathic medical schools that are in various stages of development."³

Eager to help increase the numbers of physicians in training, the AAMC is lobbying the federal government to lift its cap on the number of residency positions it supports through Medicare.³

Opportunities Opening Up in Academic Medicine

The expansion of medical schools will invariably open up new job opportunities for the under-represented in academic medicine. People from diverse backgrounds who have struggled against the barriers of tradition during their career path may now find more openings available in upper levels of administration and other leadership positions. Fueled by their passion for excellence in medical education, they should be on the alert for new positions opening up as medical training in the US expands. Newly emerging or expanding medical schools will offer the potential for many who want to elevate medical education to the highest of scientific-based ideals, and face challenges with a move into positions of greater breadth and responsibility in medical education. At the same time, academics are awakening to the importance of incorporating the values of the new generation of physicians: balanced work-family-leisure life; integration of technology to increase the efficiency, safety, and quality of medical practice; comprehensive health; creative and research-based approaches to care; strong ethics; and social responsibility that extends beyond US borders.

As a founding dean of one of the new allopathic medical schools, an individual has the opportunity to build a stellar team eager to achieve excellence in meeting the Liaison Committee on Medical Education (LCME) criteria (www.lcme.org). An aspirant from an under-represented group may now have a greater opportunity to become a health science center leader who collaborates with political and university leaders, community groups, patriarchs, matriarchs and influential grass roots citizens to bring supervised medical students and other health students into neighborhood-based clinical sites that provide culturally sensitive, comprehensive medical services and research.

The time has come for people with a different face, demeanor, and style to build academic excellence in

medicine. One such person is Deborah German, MD, who has been setting milestones in medical education, first as the assistant and then associate dean of medical education at Duke University Medical Center (1982-98), next as the senior associate dean of medical education at Vanderbilt University School of Medicine (1999-2002), and later (2005-2006) as an AAMC Petersdorf Scholar in Residence where she studied the organizational structure and leadership of major health science center systems.^{4,5} Her rich administrative experiences in academic and community health settings fueled her vision and passion for her newest appointment as the Founding Dean of the new college of medicine at the University of Central Florida (UCF) in Orlando.^{4,5} Excited about her appointment, the UCF President John C. Hitt, PhD, described Dr. German as ...”the right person to lead us into the future...”⁴

Women Leaders in Professional Medical Associations

Some professional medical associations have established a track record of having a female at the helm serving as President. Founded in 1895, the National Medical Association (NMA) elected as its first female president, Edith Irby Jones, MD (1985-86), as its second female president, Vivian W. Pinn, MD (1989-90), as its third female president, Lucille C. Norville Perez, MD (2001-02), followed by L. Natalie Carroll, MD, (2002-03), and now its most recent female president (the 106th) Sandra L. Dadson, MD (2005-06).^{6,7}

In 1982 Johanna Clevenger, MD, became the first Native American female to serve as president of the Association of American Indian Physicians (founded in 1971).⁷⁻⁹ Ten years later Dr. Clevenger served a second term (1992-93), followed six years later by Yvette Roubideaux, MD, MPH (1999-00), Melvina McCabe, MD (2000-01), Joy Dorscher, MD (2005-06), and most recently Susan Sloan, MD (2006-07).⁷⁻¹⁰ In 1994 Elena Rios, MD, founder of the National Hispanic Medical Association, was its first Latina president.⁷ The 150th president of the American Medical Association was its first woman president, Nancy W. Dickey, MD (1998-99).^{11,12}

In dentistry the first woman president of the American Dental Association (founded in 1859) was Dr. Geraldine Morrow, elected in 1991; the second woman president (in 2005) was Dr. Kathleen Roth.¹³ The American Association of Dental Schools (founded in 1923 and renamed the American Dental Education Association in 2000) had Dr. Nancy Goorey as its first woman president in 1977. Almost a decade later Dr. Enid Neidle presided in 1986.^{14,15}

Since its founding in June 1876, the AAMC governing body has been its Executive Council with a Chair (sometimes casually referred to as “president”).¹⁶ According to Marian Taliaferro, MSLS, Manager of the AAMC Reference Center and Archives in Washington, DC, the Executive Council formed the Office of (Staff) President in 1969 and appointed John AD Cooper, MD, to the position.¹⁶ He served 17 years, followed by Robert Petersdorf, MD (8 years), Jordan Cohen, MD (10 years), and now Darrell Kirch, MD.¹⁶ Since the 1980s three Executive Council Chairpersons have been women, Virginia W. Weldon, MD (1985-86), Theresa A. Bischoff, MBA, CPA (2002-03), and N. Lynn Eckhart, MD, DrPH, MPH (2004-05). One Chairperson was African American, Donald E. Wilson, MD (2003-04).¹⁶ As people from diverse backgrounds advance in positions of leadership in the AAMC, it is only a matter of time before the possibility of a diverse face and style in the AAMC leadership pipeline leads to the Office of AAMC President.

Looking for Skills in Job Listings

People in academic health interested in leadership positions should look for openings requiring skills in:

1. A vision for superlative medical training and pragmatic steps to advance the quality of medical education,
 2. Design of specialty medical and surgical programs,
 3. Professional development programs,
 4. Innovative curricula,
 5. Program evaluation,
 6. Construct of standards, procedures and supportive resources impacting people at all levels (from students to faculty to staff),
 7. Educational resources including technical skills for state-of-the-art classrooms, libraries and other ancillary services, and organizing excellent clinical teaching sites,
 8. Appointing strong standing committees such as for admissions, promotion and tenure, and recognition of outstanding teaching and scholarship (in research),
 9. Appointing strong team members for operational details such as finances, information systems, regular horizontal and vertical communication activities, and progressive innovation such as maintaining state-of-the-art programs, technologies, and resource people,
-
1. Organizing mentors for scholarship advancement,
 2. Identifying competitive pilot-study funding,
 3. Major strengths in development/fund-raising such as facility in inviting donors, groups, and organizations to provide scholarships, fellowships, endowed chairs and research institutes,
 4. Cultural sensitivity and competence,
 5. Developing policy statements for national impact on health education and services,
 6. Networking with local, regional and national hospital and community groups, and
 7. Exchanging innovative medical education and training on an international level.

The new and expanding medical schools provide fertile ground for academics from diverse backgrounds with skills in effective financing; interaction strengths, especially negotiation skills; clear communication and decision-making skills; enthusiasm; and a positive leadership style.

Less May Be Better

Some medical schools have balked at the recent campaign to expand medical school student positions. Instead, they have promoted increased efficiency. They have insisted that having more physicians does not mean that the underserved, especially in rural areas, will receive better medical care. They add that the trend among today's physicians for a better balance in their career-personal-family lives may translate into more and healthier physicians, yet may not result in more physician appointment slots for patients.³

A team at Dartmouth Medical School studied effective treatment of their patients. They determined that

a ratio of fewer physicians per patient actually led to an equivalent quality of care and fewer unnecessary treatments or procedures.³ As a result, they proposed that more efficient technology, such as using electronic records and medicine-dispensing computer systems, may be a better and less expensive way to increase the availability of health care services.

Such institutions also offer junior academic faculty in medicine the opportunity to multi-task, to mentor and to build auxiliary teams of additional academics who seek fellowships to gain experience in expanding administrative skills. For example, teams may test and implement efficiency designs that may be translated into best practice models. Publications on efficient practices in organizational medicine could be applied to medical schools and hospital systems.

Opportunities for Change Agents

Either way, in an expanding, new or downsizing medical school, potential opportunities are opening up for women, junior faculty, and other under-represented groups of people in academic medicine. These opportunities for strong catalysts, eager to be change agents, may make a significant difference in elevating US medical education to newer, higher standards of medical knowledge and therapeutic care. A door of opportunity that opens for anyone opens for everyone.

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NOTABLE

Society for Executive Leadership in Academic Medicine

“Creating the belief that you can...so that you will”

Mission

SELAM is a professional organization dedicated to the advancement and promotion of women to executive leadership positions in academic health professions.

Vision

Optimal global health will be possible when women are fully engaged as leaders in the academic health professions.

Approach

The society supports programs designed and dedicated to developing leadership and management skills for women in leadership positions in academic health professions. The society promotes collaboration and networking among its members and other organizations that share common goals.

Values

Equal opportunity – All individuals in academic health professions shall have equal opportunities for advancement to and success in leadership positions.

Excellence – Women advancing to leadership positions shall achieve excellence through professional development opportunities that enhance their success.

Community – Women leaders will be members of a global community that fosters their success.

Advocacy – All individuals will develop and promote women into leadership positions.

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QUOTABLE**Wise Words**

In April 2006, Oprah Winfrey interviewed Maya Angelou on Maya's 70+ birthday.

Oprah asked her what she thought of growing older.

And there, on television, Maya said it was "exciting." Regarding body changes, she said there were many, occurring every day. . .like her breasts. They seem to be in a race to see which will reach her waist first. The audience laughed so hard they cried. She is such a simple and honest woman, with so much wisdom in her words!

Then Maya Angelou said this:

"I've learned that no matter what happens, or how bad it seems today, life does go on, and it will be better tomorrow."

"I've learned that you can tell a lot about a person by the way he/she handles these three things: a rainy day, lost luggage, and tangled Christmas tree lights."

"I've learned that regardless of your relationship with your parents, you'll miss them when they're gone from your life."

"I've learned that making a 'living' is not the same thing as 'making a life'."

"I've learned that life sometimes gives you a second chance."

"I've learned that you shouldn't go through life with a catcher's mitt on both hands; you need to be able to throw some things back."

"I've learned that whenever I decide something with an open heart, I usually make the right decision."

"I've learned that even when I have pains, I don't have to be one."

"I've learned that every day you should reach out and touch someone."

"People love a warm hug, or just a friendly pat on the back."

"I've learned that I still have a lot to learn."

"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel."

Thanks to Eric Vartanian

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