belong there. Plastic surgery had been a gentle compromise for those who otherwise would have unilaterally denied my desire to wield a scalpel. No one thought to tell me I could not be a neurosurgeon—the very idea had never been considered. Had I sought Phil's advice ahead of time, which I deliberately did not do, I think he would have employed powerful persuasive arguments against the switch I made.

Walks in on chair of Neurosurgery —Dr. Hanbery— during daily noontime sex with his secretary. Blurts out request to enter Neurosurgery accepted in a flusterz

IRONY Ultimate act of emasculation during the expression of Male dominance — but unintentional

Hanbery is an inherently shy man - weakest during attempt at displaying strength

The chair of neurosurgery, Dr. John (Jake) Hanbery, walked with a pronounced limp on a leg foreshortened by a childhood bout of osteomyelitis, and had a markedly receding chin line that kept his face from being handsome. A pipe was his constant playmate, amusing hands and mouth, and molecules of pipe tobacco were buried layers deep in every inch of his skin. The smell of pipe smoke had defined "neurosurgeon" for the rest of the hospital ever since 1959. Hanbery hid excessive shyness behind a gruff exterior, and socially was rarely at ease. I found him very intimidating, as did most others. But he was the only one who could approve a change in my residency program from plastic surgery to neurosurgery. I did realize my request would be unexpected, unwelcome, and even laughable.

No one told me not to bother Dr. Hanbery at noontime, although, in retrospect, all except me seemed to know what went on in his office during that sacred hour. I had chosen midday deliberately, and was naively unfazed when I found the door to his office shut. After all, some read or sleep in their offices, in

addition to eating, during the programmed quiet of lunchtime. My intrusive knock seemed very loud in the silence. In response to it, I heard unexpected muffled voices. After a few seconds, Hanbery came to the door and opened it a head width. "Yeah?" he asked, while tying the drawstring of a pair of scrub pants around his waist, his usually neatly combed, thinning dark hair unruly and rumpled. My thoughts started racing: "My God, what've I gotten into?" I caught a glimpse—but it was enough—of his secretary on the sofa behind him, and lowered my eyes.

Blushing with embarrassment for both of us, I blurted out, "I want to go into neurosurgery, can I have a place in your program?"

"Oh sure—yeah, sure," he answered, and slammed the door shut. To his credit, Professor Hanbery honored his promise and gave me the one open position as the newest of seven residents in his neurosurgical training program.

That evening I told Phil I had changed residency programs. Even though I waited until he had enjoyed his first glass of wine, he was aghast. "Why do you have to pick the goddamnedest most difficult thing you can think of?" he inquired, without a great deal of gentility. But it was what I really wanted to do and he was smart enough to know it.

My joining the neurosurgery residency program in 1966 was viewed with marked alarm by the residents already in the program. Prior to making the switch I had not considered the personalities of those who were in training or the fact that I would have to work closely with a number of them. Years later I learned there had been a hastily convened dinner meeting where they, along with three neurosurgeons who had graduated from the program and who were in private practice in the local area, discussed my intrusion into their all-white-male domain. It had been more a "My God, what's the world come to?" session than a meeting to plan strategy for righting the perceived wrong. All knew Jake Hanbery was a man of his word, and if he had promised a place

to me, the place was mine. However, his judgment, as well as his sanity, was open to question.

Professor Hanbery was a dominant figure in our medical world, both feared and revered by those who trained under him. He was a gifted neurosurgeon and a marvelous teacher of both surgical technique and patient assessment. But his work bias was old-fashioned and dictatorial. On the wards and in the operating room he always adhered to a rigid pecking order, addressing all remarks exclusively to his chief resident, who, in turn, would direct the work of the junior resident and intern. During my years as a junior resident, I worked with a number of trainees, including two very different chief residents.

Nothing I did was ever good enough for the first chief resident. Doug Pontis was an unmarried workaholic with a twenty-four-hour-per-day total devotion to neurosurgery, interrupted only by Mass on Sunday mornings. He expected the same time commitment from me, even though, to him, I had no legitimate place in surgery—instead, I was his slave, and his was the only right way. I would find him at 3 a.m. on the ward writing an addendum to one of my patient assessments, adding a picayune item I had neglected or even chosen to omit. Occasionally, we would disagree over the correct diagnosis. If I, rather than he, proved correct, three days of sullen silence would follow. I was allowed to do almost no surgical cases, and spent a year of negative professional growth wondering what I was doing in neurosurgery. Fortunately, once he finished his year as chief resident, Doug left the academic world to enter private practice, and thus was out of my life. Unfortunately, his firmly fixed ideas about the proper role in life for a woman were shared by many male surgeons, including fellow resident Gerry Silverberg, whom I had initially encountered a year or so before while I was a medical student.

I had come across Gerry while he was doing a required year of general surgery before starting his neurosurgery training. At that time he was a constant source of conversation in the emer-

gency room. ER doctors and other surgeons gossiped over their cups of coffee about the humorous, and sometimes outrageous, behavior of this first-year surgical resident. Once I heard about him, I naturally looked for him and then could not help but watch him. I was fascinated by his unusual behavior, by the way he played the critical fool, demanding the center of attention, always noticeable, dominant, and up-front. He was very self-assured, laughed frequently and easily, and was very generous with sarcastic comments. Even as a lowly first-year resident he carried an aura of lofty self-importance—he was, after all, in training to become a neurosurgeon, and did not hesitate to inform anyone who would listen about his ambitious plans for a brilliant career as one of the country's best.

As fellow neurosurgical residents we now had frequent contact, although Gerry and I never served on a clinical service together. Because he had graduated from Stanford two years ahead of me, we spent a number of overlapping years as residents, and subsequently have served many years as fellow faculty members. As part of his basic persona Gerry loved to tease and test me, always for an audience. He would invite me to go to bed with him, thrust his pelvis forward, look down at and directly ask his genitals if they would like that, then laugh, and wait for a response from me. The invitations were never serious or taken seriously, and were never extended in private. At times his antics were so incredible they made me and others laugh—standing there giggling while offering me a gift of the mound showing beneath his tightly fitted scrub greens. Frequently, over the years, usually out of earshot of the patient, I have heard the penis proffered as the miraculous cure for many disorders suffered by women, especially those afflicting young, attractive ones. Numerous times in informal groups on rounds or in the clinic area, Gerry would amuse us by bragging about his sexual conquests, or would whine that his workload had been so heavy he had been forced to be true blue to his wife.

In marked contrast to Doug's and Gerry's attitude, Jason Run-

yon, the second chief resident I worked with, opened the world of neurosurgery for me, not as an abstraction, which it had been prior to then, but as reality. He also let me know that I had a legitimate place in that world if I was willing to work for it. Once we were doing a difficult case at the VA (Dr. Hanbery was not in the operating room, trusting Jason to call him if he needed help) and Jason was struggling to position an operating microscope optimally. With the impatience of youth I suggested he forget the bloody scope and do the case without it. Instead of anger at my totally improper outburst, with infinite patience Jason turned to me and said, "You and I are going to do this case correctly, using whatever it takes to make things as safe as possible for this patient." My face flushed a deep red behind my surgical mask and I shut up—I had been chastised, as was perfectly appropriate. But, at the same time, Jason had included me as a fellow neurosurgeon.

Phil and Jason became good friends. They shared athletic interests, and each had a wife with a strong sense of herself. Although Phil was aware I sometimes felt diminished and belittled by Gerry and his sexist behavior, on social occasions he and others, including Jason, found Gerry quite charming. He had a good sense of humor, was entertaining, a passable dancer, and could tell a good story. However, Phil would occasionally take issue with some of Gerry's derogatory comments, such as questioning how anyone could expect much from a mere woman. He would offer to intervene on my behalf and put Gerry in his place. More than once I asked Phil to "cool it," because, especially in the early years of my residency, when I felt like such a freak, an outburst from him would have meant goodbye to neurosurgery for me. A vocal, dissatisfied spouse, male or female, could catalyze dismissal of a resident from his or her training program. Over the years, two residents left our program after their wives made late-night phone calls to Dr. Hanbery at his home, hysterically yelling and screaming about how hard their husbands were having to work. Gradually Phil learned medical spouses were "onstage" too, and

precarious career position

they were expected to suffer the loss of their mates to the incessant demands of the hospital in martyred silence. An additional burden for spouses was to pretend enthusiasm for an abusive schedule of physician training that encompassed severe sleep deprivation and no consistent time off for regathering one's soul. For my (our) sake, Phil kept quiet.

Frances was blessed with Phils support

In my fourth year of residency Phil abruptly terminated his employment, having decided he did not enjoy punching someone else's time clock. I was totally panicked. I was not making enough money as a resident physician to support the two of us, but "not to worry," Phil said. He founded his own financial advising and consulting company, carefully choosing clients with both money and interesting financial and investment problems. His low-key, half-vocational, half-avocational business thrived, finding a home at home, and in addition to "making money with money," he developed expertise as a consummate househusband. He did all the grocery shopping and prepared most of our meals. Friends thought his life very weird, and more than one told him he was being cheated with regard to his marriage contract. Some were just plain envious—Phil now had complete control over his daily time clock. But his lifestyle was not seen as legitimate, and certainly not very manly. However, from the time Phil deserted his own conventional career, *my* career became *our* career, and he has been an active participant in my professional development since. He keeps me tethered to the real world, and is quick to delineate, then castigate, the inconsistencies, abuses, and outright fantasies and flaws that characterize the very bizarre world of academic medicine.

Distance running had become a social, as well as a psychological and physical outlet for us. With a group of friends we entered the annual Bay-to-Breakers footrace across San Francisco in 1971, the first year women were officially allowed to participate. I had gone to the city to run the 7.8-mile race for fun, and

had not really thought about the competition. Unexpectedly, I was the first woman to cross the finish line, and, over the years, winning this race has been my "main claim to fame." As I struggled to catch my breath, the waiting press had only two questions for me: "Are you married?" and "Where do you live?" The newspaper article the following day informed its readership that a "Palo Alto housewife" had won the women's race, despite the fact that I was an M.D. halfway through an eight-year neurosurgical training program. How could they know that one of Phil's favorite comments, said with a smile to guests at our home, was, "In this house, a doctor cleans the toilets!"

In 1973, Dr. Hanbery asked Gerry Silverberg to join him on the faculty to help with a rapidly increasing clinical load. It was an invitation Gerry had expected ever since his internship years before. During my year as chief resident, he and Hanbery were my teachers, and I learned a great deal from him. Gerry had developed into a savvy technical neurosurgeon. He did difficult cases, his patients did well, and he pioneered new operative techniques. But he was never able to develop a noteworthy research program—in fairness, he was encumbered with heavy clinical responsibilities and was not offered protected research time. The lack of a research component hurt him at promotion hurdles. He owed, in every sense of the word, his academic career to Dr. Hanbery. He was awarded tenure and kept on the faculty only because Dr. Hanbery threatened to resign if Gerry was not promoted. Dr. Hanbery told the dean he would establish a competing practice across the street in partnership with Gerry. Neurosurgery brought in considerable money, a percentage of which accrued to the dean in the form of an internal tax. The threat of relative poverty forced the dean to capitulate.

I too owed my career to Professor Hanbery. For years he suffered outwardly good-natured but serious ribbing from colleagues for having taken a woman into his program. Not only did he

train me but in 1975 he unexpectedly asked me to join the faculty. He and Gerry had grown tired of covering both Stanford and the VA on a daily basis, and decided to rid themselves of the latter inconvenience by adding a third faculty member. When the invitation was offered I had been exploring private practice opportunities and had not previously seriously considered an academic career. In addition to being named assistant professor at Stanford University, I was also asked to take over as chief of the Section of Neurosurgery at the fully affiliated VA hospital in Palo Alto, with responsibility for directing its program of residency training. I divided my time between the two facilities. I operated and ran a clinic at both places, but maintained my main office and established a research enterprise at the VA.

Dr. Hanbery had always been an aloof and not very approachable person. Initially I believe he was ambivalent about whether I would, or even should, succeed in academics—I had been hired primarily to make his and Gerry's lives easier. While grudgingly supportive in the early years, he never provided me with information about academic process, never held a performance review with me, nor did he provide start-up money for my research program. In order to qualify for tenure, a nationally recognized research effort was essential, but I was left either to make it or not on my own at the VA. Were one to confront Dr. Hanbery about this apparent lack of formal performance evaluation and constructive help, he would have answered, "I'll let her know if she does something wrong." It was the way he functioned in his academic world.

I had become a comfortable fixture at the medical school during my long, eight-year residency. Once my faculty appointment was secure (I was the first and only female in any of the surgical disciplines), the Department of Surgery elected me to represent it as a member of the Medical Faculty Senate. Since I had not yet proven myself as a faculty member, I thought my fellow surgeons were telling the rest of the medical school, "Hey, we can be avant-garde and are more than willing to join this newfangled, changing

Finding Mentors

world." I also felt there was an element of "Look what we've got—isn't she cute?" in their behavior. At the first meeting of the Senate, I was, to my great surprise, elected its chair. Never before had the chair been a nontenured member of the faculty, let alone a woman. The dean's office insisted that memos about Senate business be addressed to me as "chairman," despite my clearly articulated preference for "chair." With a bit of rudimentary feminism, I believed then, and certainly do today, that language is a profound indicator of value.

As chair I became a voting member of the dean's Executive Committee (composed of all the department chairs) and had access to all its confidential information, including promotion and appointment data about other faculty members. I learned more about the requirements for tenure at Stanford Medical School by reviewing promotion papers than from any other source. Fortunately for me, the information supplanted the need to find a personal mentor or to bother Dr. Hanbery. I had no role models—there simply were no academic women around in my surgical world, and I did not search beyond it. However, I rapidly learned others considered me to be a role model for them, even though, in the early years, I had grave doubts about my own survival as an academician. Tenure was, and is, very difficult to earn at Stanford University.

Shortly after I joined the faculty, the Dean of Students asked me to meet with a female medical student who had encountered some interpersonal problems on her surgical clerkship. She was being subjected to what I had come to recognize as the usual verbal diatribe from Stanford's male surgeons: "Dollface, you should be home raising beautiful children," and "Why would anyone with your looks want to be here doing this messy work?" While she scrubbed her hands and arms at the sink, the faculty surgeon, who waited to wash his hands until his surgical skill was needed in the case, would give her an uninvited neck massage and whisper in her ear, "Wish I could be doing this with you somewhere else." The Dean of Students had no intention of changing

the behavior of the surgeons; that was the way they were. I was to counsel her so *she* could adapt to the operating room—a rite of passage for every female medical student. I remember being quite surprised by how offended she had been. After all, the operating room nurses tolerated worse abuses; her breasts were not being fondled, her crotch was not being grabbed, she had not been propositioned. Her complaints were about behavior I experienced every day, and I was of no help to her, giving her the standard litany of "toughen up or you're not going to make it." She left my office close to tears—I had been anything but the ally she expected, and she was profoundly disappointed. Changing the surgeon's world was not part of my agenda. So I defended it. How could a lowly, know-nothing medical student know enough to criticize it? I did believe that as numbers of women increased in a particular arena, discrimination and sexism would decrease. So with time, inevitably the surgical culture would also change, although I never gave any thought as to how rapidly, or even when. Since I saw no evidence of imminent change, I decided it was better to put up with it and shut up.

Every Thursday at noon the entire surgical faculty gathered for lunch, and, until I joined them in 1975, the meetings were a loud vocal stag party. Faculty surgeons who were not otherwise occupied in the operating room would converge for free food and raucous humor, to share the latest dirty jokes, and to hear an update about the state of the surgical department and the school. Politically these were important meetings to attend. One acquired information and solidified and authenticated one's membership as "surgeon." I desperately wanted to belong, and never tried to diminish my colleagues' "fun." The meetings were, at times, downright disgusting and the "humor" frequently was at my expense.

The group would sit around a large, long table, and one of the surgeons would play a favorite game if he happened to take the seat next to me. He would place a caressing hand on my knee and begin moving it up my thigh. The action was overt—every-

one in the room knew what was happening. I would grab his offensive fingers and place his hand, with a loud thump, back on the table where it belonged, and where everyone could see it. At the same time the caresser would be told to "keep your goddamn hand to yourself." Everyone, including me, laughed. After all, none of this was serious, he meant no real harm. The group delighted in having this game played repeatedly and I could not always control who sat on either side of me.

During the luncheons, the surgeons spent considerable time insulting each other over sexual prowess, or, more often, its apparent lack, egging each other on to ever more outlandish, ribald comments. Urologists in the group were pressured, humorously, to divulge information about their colleagues' ability in bed, or whether or not they could still "get it up." These noontime sessions did expand my entertainment repertoire with some of the funniest dirty jokes I have ever heard.

I was well prepared for the inevitable skirmish, which, on occasion, I won. Once a noted surgeon and I were each building a sandwich and I looked at his, then back at mine, and said, innocently, making idle conversation, "Mine looks better than yours." Without a moment's hesitation, he answered, "And I'll bet it's longer and stiffer too." I flipped him the finger, much to his and the crowd's delight. On another occasion, as I entered the room for lunch, a male colleague yelled out, "I can see the shape of your breasts and nipples even through that white coat!" All eyes turned to appraise my fully, and nonprovocatively, clothed body. My face turned red, and an appropriate, incisively belittling reply, for a moment, failed me. Then I answered, "And I noticed yours is hanging on the left today, sir!"

For the most part I enjoyed these noon meetings, finding psychic survival to be a challenging, toughening experience. I realized only much later, rather than being considered a surgeon, I was instead seen as an embarrassed, compromised sex object—but one that could usually hold her own.

In general, surgeons are gregarious, friendly individuals when

they are with each other. While at work, most would rather be in an operating room than in any other place, such as in the clinic or emergency room, where they have to deal face to face with patients. The environment in an operating room is rigidly controlled, and every participant has well-defined duties. The surgeon is "king," the patient is asleep, the anesthesiologist is viewed as a lesser professional, and the nursing staff is obsequiously subservient. It is a culture that breeds arrogance, rigidity, and an inflated sense of self-worth. It is small wonder that many surgeons do not develop an engaging "bedside manner," and see patients as objects rather than as people with feelings, pain, desires, and fear. Objects are far easier to control when they are bereft of emotionality. A surgeon's value is in his surgical skill, not in having to be nice to people. Thus surgeons are most comfortable with their fellow "kings," because they have a commonality of experience in having perfect, delicious control over what they do on a daily basis.

During residency, and later as faculty, I had known about and witnessed episodes of blatant discrimination and harassment of women by surgeons. Some of the outwardly nicest, seemingly kindest men become total maniacs in an operating room, where they have absolute power to act out almost any way they desire. Operating room nurses are especially vulnerable to the whims of a surgeon. Seductiveness is combined and interspersed with temper tantrums, instrument throwing, abusive name calling, and irrational requests. Some treat their nursing staff like little dogs, often reducing them to whimpering, cowering creatures whose large, timid eyes fill and overflow with tears and whose tails remain firmly tucked between their legs. When scrubbed for a case a nurse cannot use her hands to fight unwelcome advances unless she is willing to break a sterile field and potentially endanger an unconscious patient. It is not a democratic society. A nurse and her actions are subject to unilateral criticism from a surgeon after a case is finished, followed by a stinging reprimand from a nursing supervisor—anything to keep the almighty surgeon happy.

Thus, most OR nurses I saw kept quiet and endured the abuse without complaining. It made life much easier. I too swallowed hard and accepted the episodes I witnessed as being part of that peculiar environment.

Woman-as-surgeon has never been a part of this surgeon tableau. The women surgeons I know, for the most part, have avoided developing the bad interpersonal traits exhibited by some of their male colleagues, and most have an engaging touch with patients. Many male surgeons seem uncertain about how they should treat or communicate with a female surgeon and where she really fits. She is not subject to the same control he has over nurses, but she also is not equivalent to him or to his male surgical colleagues. Not uncommonly, "humorous" flirting is used, more or less unconsciously, to establish her inferior status in his own mind (this is also uniformly true when he deals with nurses). Many surgeons have no understanding of why they have a compulsive need to flirt.

During residency I had been consumed by the job and need for sleep, in that order. The Vietnam War and the student activism it spawned had come and gone without causing any blip in my cloistered, focused life. Phil had been happy when I accepted Dr. Hanbery's offer of employment, but mistakenly believed that a faculty position would provide more free time for both of us. It did not. I no longer had to do all the routine "scut" details of patient care twenty-four hours a day, leaving those chores to the interns and residents. But life was now occupied with equally time-consuming patient assessment, operative decisions, surgeries, and total responsibility for many patients' lives, along with a growing research enterprise studying the immunology of brain tumors, where laboratory animals had to be observed 365 days a year. Intrusions from my beeper and nighttime phone calls remained an integral part of my life.

Every academic is also expected to teach. While I give the

occasional standard-format lecture to preclinical students, my teaching is predominantly tutorial, and almost exclusively at the resident level. Until 1988 all the residents in our program were white and male. That year, to fill a sudden vacancy, a female medical student who had matched in neurology but who had expressed a strong interest in transferring to neurosurgery was added to our program. Thus, for the majority of years of my academic career, the residents I trained were men with a variable degree of willingness to follow directions from me—or from the other faculty. Only once, early in my career, have I ever ordered a resident to leave the OR—he was totally uncooperative, insisted he could do the case without assistance or direction from me, and was, I thought, endangering the patient. He was asked to leave our training program shortly thereafter—I was not alone in having problems with him. Resident behavior is somewhat controlled by fear generated from hierarchical order. All faculty, regardless of gender, possess the power to make or break a resident.

During my residency I had spent minimal time contemplating any role as a teacher in a future professional setting, but I rapidly learned to adapt and adjust to each new resident, melding my personality peculiarities with theirs. Some residents need to develop increased aggressiveness; others, more commonly, need to be held back. One acquires an instinct about how much tether to give each resident, when to back off, and when to apply a sharp jerk to the chain. The patient's welfare is always the number one priority, and an operating team that works well together and understands each other achieves the best results.

One of the first cases I did as a faculty member was on a twenty-eight-year-old man who had suffered from a seizure disorder since childhood. He had been referred to me when a CT scan (Stanford had acquired its first clinical scanner in 1974, a year before I finished my residency) revealed that his epilepsy was caused by a

tangled knot of abnormal arteries and veins in his brain, called an arteriovenous malformation (AVM). Total excision of these lesions usually makes seizures easier to control with medication and eliminates the threat of a future brain hemorrhage. While removing the abnormality the resident working with me and I alternated positions between being operating surgeon and assistant, and a number of times I admonished him that he was in danger of losing his left one (testicle) if he did not stay closer to the AVM in line with my verbal directions. The hypothetical threat was one I used frequently and almost unconsciously—yes, I am burdened with my own set of faults. Surgery went quite smoothly, but was exacting and intricate and took eight hours to perform. Postoperatively, the patient looked terrific. Before going home that evening around 9 p.m., I dropped in for a last-minute check on his condition. He was talking to me about his father when he abruptly stopped in mid-sentence, and rapidly became deeply unconscious. The resident and I rushed him back to the operating room and removed a blood clot that had formed in the resection bed in his brain. We finished at 1 a.m. When he awoke, his left side was paralyzed. I was devastated—things had gone so well during the first surgery, and he should have been completely normal. What had gone wrong? Had we not controlled the bleeding carefully enough at the end of the case? Had we left part of the AVM behind, allowing its fragile vessel walls to break and bleed? While the resident had been somewhat overconfident about his skills during surgery, he was very uncomfortable managing this case that had gone sour. So the remainder of that truncated night's sleep was interrupted by numerous phone calls for decisions about controlling the patient's blood pressure, his breathing, his blood count and neurologic status. At 7:30 the next morning, I started the first of three cases which had previously been scheduled for that day. The patient with the AVM remained completely paralyzed for an agonizing three days, then had gradual return of some function and was able to ambulate awkwardly, but without assistance, when he left the hospital.

During my career, both men and women have served as surgical interns, but, when they rotate on to our service for their month of neurosurgery, they are primarily responsible for the care of patients on the wards and spend only minimal time in the operating room. The occasional medical student (both genders, but more men than women) will serve an elective clerkship on neurosurgery, gaining some operative experience, but their time with us is short, and they are so intimidated by the whole scene they will do whatever is asked of them without asking questions. Even with this skewed database, I find, in general, that women are less aggressive as surgeons (certainly at the beginning of their careers) and far more willing to ask for help and follow directions than are men.

DO GENDER-SPECIFIC DIFFERENCES EXIST?

I was able to establish control over work activities at the VA and Stanford, but after joining the faculty I rapidly learned how much of an unwelcome novelty I would be to the "old guard" of my peer group of academic neurosurgeons away from Stanford. After being on the faculty for a year, I submitted a paper from my fledgling research program for presentation at a meeting of the American Association of Neurological Surgeons (AANS), one of our two national organizations. Amazingly, it was accepted for one of the prestigious plenary sessions. I was absolutely thrilled, and scared to death.

I find national meetings miserable affairs, held in a variety of nameless cities, at sterile, overpriced hotels. Scientific presentations are given in huge ballrooms filled with stale, cold, air-conditioned air to an audience haphazardly distributed in row upon row of uncomfortable folding chairs. Behavior of neurosurgeons at these gatherings resembles that of a bunch of stallions in heat, as the ritual to establish a new, current rank order is repeated year after year. Neurosurgeons have huge egos. Friends

WOMEN ARE EXCLUDED FROM THE GAME

AND IF THE SAME BEHAVIOR WERE EXHIBITED BY A WOMAN, IT WOULD WORK TO THE CONTRARY

become two-faced strangers as they self-promote, backstab, and vie with each other for recognition. In general, women have not learned how to advertise themselves or their accomplishments in this way, and, as such, are ill equipped to play this game. The scarce female neurosurgeon is left without an assigned ranking, understandably and almost inexorably relegating her to the periphery of the profession.

At that first meeting I was so alone, even though surrounded by suits. I knew almost no one, and had no one to make introductions for me, as Dr. Hanbery had chosen to skip the meeting. After I presented my paper, Dr. Roget, an eminent neurosurgeon whom I knew by reputation only, hailed me and asked me to discuss my research program with him. I was ecstatic. He asked me to sit because he said he could not talk to women when they were standing. I obediently sat down. He told me he thought it was marvelous that the AANS program committee had decided to include an immunologist on the program. He continued by saying that neurosurgeons really are pretty uninformed about immunology, and do not know it can be used to look at and maybe even treat some diseases of the nervous system.

"I'm sorry, Dr. Roget," I interrupted with some pride. "I'm not an immunologist. I'm a neurosurgeon on the faculty at Stanford Medical School." He jerked back in his chair as if I had slapped his face, peered imperiously at me over half-frame spectacles, and without another word stood up and rapidly walked away to join three of his male colleagues. After a moment of disbelief, I asked myself what in hell I was doing in this strange world.

I experienced a sudden wave of uncertainty about my future, along with profound loneliness. Dr. Roget's behavior told me the image just did not compute for him. It was my first conscious realization that role stereotyping is the most powerful force affecting the career of a woman surgeon. No matter how good you are, if you do not look the part the automatic assumption is you cannot play the part. Interestingly, surgical peers have more dif-

ficulty dispelling this stereotyped image and thinking than do patients. In my experience as a surgeon, patients have accepted me almost without question, primarily because of their perception that I had to be "better than the boys" to have made it.

Dr. Roget had been able to visualize me in the role of a female research immunologist, but the thought of my opening someone's head to mess around with a brain just was not part of his definition of "woman's work." That I, a woman, could develop and present a scientific paper as a neurosurgeon was unfathomable to him.

A pivotal component of an academic career revolves around a research laboratory, research funding, research results, and publications, especially those in highly prestigious journals. In truth, probably no more than a few dozen other scientists, working in the same field, have ever read any of the publications generated by my laboratory, yet academic success, especially in medicine, is welded to an investigative enterprise which produces published papers—and continued grant support. Once my laboratory was established, I published regularly, and for sixteen years managed to obtain uninterrupted monetary support from competitive grants.

With my gender-neutral first name, for years I was referred to as "he" in grant critiques from funding agencies. My first name would be spelled correctly on the front sheet, but the summary would read, "Dr. Conley has been quite productive, and his present proposal is well written and he provides good experimental detail. He is well trained and has a good bibliography." I often wonder how much research funding I received was for being a good research scientist as opposed to being a good *male* research scientist. Maybe I should thank the name my parents gave me for my research career. Maybe I could have done even better had I not relinquished my maiden name, in order to capitalize on my father's reputation with a last name recognized by the National Academy of Sciences. Perhaps I should have written a polite, or even indignant, letter to the granting agency, stating, "For your

records, I am a 'she,' not a 'he.' " But I feared such action might have insulted those who controlled my academic future, resulting in a lower score on my next grant application, followed by a decrease or cutoff of funding. So I kept my mouth shut, laughed, and felt sorry for women named Susie or Mary Ann. After all, I had learned how to play this game and thought I was thriving.

By the time of my tenure review in 1982, Phil and I had decided, without any formal discussion about the pros and cons, that we would not have children. Having children never seemed to fit into our lives—I was always a student, an intern, a resident, or a faculty person, driven to succeed. So instead of having our own, Phil and I "adopted" grown children, students at Stanford, usually student athletes. For many years we nurtured our "kids" psychologically, and, on occasion, financially, and take great pride in their subsequent achievements as business, legal, and medical professionals. Our daily surrogate "children" have been a succession of both dogs and cats—dearly beloved little creatures who share their uncompromised love and devotion and liberally enrich our lives.

An untraditional family life was one of the trade-offs we informally accepted with each other so I could build an academic career, without need to compromise on the standard amount of time required for a decision about tenure. I wanted an unbroken path of credentials and accomplishments, without excuses or absences, a record that would read as having been played entirely by the prevailing (masculine) rules: an academician not burdened by child care responsibilities and, additionally, having a supportive spouse—at home. The few married women academics I saw at Stanford were expected to have children, and when they did, they gracefully stepped off their committed career paths to be mothers for whatever time it took. The problem was that, once off, they never got back on. They spent their many productive academic years as Senior Research Associates rather than as full

professors. At the time of my tenure review I had not produced a child, so I had to be viewed as someone who ostensibly was there for the long haul, someone who was competitive along with the rest of them, someone for whom no given set of rules really applied. Interestingly, for the career woman, both childbearing and childlessness are regarded negatively. However, it would have been far less threatening for many, I believe, had I chosen motherhood, and only secondarily pursued a more leisurely nonacademic career in neurosurgery.

I was awarded tenure in 1982, almost on time, but not without some personal turmoil. A tenure review is a very emotional experience for any candidate—it determines if one has an academic future. I knew the review had been started, but was not informed of milestones along the way—an experience that was not unique to me. One of my earliest childhood memories is of when my father had been awarded tenure years before. At that time my folks threw a happy party with friends packed into the formal living room (where children were not usually allowed) and spilling out onto the large covered porch (which was our play yard on rainy days). I vividly remember the adult mess made with bottles of champagne, the sound and sight of popping corks, the white head of frothy wine spilling over the thick glass mouth to form a bubbling cascade down the sides of the bottle. Significantly, no one yelled at all the funny people for spilling on the rug when the bubbles were not captured quite quickly enough. I had enjoyed just being there, in that special room, among the pant legs and skirt hems of my child world, looking up at friendly, warm faces, accepting sips of champagne and rewarding those who shared with increasingly tipsy little-girl giggles.

In 1982 I had hoped to relive my memory and celebrate a positive tenure decision in June, but heard nothing as the month came and went. As my worry and concern increased, I asked my father to make some discreet inquiries—fortunately he was there when I needed him and few in our university community knew we were related. It turns out the professor of medicine who was

chair of my tenure committee had gone on vacation without convening his group beforehand. I was not informed of this delay, which had nothing whatever to do with my suitability for a tenured appointment. A favorable decision was reached in early September, but after the uncertainty and mental distress, and in marked contrast to my father's happiness at the time of his tenure award, Phil and I felt there was no need to waste even a single bottle of champagne over mine.

Shortly after the tenure decision, one of my surgical professor friends, eight years older than I, one day unexpectedly asked me, "Fran, why isn't what you have good enough?" I do not believe he would have asked a male academic the same question. Men are expected to be competitive, to advance their careers as rapidly and as far as possible. Initially I considered my friend's comment a compliment—it implied I had done far more than he ever thought I would, especially given the environment I had chosen to work in. After mulling it over, however, I grasped his hidden meaning. I had not heard it, because I did not want to believe it. He was telling me I had come far enough, thank you, and should stop before I became any more of a competitive threat—after all, now that I had tenure my academic position was secure, guaranteed for life, and there was no need to accomplish more. I would be happier, the school would be happier, the academic world would be happier, were I to fade contentedly into the woodwork and live out my academic career as a well-behaved, good little girl. The rules governing my work should have been gender-neutral—I had as much right to the work and the rewards as anyone else. But more than once over the years I had been told in all seriousness that I did not need to be paid as much because I was married. Of course, the doctors who told me so were also married and occasionally their wives even worked. I thought they were kidding. I was putting in just as many hours as everyone else, and had always pulled my fair share of night and weekend calls. I deciphered their true message only much later. They considered my getting rousted out of bed at 3 a.m. to care for a

IS SHE REALLY PLAYING THE GAME? SHE ISN'T STAYING IN HER ACCEPTABLE PLACE

patient to be not worth as much as similar care provided by one of my male neurosurgical colleagues. I now know the medical system has always assigned increased value to work done by men.

In 1984, Dr. David Korn, professor and chair of the Department of Pathology, was appointed dean of the School of Medicine. Faculty had been divided over the selection. The final choice between a clinician and a basic scientist was driven more by who could attract the most research money than by personality or competence in managing people. The humanistic component that is the real force behind any first-rate medical school, and that had been found in former occupants of the dean's office, was forgotten in the excitement generated by an era of proliferating biomedical research. For the first years of Dr. Korn's deanship, the medical school built its enviable reputation as a world-renowned research institution, and was able to attract the most highly regarded young medical research scholars and scientists. Money flowed, buildings were constructed, institutes and corporations fought among themselves for the privilege of a resource partnership with Stanford University's prestigious medical school. It was a glorious, golden era, a time when Dean Korn made a flippant remark to me at a reception after he had enjoyed a couple of glasses of wine to the effect that wouldn't this be a wonderful place if we didn't have to worry about students and clinical faculty?

I took a year of sabbatical leave in 1985–86. The practice of medicine was changing with the advent of managed care. I wanted to understand the future and be prepared for it. In a move I thought would build career strength, and with Phil's enthusiastic support, I went to Stanford's business school for the year to learn skills that would enhance my ability to make decisions about the future of medicine, especially were I to end up in an administra-

tive position. More and more doctors were finding value in having some business education. Just prior to my starting, Dean Korn had told me humorously that I should take over his job as dean for a year and that *he* should be the one going to business school.

In my Sloan program, a one year Master's degree in Management Science, I learned that survival in business meant understanding and keeping pace with all aspects of the external world, the ability to make decisions based on incomplete information, a willingness to take risks, and the availability of accurate cost-benefit analyses. Dynamic change was rewarded; complacency led to failure. I studied finance, cost accounting, strategic planning, organizational behavior, and how to analyze power. Professor Jeffrey Pfeffer taught the class on power. The taboo subject was mesmerizing. We learned to analyze organizations through the way management used and recognized power. Who has it? How did they get it? How is it identified or validated within the organization? Is it shared, and, if so, how, with whom, and why? How is it used? And, finally, how is it lost? Because I recognized the tenets Professor Pfeffer taught were applicable to a far wider arena than business, I invited him to explore power dynamics in the VA operating rooms the summer after I received my degree. My particular interest was to determine if male and female surgeons used dissimilar forms of "power" in their surgical domains. I was convinced my style in the operating room was quite different from that of my male neurosurgical colleagues.

Jeff rapidly became a fixture in the surgical suite, someone who was there but could be ignored, the consummate observant psychologist. He found watching surgery boring, but was fascinated by hierarchical interplay in the operating room. He rarely observed me (I was the only woman neurosurgeon, so comparisons were impossible) but chose instead to spend most of his time with general surgeons at the VA, where women were represented both as faculty and as residents. To no one's real surprise, Jeff found there were definite stereotypical gender differences. Male

Male surgeons were top-down, dictatorial managers, "captains of the ship," who frequently used anger to obtain obedience from their nursing staff. Women surgeons, almost uniformly, used a consensual management style. The staff worked together as a team to complete a task (the operation). Anger was rare; instead, a bantering type of humor prevailed. Significantly, both management styles yielded equivalent end results—a well-performed operation and a satisfied patient.

Anger is a powerful management tool and Jeff was intrigued by its differential use by male and female surgeons. He asked me what I did if I was genuinely angry. My answer: "If I'm angry, really, really angry, I let it explode—then it's very effective, because I use anger so very sparingly the rest of the time." Most of the time I feel prohibited from using anger, and often internalize exasperation rather than vent my displeasure. Another pointed observation Jeff made was, "My God, you people touch each other a lot, and I'm not talking about when you're with patients. You touch one another at times and in ways that would be totally unacceptable in any other occupational environment I can think of."

The year at the business school away from neurosurgery (although not from my laboratory, which maintained a high level of productivity) provided a marvelous time of intellectual growth for me. It was such fun to learn a new language, new approaches, to think and write creatively again. During the year I learned Gerry had informed mutual friends at national meetings of neurosurgeons that I was abandoning neurosurgery and obviously lacked the requisite dedication to my career (why would anyone want to go to business school?). However, I did return to work as planned, but now was armed with a fund of knowledge that neither he nor Dean Korn possessed. I had experienced a new world, one where profit, accountability, vibrancy, creativity, and merit counted. By comparison, academic surgery at Stanford, ruled by tradition and hierarchy, seemed dull, restrictive, and compromised.

Resuming my duties, I asked Dr. Hanbery to prepare the necessary papers and documentation required for promotion to full professor. Initially he demurred, telling me I had not published enough. I could not believe it. It turned out he was completely unaware of my laboratory's record of publication. Instead of drawing his attention to each and every paper I published (since he did not have the background in immunology to understand them), I had been content to update my vita on a regular basis, giving each revised copy to the departmental administrator, who dutifully filed it without comment. In contrast, I learned my male colleagues always prominently displayed a copy of each of their published papers on Hanbery's desk, where it could not escape his attention. Once he took a look at my vita Hanbery was convinced I deserved the promotion.

Gerry wrote a letter in support of the action, just as I had written a letter recommending his promotion two years before. Mine about Gerry was quite bland, ignoring any character issues, and had concentrated on his skills as a surgeon and teacher. One of the bizarre inconsistencies at academic medical centers is "confidential" information which rarely remains confidential, and the "honest" solicitation of opinion that is not expected to be entirely honest. Early in my career I wrote a letter supporting the promotion of an excellent anesthesiologist. It was extremely laudatory except for the statement "He is occasionally difficult to work with in the operating room." And he was! A flurry of letters and phone calls ensued asking what I had meant by the comment, would I rethink it, would I rewrite the letter please? I did.

I was the first woman to become a tenured full professor of neurosurgery in the United States. By this time Dr. Hanbery had developed into a strong advocate of mine, and took tremendous pride in my having "made it." Now instead of being teased, he received congratulations from his fellow program directors for having had the initiative to train and develop the career of one of the country's first female neurosurgeons. At the same time,

Gerry's attitude toward me, which had been fairly neutral since I joined the faculty, started to change in subtle ways.

Because of Dr. Hanbery's support, I had done my share of difficult cases and had developed a steady confidence in my surgical abilities. However, Gerry's behavior began subverting my position as "the surgeon." Sometime after my promotion I operated on a forty-five-year-old man at Stanford. Three weeks before, he had suffered a grand mal seizure for the first time ever. Epilepsy starting in this age group means a brain tumor until proven otherwise. The CT scan revealed an irregular white-rimmed doughnut, consistent in appearance with a highly malignant, rapidly growing cancer in the left anterior frontal lobe of his brain. Surgical resection would remove the vast majority of the lesion without undue risk of causing permanent paralysis of his right side or leaving him with disordered speech (the left side of the brain controls the right side of the body). Without surgery he would live a few months. With surgery, followed by radiation therapy to his brain, his range of life expectancy would be extended for nine to eighteen months. He had a daughter who was planning her wedding the following summer, and he was determined to walk her down the aisle.

An inexperienced but aggressive junior resident was working with me. He had scrubbed on only a few craniotomies in his nascent neurosurgical career and was thoroughly enjoying the chance to do a tumor case. For once, he was following my directions reasonably well, and I was not having to threaten him unduly. A piece of skull overlying the area of the tumor had been removed, and the dura (a thick, fibrous lining protecting the brain) had been incised and peeled back. I have a penchant for neatness during cranial surgery, and in spite of under-breath grumbles from the resident, he draped and clipped clean towels around the edges of the opening to the brain. The brain color was paler than the usual light salmon, and the normal wormlike gyral pattern was flattened; both observations indicated increased intracranial pressure. In the middle of the operative field the gyral

pattern disappeared altogether, replaced by what looked like the top of a mushroom cloud from an atom bomb. The resident cauterized a small punctate area of brain surface in front of the abnormal area, and, following my verbal direction, was passing a hollow large-bore needle into the necrotic liquid center of the tumor. Suddenly, Gerry, laughing, noisily burst into the operating room and loudly asked me, "How's it going, honey?" All at once, I was no longer the neurosurgeon in charge. I had become one of his "honeys"—again. After looking at the tumor and telling the resident he was doing a good job, he left.

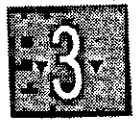
For a moment all work stopped and the only sounds in the room were from the respirator and the steady beep of the pulse monitor. "I don't know why he can't call me Fran," I finally said, breaking the silence. "I'm not his goddamned honey!" The circulating nurse, an older woman who had worked in the operating rooms from the time the hospital opened in 1959, and was of an age where she might have once changed Gerry's diapers, purred in a throaty voice, "That's O.K., he doesn't know my name either. If he didn't call me honey, I'd think he was sick." It took five minutes for me to reestablish a proper degree of control over the male resident—he had abruptly decided it was beneath him to work for a "honey." The remark also forced me to revisit the past, to return to my early days as a surgeon and ask myself, for what seemed like the millionth time, "Is a honey, especially *this* honey, good enough and talented enough to be doing this operation?" The patient not only escorted his daughter at her marriage but also lived to see his first grandchild.

I slowly began to understand that the combination of my academic title, a robust research program, and national recognition by fellow neurosurgeons (some of which was due to the fact that I was a woman) posed a considerable competitive threat to Gerry. He could not consider my training or functioning as a neurosurgeon to be of inferior quality to his. To do so would be self-criticism—we were both products of the same program, and he had taught me. Although he was two years ahead of me and had

a full-time position at Stanford (I worked at the VA as well as at Stanford—an assignment with less prestige), Gerry chose gender as the means by which to establish his superior status. He defused my competitive threat by having our workplace acknowledge his male dominance, and more than ever before, "Fran" became "honey."

Yet at this point, I had never considered Gerry's behavior toward me as harassing. Harassment was something that happened to weak, vulnerable, younger women who did not have enough gumption to stand up for themselves. I was one tough hombre, too secure in my position and too mature to let myself be victimized. Gerry was simply part of that system that educated me, trained me, employed me, and toughened me, and nothing about that system was going to have a negative effect on *my* career. I had effectively insinuated myself into the cloistered world of academic neurosurgery and had proven I could make it. With Hanbery's presence, Gerry was like an annoying little gnat who could be brushed aside with the sweep of a hand. Despite the negative undercurrents from his running commentary I had earned the respect of our colleagues. All of us dismissed his off-the-cuff verbalizations as harmless.

Wrapped and totally immersed within the competitive cocoon of academic medicine, living every day at a great distance from the "real" world, I was all but oblivious to the fact that a woman's movement had started, and, selfishly, had no idea how other women in my own world were faring. I learned about that a couple of years later when what had been a low-key, almost hidden conflict exploded into open warfare.



When I joined the faculty in 1975, I knew Gerald Silverberg was the chair-elect for our department. He was Hanbery's personal choice, and over the years I never questioned that decision. Also, I had never thought much about what a switch from Jake to Gerry as chair would mean for the department and me. It is a human foible that, unrealistically, we assume our world will always be the same. Besides, I knew Gerry adored Dr. Hanbery and had watched him endeavor to become his clone. He adopted Hanbery's mannerisms, his pattern of speech, affected a pronounced limp similar to Hanbery's uneven gait, and even smoked a pipe for a few years. Blind loyalty had never allowed Hanbery to see or acknowledge any faults in his protégé, and he was steadfast in his support of him. Nevertheless, Gerry became increasingly restless about his own future around the time I was promoted to full professor.

By 1988 the department had added three neurosurgeons in junior faculty positions for a departmental total of six professionals. Two of the three additions had trained at Stanford, under the tutelage of Drs. Hanbery, Silverberg, and Conley. For years