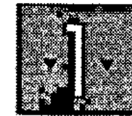
with the university in either the tenured or the Medical Center line.

Although the school of medicine employs the largest number of faculty of the university's seven schools, the size of its entering class is small—only 86 students are accepted per year. In 1991, 40 percent of the entering class were women (17 percent were targeted minorities). As it turns out, however, the structure of the professoriate is more important than the composition of the student body in establishing the prevailing tone. In 1991 only 9 percent of the full professors on the clinical faculty were women (there were no minority full professors). That in itself ensures that Leland and Jane Stanford's wish that women be educated to the same extent as men, and treated as their equals, remains unfulfilled.

I speak from personal experience. I was educated at Stanford, and I teach there. I am a tenured full professor of neurosurgery, and for thirty years have cared for patients in an academic medical setting. What follows is my story, one of many that could be told by women doctors across the country, about this institution and many others like it.



On May 22, 1991, I resigned my position as a tenured full professor of neurosurgery at Stanford University School of Medicine. At the time, it seemed the only realistic choice I had. In retrospect, I had little insight or knowledge then about the complex societal issues and academic power games that contributed to my decision. I was fifty years old, had been a faculty member with the school of medicine since 1975, and had many ties to Stanford's academic life and history. Stanford University has always been my home, as my father is an emeritus professor of geochemistry and I had grown up on campus. I also hold undergraduate, medical, and business school degrees from the university.

My saga really began thirty years before on a picture-perfect day of California sunshine in the fall of 1961, the day I matriculated at Stanford's medical school. I was not there as the result of a great deal of preplanning. For financial reasons, I had transferred to Stanford for my junior year (tuition was free to faculty children who qualified for admission). I had spent my first two undergraduate years at Bryn Mawr College in Philadelphia, an

all-women's school. The time there had been liberating and exhilarating. I saw women as professors and student body presidents, women who sparkled with wit and intelligence and were highly motivated to do something important with their lives. At Bryn Mawr I learned I had the intelligence to do whatever I wanted in life. That lesson, unfortunately, was incomplete. The unfinished message was that intelligence and capability would not be enough. In addition, I would need to wage a lifelong battle to overcome imprinted cultural expectations, especially those defining a woman's limits, and be willing to persist in the face of misogynistic antagonism.

In contrast to my happy Bryn Mawr years, I was miserable during my junior year at Stanford. I felt I was back in bondage, tied by the same social constraints I had experienced in high school, where girls learn a fragmented self-image derived, in part, from the overt gaze of men assessing their desirability as females. At Stanford dating was more important than academic achievement, the only voices in class were resonant and deep, and career expectations for men and women students were very different. Early in my teenage years I had decided I wanted to be a doctor, not just a Mrs., although I certainly anticipated marriage as well. When I was young, our family doctor was a female general practitioner (unusual in those days) and I remember both awe and dread at visits to her office—it always had a strong antiseptic, sterile smell to it, and she was a bit aloof, and very intimidating. But, to a child, she exuded tremendous power reflected in pills, injections, pain, and soothing. Perhaps her example guided my unconscious career choice; I can think of no other reason for it.

But the undergraduate environment at Stanford was not supportive of women's professional development. A woman's intellectual life was not particularly important. Societal dogma held that women were not career-oriented, and would use their high-powered education as wives and mothers in order to provide intelligent companionship for a husband, and additionally, to

nurture the next generation of boy children, imparting an intellectual advantage to *their* worldly endeavors. My dorm mates, all women in those days, gave in to this societal pressure, and would relive, week by week, their freshman year, a year in which, as "new girls on campus," they had a date, sometimes two or three, every weekend. Returning to campus as sophomores, or as upperclass undergraduates, they found themselves a used commodity with tired dreams, supplanted each year by the incoming group of brand-new, insouciant faces.

Not wanting to spend any more time than necessary in Stanford's stultifying undergraduate environment, with deliberate intent I applied for early admission to its medical school for the next academic year, and, fortuitously, was accepted, partly perhaps because my father was a prominent member of the Stanford community. In order to obtain my undergraduate degree I would complete my senior year and first year of medical studies concurrently. In the 1960s very few women were being admitted to medical schools. During the one and only interview I had I was asked if an application to the school of nursing might not be more appropriate. I told the interviewer, probably more bluntly than necessary, that I had more ambitious plans and had confidence in my ability to succeed.

An unusual number of women, twelve, joined sixty men to hear the dean's welcome on a warm Indian summer day in mid-September 1961. Medical school classes before and after mine had the more normal allotment of two to six women per class. We rapidly realized we would owe the profession a lifetime of undying gratitude for the gift of just being included. There were no people of color in my class, and I do not remember ever questioning why not.

Affirmative action had not yet been introduced to the medical profession, although in a few years it would become a major factor driving admission programs to increase much needed diversity in medical school enrollment. All of us were eager and

ready to start a new, innovative five-year medical curriculum which was unique to Stanford, and a deviation from the standard four-year M.D. program offered by most other schools.

After a gentle day of orientation, medical instruction began harshly with gross anatomy. A home for the dissecting laboratories had not been included in the plans for the beautiful, new medical school, and this important component of medical education was taught where it had always been since the turn of the century, in an old, dingy two-story brick structure erected at a time when building codes for earthquake protection were unknown. The huge dissecting room on the first floor was permeated with death. Its atmosphere suggested that death did not require more sumptuous quarters, nor did those who worked with the dead. Even though another generation of young doctors would spend innumerable hours learning about the marvelous intricacies and secrets of the human body, a comfortable learning environment was not deemed to be particularly important.

Two parallel lines of wooden dissecting tables, each with a cadaver covered by a thick white plastic cover, were arranged along opposite walls in the large, poorly lighted room. The tables bore many scars and undoubtedly had seen more dead people over the years than most of us would in our entire professional lives. I, along with many of my classmates, had never before seen a deceased person, and I am not sure any of us relished the thought of spending the next ten weeks in an intimate relationship with a dead body. In some ways, removing the white shroud covering my assigned cadaver that first afternoon initiated an educational process of emotional separation from human suffering, where meaningful connectedness to another person became of secondary importance to the mind-numbing tasks of acquiring detailed knowledge and trying always to have the correct answer. Scientific knowledge and discovery have fueled our understanding of the body's machinery. We were taught great reverence for science, but little respect or empathy for the soul.

The rigid body under the cover was that of an elderly, over-

weight female partially wrapped in wet muslin. A tag with a number but no name was tied to the big toe of her right foot. Mottled discoloration decorated her back and buttocks where blood had settled after death before the embalming process forever fixed it in place. She had a distinctive, albeit somewhat distorted, face, and it was difficult to envision this body as ever having been a living, thinking person—someone carrying her own personal life's baggage of problems and joys. How had she died? Had death been unexpected? Had she worn glasses in order to see? Did she have cherished dreams that remained unfulfilled, tasks that she would like to have completed before her trip to eternity? And why had she chosen to donate her body to medical science, where medical students would inflict the final insults on that physical "container" which had housed and nurtured her spirit for so many years?

We little realized that first day how pervasive a companion the heavy smell and touch of greasy formaldehyde would become, earning it a permanent place in the memory bank of every physician. It was an odor and feel that not even a good hot shower and shampoo could erase. Or that we would become accustomed and oblivious to the fact that little bits of dead flesh would cling to our clothing and shoes, and entangle in our hair, traveling with us to other classes or even home, as if the dead were making a futile attempt to retain a tenuous tie to the living. It was all deliberately impersonal, a detachment that came from studying each organ or anatomical region as a separate entity rather than as part of a whole. We would find a similar detachment in later years of medical school, and in my career, when patients were anesthetized and draped for surgery. There, too, once asleep in suspended animation, patients lose their name, have no job, no cares, fears, no family, no love. They become the "hernia," or the "gallbladder," or the "brain tumor." For a few hours the surgical patient becomes an object, an area of surgical interest with pathology to correct. There is no need for humanity in these corners of medicine, and from the very beginning, we were care-

fully taught to disconnect emotionally from the dead flesh on the dissecting table, and subsequently from the patient in the operating suite.

And yet, occasionally, for brief moments, humanity would surface. A week after gross anatomy started, one dissecting team tied a yellow, helium-filled balloon to the toe of their cadaver. All of us were working at our assigned table when the anatomy professor entered the room. He was a slight, kindly man, his impassive face sculpted with deep furrows, who held himself very erect and had a demeanor which suggested a degree of resigned boredom from having taught the same unchanging discipline year after year to each new class of medical students. We all looked up, wondering what his reaction would be. After a quick glance around, he immediately went over to the cadaver-with-balloon and in a quiet voice that somehow was amplified in the sudden silence, so that all of us heard him, told the team that this person had been a friend of his—a good friend. He had been a scholar, a writer, a bon vivant, a person who requested he be allowed, with his death, to contribute to the education of others. All the professor asked, humbly, was that the students, all of us, honor that contribution appropriately. Head down, eyes on the floor, he quietly walked self-consciously from the room, away from our unanimous gaze, and when he returned ten minutes later, the balloon was gone and we were back at work.

Despite a knowledge revolution in biomedical science that began in the mid-1950s, I found the preclinical curriculum (the first three years of medical school) offered to us to be stylized, serious, and neither conducive nor receptive to imaginative thinking. Challenging "known" knowledge and "what would happen if?" games were not encouraged. Learning was rote, and students who memorized well tended to do well. We learned physiology, pharmacology, biochemistry, and pathology from the "normal" perspective of the 70-kilogram man, the paradigm upon which all

traditional medical instruction was based, and still is, although to a slightly lesser extent.

We were taught that deviations from the male paradigm were, ipso facto, abnormal. Because they did not happen in the life of our normal hero, my classmates and I accepted without question the borderline pathology of women's reproductive functioning (almost the totality of "women's health" at that time), and we learned that only highly trained medical practitioners (mostly white men) could ease women through menstruation, pregnancy, and childbirth. Breasts of female cadavers were an unnecessary appendage summarily removed with rapid scalpel strokes in order to reveal the musculature of the anterior chest wall, which was then studied in intricate detail. I learned far more about the anatomical planes breached by a hernia than I ever did about the anatomy of the uterus, fallopian tubes, and ovaries. Middle-aged women beyond their childbearing years were not diseased, by and large, they were just depressed; menopause was an educational afterthought.

In a daring lecture session, sex between male homosexuals was discussed (twenty years before the AIDS epidemic began), although it was never graphically described and the act only alluded to by innuendo. And while we were taught that this certain aberrant behavior did, indeed, occur, it was, in the words of the male gynecology professor who discussed it, "yucky."

Most men, we were taught, only visited a doctor when they were genuinely ill. Men, but not women, died suddenly from heart attacks (actually, cardiac disease is also the number one cause of death in females, as was true of my cadaver) brought on primarily by the stress in their lives of unending, selfless work and no play, and wives who did not understand them. They also were plagued with prostatic hypertrophy and prostate cancer, and worse, some men even became impotent, a condition that merited a thorough investigation as to its cause and its possible reversal, almost regardless of the age of the sufferer. Men were thought to be more susceptible to lung cancer than women for unknown

reasons, and certainly died of the disease in far higher numbers—it was just another of their excessive life's burdens. All my classmates, both male and female, blindly adopted the masculine orientation of our education—we did not know enough, or how, to challenge it. After all, the medical world we wished to be part of was one created by men—male professors, mostly male students, and 70-kilogram male patients.

The linkage between smoking and lung cancer had not been affirmed in the early 1960s. Smoking was even permitted in lecture halls when I was in medical school. Many days after lunch, two of my more asinine, self-centered male classmates delighted in smoking, not just cigarettes, but cigars, filling the close, noncirculating air with thick, heavy swirls of foul tobacco smoke. I find cigarette smoke abhorrent, but cigars are an abomination of the devil. Pleas of physical illness—I learned and perfected the art of programmed retching—and disgust from some of us women (including one who was pregnant) were greeted with derisive laughter by the two smokers, who told us we had to think and act like men if we wanted to be "real" doctors. I took antihistamines regularly during the first three years of medical school, and unfortunately drowsed through more than one afternoon lecture.

Between my first and second year of medical school, I met Philip. At the time I was not romantically involved with anyone. After returning to Stanford, I had met and dated a steady beau, a well-built gymnast and motorcycle aficionado. For two intense years we had great times together at football games, the beach, and fraternity parties, but pragmatically parted ways at graduation (undergraduate degree for both of us) without much emotionality. We had decided our futures were hopelessly incompatible. While we had talked about marriage, I could not understand why anyone would voluntarily join the Marine Corps, and he could not envision enduring four more years of all-consuming medical stud-

ies. A month after he left for Quantico, I literally ran into Phil, along with his javelins, on an athletic field at Stanford. I had watched the Russian women annihilate the Americans in the javelin competition at the U.S.A.–U.S.S.R. track meet in 1962, and decided it was an event I should try, even though I had never met any javelin throwers, much less held a javelin. So, with uncharacteristic bravado for me, I caught up with Phil as he was running warm-up laps, and breathlessly asked him, a total stranger, to teach me how to throw one. At the time he was an international track and field competitor who had represented the United States in the javelin at the 1956 Olympic Games in Melbourne. When we met he was still competitive in that heady world of true excellence few athletes ever attain. He is a very attractive man, and I was sure he already had a significant other. But I was not after him—I wanted to try throwing a javelin, which I thought was a beautiful event.

After earning a bachelor's degree in engineering from Caltech, Phil had finished his M.B.A. at Harvard and had moved West only a month before to join a small high-tech start-up company named Raychem. He was juggling his junior management position, requiring total dedication to a company trying to establish itself, with his own unfinished athletic dreams. Finding quality time to pursue the latter was difficult enough without distraction from a determined woman asking him to teach her. It was not love at first sight. Today Phil tells friends the attribute that cinched the relationship for him was my ability to do fifteen pull-ups "the hard way" (palms facing out, rather than in, on a chinning bar). I found I was not a great javelin thrower, but enjoyed trying.

As a second-year medical student I was not particularly interested in an amorous relationship which might jeopardize my goal of becoming a physician. However, our common bond of athleticism and similar educational backgrounds led to dates, martinis, lamb shoulder chops cooked on a tiny grill, and a diamond engagement ring. We were married the following summer in the

backyard of the house I had grown up in on campus. I made my own wedding dress.

For most women, heterosexual marriage then represented a willingness to ally oneself with male power and patronage, and in 1963 I was happy to comply with this pervasive societal expectation. My conventional upbringing had always led me to believe that someone would be there to take care of me—and I had found him. It never occurred to me that in the future I might earn more than Phil did. Without second thought, I took his surname and fully intended to fulfill my obligations as a good corporate wife along with my medical studies. But marriage was also unsettling. Overnight, my identity changed. For twenty-three years I had been a Krauskopf. Now, suddenly, I was a Conley, but not a whole Conley—I was part of a Conley couple, and my individuality became subservient to our uniqueness as a couple, in which society defined Phil as "head of household."

However, ours was not destined to be a traditional family, even though I grew up in one. My father was always the "professor," the protected resident intellectual. My mother stayed home, raising her four children, until I reached high school. Then she returned to work as an educator and counselor for grades seven through nine. My mother wrote the checks and maintained the cohesion of the household, involving my father in the lives of his children even when he would rather have been reading about earthquakes and volcanoes. In general, in my family, men were responsible for gardening, garbage, and automobile maintenance. Cooking, cleaning, sewing, mending, and ironing were the feminine chores, although my siblings and I were cross-trained to an admirable extent. Education was extremely important to both my parents and all of us were expected to get a college degree. Beyond that, I was encouraged in my career choice, but not pushed. My sisters, a multilingual stewardess who flew with Pan Am for many years and a librarian/writer, as well as my brother, an architect, all married and produced the anticipated grandchildren,

thus removing pressure on Phil and me from my family with regard to the next generation.

Many have described Phil as a six-foot-three Paul Newman look-alike, a most desirable bachelor who was ready for marriage and not interested in delaying his life's plans by waiting for me to finish medical school, even though my degree would irrevocably change the life he had envisioned for himself. Over the years marriage to Phil has given me legitimacy as a female who operates in a macho man's world. Those who would label me "emasculating" think twice about it after they encounter Phil. When we are together, the contrast between us makes me appear very feminine, an image I enjoy. I do not enjoy, however, being ignored, something that happens quite frequently when we function as a couple. Only rarely am I asked whether or not I work. At times at social affairs I am tempted to wear a T-shirt embossed with "I'm a brain surgeon—if interested, ask!" Physically imposing and handsome, Phil gets the attention, especially from women. In retrospect, we both agree Phil had no idea of what he was getting into when he answered, "I do."

Phil generously taught me life's perspective from the masculine viewpoint. He is an only child whose mother died when he was just a year old. Phil has no recollection of her, but keeps a portrait of a beautiful young woman with short, wavy dark hair, looking beyond the camera with a slight smile, on the top of his dresser. A picture of his father, in judicial robes, occupies the opposite side. Phil was raised by his father and, for a few years, his grandfather. When I met him, his father was presiding justice on the Fifth District Court of Appeals for the State of California, and had softened his male world with a late-life marriage to a remarkable woman, a Vassar graduate, whose very life educated Phil about strong women. Reflecting his frugal, all-male upbringing which lacked a consumer focus, Phil holds a tight rein on family finances, is a shrewd and careful shopper (always seeking bargains), a gourmet cook, and a lousy janitor.

Phil and I discussed and, without much thought, accepted the fact that my female classmates and I had to "let the boys be boys." Informal medical education taught an understanding of, if not appreciation for, dirty jokes and innuendo. To combat my total naiveté, I enlisted Phil's help and have him to thank for enriching my stunted virginal vocabulary. He even taught me the intricacies of games boys play—chugalug events, pissing contests, and lighting each other's farts with matches. In class, embarrassed girlish laughter joined the "hee-haws" of our male classmates when centerfolds appeared in the middle of medical lectures, ostensibly to add a wake-up jolt to otherwise uninspired didactic presentations. Augmentation mammoplasty had just been added to the medical armament in the 1960s. I reacted with skepticism when a plastic surgeon professor told us all women wanted the "really big ones"—every woman secretly fantasized about having breasts like Marilyn Monroe or Jayne Mansfield. The baggy implants (size: large) were passed around during class so we could feel how well they mimicked real, flesh-and-blood breast tissue. One of my classmates was teased unmercifully when his wife actually had a mammoplasty. He giggled with insincere embarrassment from the attention, and for many years delighted in photographing her and displaying pictures, on demand, of her scantily attired silicone cleavage. In medical school, however, little was said or taught about the psychology of a society raising girl children to believe their acceptance and success in life were dependent on the size and shape of their breasts.

Other vivid memories remain from the first years of medical school. In a small group session the male professor slapped the rump of one of my female classmates in a manner akin to spanking a naughty child, because she did not know the answer to his question. More often, as women, we were ignored, even if we had the right answer. While learning pathology by looking at slides of tissue, we were divided into groups of four. Three men joined me. One day as we were studying a slide, the professor dropped by our group and asked for our best guess of the diagnosis. After a couple of seconds I offered the correct answer. The professor looked at me and said, "Oh, I'm so very sorry. I didn't see you." The women in my class learned to deflect a few of the constant, almost daily insults, but we absorbed many more offensive slights that often had little to do with bad performance and everything to do with fortune of birth. We learned and accepted, without thought or any malice, the fact that most professors were congenitally deaf to the wavelength and decibel level of our female voices. Perhaps it also was difficult to hear us because every sentence we uttered ended with a question mark conveying uncertainty, even if none were there.

After three years of classroom and laboratory study we became clinical clerks and spent the last two years of medical school on the hospital wards and clinics in tutorial relationships. The pattern of the two years of clinical training remains the same today. Each medical student joins a health care team usually consisting of one or two residents, an intern or two, and an attending physician. The sick patient becomes the primary educational device, one's textbook, so to speak. One learns the art of taking a medical history, of doing a complete physical examination, and integrating those findings with the science of laboratory and radiology studies to arrive at the correct diagnosis. Once the diagnosis is confirmed, the team institutes what it hopes is appropriate therapy. The medical student or intern is the first to see each assigned patient, regardless of time of day or night, is expected to have the latest update on every patient's condition, the most recent laboratory values, and knowledge of the literature about each patient's disease. Lack of preparedness, or the wrong answer, is rewarded with ridicule, taunts, and ever more work, leading to a vicious cycle of severe sleep deprivation yet never being completely caught up. Once the cycle is established, the patient becomes the enemy, the doctor a wounded human being.

The training of a physician tends to be a demoralizing, dehumanizing process in which a medical student or young doctor is told, time and again, "you aren't good enough, don't know

enough, and I (the professor) doubt you ever will have the requisite abilities to be successful." The intent is to spur the initiate to work even harder to gain knowledge and know-how. Most students do gracefully jump over this hurdle, and once over it, look back, vindicated, and, with a great deal of smugness, use the same harsh didactic techniques on those who follow, ensuring the perpetuation of a debasing learning process. However, women face a second hurdle, set close enough to the first, so that some never see it, let alone jump over it. We hear two messages: in addition to being ignorant, we are told we are also second-class citizens. Whether a woman develops into a confident medical professional depends to a great extent on whether she clears that second hurdle, or crashes into it, sprawling, spread-eagled, onto the track.

Doctors also are not taught to respect their patients. We teach doctors to "care for," as opposed to "care about," a patient, but, unlike the care rendered by nurses, an M.D.'s care is delivered from a position of power. The patient is an object with a disease that mystical medical knowledge and expertise can help or cure. The patient is weak; the doctor is strong. Can strength ever admire weakness? Genuinely empathize with weakness? Weak patients are sick twenty-four hours a day, seven days a week, 365 days a year, constantly sucking strength and energy from their physicians. If the patient had not fallen ill, all of us doctors and medical students could repair *our* wounded existences. Daily we try to regain balance in an effort to lose as little strength as possible from our lives, and live just like other human beings. Thus we attend to the unending chores of evaluating, admitting, and caring for patients as rapidly and expediently as possible, so we can sleep, eat, make love, or go to the bathroom. This life leaves almost no time or emotionality for humanity, for spending an extra five minutes just talking, or shedding a few shared tears with a patient over life's unequal burdens. Doctors are taught, above all else, and whether it be true, that they are strong, emotionally and physically, even when totally exhausted or sick themselves.

As women students, we were as well prepared as the men for the rigor of hospital work. However, we had not anticipated that we would also be dealing with horny residents, and the occasional horny attending physician. Woman as "fair game" was accepted as an integral part of the world of medicine—any woman: nurses, medical students, physical therapists, interns, residents, laboratory and radiology technicians, as well as the occasional female patient. Today it is still accepted. And some women need little in the way of coercion. The doctor is god, and every hospital is endowed with god groupies eager to satisfy sexual appetites in exchange for bragging rights—or a job, a promotion, or career advancement. Over the years I have received my fair share of initiating overtures. My wedding ring, or theirs, meant nothing. In the hospital, one-night stands, or prolonged affairs, are so easy. Call rooms have beds; many also confer privacy, as does the occasional linen closet, especially on the graveyard shift. Excuses to the spouse at home are glib and believable. "My services are needed at the hospital—I'm saving lives." How can such nobility be denied, or even questioned?

Once we reached this "hands-on" part of medical education—patient care—all students became conscious of a separation—never articulated, but openly practiced—between classmates based on gender. Because it was part of the medical system, it was sanctioned by the school, and in fact no one, including us women, viewed it as discrimination at all. The men learned they would become novitiates in a discipline of their choice, eventually ascending to a level of power and control where the work and servitude of less powerful others would not only accommodate their needs and desires but also build their very careers. The message heard by us women was that only a certain few disciplines were open to us, and that we should not expect a built-in support system. Dedicated career counselors steadfastly maneuvered us

into pediatrics, psychiatry, pathology, general internal medicine, and family practice. My female classmates all complied.

When I started medical school, I had never envisioned pursuing a nontraditional career path. Early on I considered a career in psychiatry, perhaps in response to my mother, who, as a secondary school teacher, used her children as guinea pigs when she took a course in abnormal psychology and learned to administer psychological tests—on the four of us. But psychiatry in the 1960s seemed to consist primarily of treating drug-induced psychoses, and was a field where the practitioner had little apparent impact on a patient's life, or even mental health. It was not what I had in mind. I did not deliberately choose to buck the system and defy the status quo, but I was mesmerized, truly fascinated, by surgery.

During the first year of medical school I had signed up for an elective class called Introduction to Surgery, joining ten of my male classmates. They all thought there was a good chance they would choose surgery for their ultimate career. I took the class with no intention of going into surgery. I needed one more unit for graduation and thought the class would be interesting and not terribly demanding on my time. On the first day, the professor, who came to academic surgery from a military background, locked the door behind him after he entered the classroom, an unusual and dramatic move used to communicate that his class would start and end on time. After carefully inspecting his audience, his eyes returned to focus intently on me. He said slowly and deliberately, as if he and I were alone, "There are women who have finished surgical training, but there are *no* women surgeons." I scrunched into my padded folding chair, trying to make myself smaller, less obvious. But I was not about to get up and leave, not in front of him and all the others, brave unlocking that damn door, and give him the pleasure of a forced exit. After a long, very quiet pause for effect, the professor launched into his lecture on the surgical correction of hernias. I attended that class every week thereafter, mostly out of spite. The professor totally

ignored my presence for the remainder of the quarter, his eyes always deftly skipping over my defiant gaze riveted on his face. I did receive my one unit of credit.

Thinking there was very little possibility I would, or could, go into surgery, I had taken the required surgical clerkship as my first clinical rotation, in order to get it out of the way. Unexpectedly, I fell in love with the bright lights of the operating theater, the world of sterile instruments, the drama of life and death, the actors—decisive, cool under pressure, with magic hands. Surgical clerks spend most of their time in an operating room at the end of a retractor holding organs and tissue back so the surgeon has a clear view of the pathology, and for long periods of time are unable to see anything but the surgeon's back. But there is an incision to close after the pathology has been corrected. Suturing surgical incisions on an anesthetized patient is where all doctors place and tie their first awkward stitches. I lived for cases to finish, tolerating hours of tedious boredom, knowing at the end I could usually cajole the surgeon into trading places with me. Positioned over the incision, my gloved hand would receive the slap of the loaded needle holder from the scrub nurse. It was such fun, and so very natural, perhaps from having learned needlework as a child.

A specialty that included surgery along with medicine was obstetrics-gynecology. In general, it was a happy discipline. Most patients I cared for were young and without complex medical problems. Out-of-wedlock teenaged pregnancy was a rarity, and most births were a joyous occasion for an involved couple. Men, however, were still infrequent visitors to the delivery suite. The presence of a "partner" did not become commonplace until the mid-1970s, a few years after heavy anesthetic sedation ceased being used. Four days before the end of my obstetrics-gynecology rotation, I helped a woman with Irish red hair deliver a beautiful baby girl. The baby's head was decorated with tufts of soft fiery red hair. I had talked with the mother-to-be after she was admitted in labor, and was distressed to learn that she really did

not want her baby. It had been a mistake, she had a young son, and her husband did not want another child, but he especially did not want a girl. Their religion made abortion untenable. Moments after birth, I showed the baby to her mother, expecting that maternal instincts would overcome her negativity and she would reach for her child. Instead she began crying and turned her head away from her perfect creation. "My husband will never forgive me," she said through her tears. "He'll never love her as he does our son." I was stunned. Here, an intelligent, college-educated woman accepted, without question, the total dominance of her husband and his thinking over her, as well as the second-class citizenship of her new daughter within their family unit, and in the world.

I truly enjoyed obstetrics-gynecology, perhaps because, at the time, it covered almost the totality of women's health, and rotations on medicine, neurology, endocrinology, cardiology, anesthesiology, and radiology were fascinating, but all somehow lacked the quick decisive and mechanical aspects that I had found so enticing about surgery. I hated pediatrics. It was like practicing veterinary medicine. Most of the time the patient could tell you nothing, and each usually came with two highly anxious, irrational parents who detested medical students and would go berserk if I were sent to draw blood or start an intravenous line.

Gradually, as I found other clerkships to be less rewarding, I decided there was no compelling reason why I could not be a surgeon. Surgery excited me and I thought I had the aptitude to do it and do it well. I gave very little thought to the "surgeon personality" and whether mine would mesh appropriately with it—it was the discipline I was after and my choice was made without considering any future interface between me and the players who were already there. Once I articulated my plans for my future I began hearing from many well-meaning professors

not that I "could" not be a surgeon, but that I "should" not aspire to be one.

For the national intern match in my last year of medical school, I listed both surgical and medical programs, hoping the former would prevail, but keeping backup options. I had decided to try for a plastic surgery program, figuring it would be the most receptive surgical discipline within which to defy the traditional tenet that "a woman cannot be a surgeon." I matched in plastic surgery at Stanford, primarily because I was known as having sufficient stamina to endure three years of general surgery, which is part of the required training for ultimate board certification as a plastic surgeon.

After five years of medical studies and hospital training nine of the twelve women in my class graduated in company of forty-six of the sixty men. Four of the women headed for careers in internal medicine, two in psychiatry, and one each in pediatrics and pathology. All but one of us married. One of my female classmates was married to a truck driver and already had five children when she had started medical school. She seemed a very unlikely candidate for medical training. Quiet, reserved, resourceful, always guarded, she headed for a residency in psychiatry and eventually established a successful private practice. Another classmate conceived and gave birth to three children before graduation and ultimately became a hematology professor at Stanford. Three women married male classmates, and all of these marriages eventually failed. Because of our relatively large number, none of us women had been viewed as being unique, so having to play a role as the "first and only" was never an issue during medical school.

The school had originally expected to graduate seventy-two identically oriented intellectual (as opposed to physical) physician packages, leaving each of us to determine our future "fit" within medicine. But in our world, "physician" was equivalent to "male" and the identity transfer from student to medical professional was difficult for women. We had worked hard for our

M.D. degrees and in the process had really been forced to view ourselves as doctors first and females second. Identity as a woman was buried under our starched white lab coats, although the ability to care for women, as well as men, was not. I believe most of my class, both men and women, as beginning physicians, found caring for male patients more comfortable—they were a known commodity with defined health problems. By contrast, women patients seemed terribly complicated, because beyond childbirth so little was known then about their medical conditions and needs.

While I was friendly with my eight female classmates, we never formed true collegial relationships. We never learned to work together and support each other. I have maintained no contact with any of them outside of class reunions. Through subtle, unconscious social pressure, it seemed more important to be regarded as "one of the boys" than to be seen running around with a bunch of women.

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After graduating from medical school in 1966, I started a rotating surgical internship—the first female to do so at Stanford University Hospital. As with acceptance to medical school, I was so happy to just be included I would have walked on my hands for the entire year if that was what it took to belong and be a part of this exclusive group. Although I was required to live at the hospital every other night during my first two years of surgical training, there were no on-call quarters for a woman surgeon. When the hospital had been built in 1959, the surgeons' on-call room consisted of bunk beds, dormitory style, for men only. Seven years later the head nurse on the orthopedic floor discovered I was trying to get a precious few hours of sleep, in between the almost constant nighttime phone calls, curled up on a tiny, short couch in a room used during the day for grieving relatives. Like a mother hen clucking over her helpless chick, she insisted

on rolling a hospital bed into her cast room, next to a wall phone, and there I spent most on-call nights during my intern year.

In a passive-aggressive way, nurses can make life very difficult for an intern. Alternatively, if they admire and like an intern they can be of incredible help during that arduous first year. I have always had a decent rapport with nursing staffs, although not all women doctors have been as fortunate. Nurses endure arrogance and abuse from male physicians as part of their job; they do not expect, or tolerate, the same behavior from female physicians. I find nurses enjoy being part of the decision process and appreciate being thanked for their efforts on behalf of my patients. Being married also helped in my relations with nurses. Most enter nursing school with the genuine altruistic desire to "help people," but some also harbor a defined, or subconscious, ulterior motive of landing a physician as a mate. I presented no threat to any with such personal matrimonial ambitions.

It is obvious to anyone visiting a hospital that women have always been an integral part of the medical profession, although, until very recently, not frequently as doctors. The majority of women still participate in very defined, subordinate roles. If every female nurse, technician, and hospital housekeeper in this country were to go on strike, modern medicine in the United States would come to an abrupt halt. In the late 1800s women were thought incapable of practicing medicine; they had more need for medical care than ability to provide it. Medical training was considered too rigorous for the frail woman who was defined more by her uterus than by her brain. Exclusionary tenets denying admission of women to medical school never took into account the fact that nurses (women) worked long, brutal, physically punishing hours day in and day out, despite being burdened with the same biology of "temporary insanity" as those women wishing to be doctors. Thus, nurses became a subservient convenience, an essential part of that medical world established by men for the comfort of men. They were carefully taught to regard the doctor as a demigod,

all-powerful, all-knowing, someone who could demand and expect perfect obedience.

Nurses' education and training, however, while rigorous, lacks the inhumane qualities inherent in the education of a physician. Even though required to do ugly things to a patient's body, such as giving enemas, inserting urinary catheters, or injecting often painful substances into flesh, they learn to deliver compassion and care when performing their duties. Unlike doctors, nurses *are* taught to respect their patients and are regarded by many as "angels of mercy" as they attend to chores others would shy from (such as cleaning up a large volume of incontinent, odoriferous stool or vomitus laced with blood and stale alcohol) in order to maximize a patient's comfort. Certainly their ministrations on an intimate level, where the dignity of a patient is preserved at all costs, stand in stark contrast to the aloofness of the physician. While making quick rounds, an M.D. usually stands at the foot of a hospital bed, staring down at a patient who, in more ways than one, is already down.

As an intern, the hospital became my entire world and any semblance to a normal married life for Phil and me disappeared completely. I was assigned to the orthopedic service at the time of our third wedding anniversary. Around 4 p.m. I finished helping a private orthopedist in the operating room but found six new patients to admit when I returned to the ward. And this was my night off! I dragged home, dead tired, at 11 p.m., having completely forgotten the significance of the day. Phil was sitting, hips slouched forward, on the sofa in our small apartment, his head on the rounded back of the couch, neck extended, mouth open, softly snoring. A warm bottle of champagne, unopened, and two empty fluted glasses were on the coffee table at his knees.

For survival Phil developed his own independent life with friends, social activities, and his own time clock. I spent much

more time at the hospital than with him, felt guilty for doing so, but was powerless to change anything about this unyielding and unforgiving system. When I could join him in a scheduled activity, I did, but if I were "on call" he went by himself, and usually had a good time. I was not very good company anyway. Many times I fell asleep during dinner or even while conversing with guests. Phil has always kept scrapbooks about his and our life. The contents of these bound collections include snapshots, stubs of theater tickets, announcements for athletic events we attended, newspaper clippings, and pertinent portions of letters from friends. I am almost completely absent from the pages of scrapbooks covering the first two years of my career.

Phil expressed considerable resentment over the demands on my time and, either as retaliation or in desperation, established close and enduring friendships with a few women from his own work environment. This was not the happiest or closest time for us in our marriage—I did not know what to think about these relationships, and struggled to find a proper balance between work, which I loved, and the man whom I also loved. At the time I was quite confused, but probably should not have been so concerned. Phil had not had much contact with females as he was growing up, and unconsciously sought intellectual bonds with women in order to learn more about them. Over the years of our long marriage I have found that Phil truly enjoys a mentoring role (athletics, personal finance and taxation, wine appreciation, in-laws), adding richness and discovery to his own life through close interaction with carefully chosen others—both women and men. We are a great team and our marriage has survived despite our peculiar lives. Although social and gregarious when he wants to be, Phil learned, during our early years together, not only to savor but also to require long periods of hermitlike solitude as insulation against constant on-call interruptions to our two-person family peace—a trait that persists today. Weekends, on my "off" time, we began running together—first one mile, then

two, progressing to six, ten, and more—finding comfort in each other's company and reduction of life's emotional stress in the physical activity.

When Phil and I have not seen each other for a few days, in a pattern that evolved from those first years, our next conversation is a recitation of what he has done in my absence. The world of medicine remains sealed within the walls of the hospital, unless I have lost a patient unexpectedly and need to share my frustration and grief. Early on I recognized an overpowering need to separate my world at home from that of the hospital. Phil has never been particularly curious about my daily patient care activities, and has never watched me operate. However, once I began working as an intern an important priority shift occurred in our relationship—the patient, not Phil, was now number one. It was as if medicine had become, not a mistress, but my demanding child; and as many new fathers find, that child was very hard on Phil's ego. One evening after I was called back to the hospital, Phil angrily burst out, "Why do *you* have to go?" I told him the patient was someone's father, and I was obligated to help him however I could. Adoring his own dad, Phil finally saw the patient as a person in a relationship with another, and slowly began to understand my life, its priorities and pressures. Understanding it did not mean he had to like it.

One day I was assigned to scrub with an old, revered, private general surgeon who was scheduled to perform a radical mastectomy, the only accepted therapy for breast cancer in those days. Community physicians have always participated in the teaching programs of the medical school in exchange for house staff coverage at night for their patients. While anesthesia was being induced, I introduced myself as his assistant for the case. Nonverbal communication in an operating room is with the eyes. The surgeon's eyes communicated shock, maybe even disgust, at my presence in his operating room. While I did scrub, I was not allowed

to touch instruments or the patient, hold a retractor, nothing. Fortunately, I could learn by just watching, as the surgeon was a masterful technician. His experienced hands deftly separated the breast and lymphatic tissue from the muscles of the anterior chest wall. I winced as a portion of the patient's femininity was callously plopped into a stainless-steel bowl: The breast, resting in thin bloody fluid flecked with round fat globules, had landed nipple-side up, defiantly, like an accusatory eye, as if to say, "How could you? I, who have been loved and caressed, and fed the next generation, deserve better." The cancer was not visible. A pathologist rapidly left the room with the steel bowl and its contents. During the entire case the surgeon did not talk to me, but kept looking up from the surgical field as he worked, hoping I was but an apparition that miraculously would disappear, as the breast had, if he glanced at it often enough. Following the case, with his surgical mask still tied in place covering his face, he quickly retreated into the doctors' (read "male") dressing room, where he could escape. Women students have similar experiences today, although the surgeon is usually more subtle.

Women surgeons have always changed into their scrub clothes with nurses, in what used to be called the nurses' dressing room. At Stanford, during my training, this was a tiny, impersonal room invariably crowded with too many bodies and containing too few lockers to accommodate everyone. I did not have an assigned locker, hung my clothes on a hanger if I could find one, and kept all other valuables in my car. In contrast, the doctors, dressing room was a huge lounge, complete with an overabundance of lockers, along with recliner chairs, the latest magazines, and soothing music. Some years ago a female medical student, on the first day of her surgery rotation at another medical school, was led to the nurses' dressing room to change. She refused, stating she was training to become a doctor, not a nurse. Head held high, she entered the doctors' dressing room and proceeded to disrobe

in front of some male faculty surgeons. Her dean asked her to pay him a visit the next day for a frank discussion about her inappropriate behavior. But slowly, hospitals, including Stanford, have changed signs to the operating room dressing areas to "Men" and "Women" in order to reduce the stereotype that only men are doctors and that all nurses are female. When new operating rooms were built at Stanford in 1987, the dressing areas for men and women were equal in size, and a lounge was added for the use of all operating room personnel. However, much informal discussion about cases, both pre-and postoperative, still takes place in the dressing area, and women surgery interns and residents are distinctly disadvantaged by missing this component of informal education.

As an intern I do not remember being at all concerned or inconvenienced by comments and actions that set me apart from the rest of the group. I shrugged off a series of lewd remarks and jokes precipitated by my having to share sleeping quarters in the emergency room for a month with a fellow male surgical intern. In the operating room, I did not consider having my neck massaged or kissed while scrubbing, the friendly arm draped across my shoulders, the playful tickling of my rib cage as anything other than innocent affection. I put up with all of it. I wanted these people from this strange world to like me, to be my friends, to welcome me into their professional world. Depending on the individual and the type and degree of physical contact, sometimes the attention was welcome, sometimes not. Inherent in a doctor's professional degree is the right and expectation that hands will be placed physically on another's body, sometimes on very intimate parts of another's body. In the doctor-patient relationship, the patient has deferred to the physician's capability and knowledge, and in so doing tacitly approves of being touched by another. It is a power play where the doctor holds all of the power. Some doctors, however, forget that the permission to touch does not necessarily extend to co-workers or peers. They touch indiscriminately to the point where it becomes a part of their basic

Power

Restaurant incident

personality. Had I given it any thought, I would have been attuned to the power elements in many episodes of touching I experienced, and recognized them as the belittling, controlling gestures they were. But none of the women in my world (nurses, for the most part) ever made an issue of this touchy-feely, flirtatious, and at times not very attractive behavior, and I certainly was not willing to call attention to myself by doing so. Besides, chronic fatigue precluded thinking about power and power relationships. The only energy I had for thinking went to patient care and getting the job done. I had learned to keep up and was having a fine time as a member of our exclusive surgical intern group.

Every few months the Department of Surgery hosted a dinner for the house staff (spouses not invited, so it was an all-male-plus-me gathering) at a local restaurant—a gratuitous "thank you" for our unending hard work. Liquor flowed freely, many resident, staff, and faculty physicians would drink to excess, and occasionally the restaurant would get trashed. On one occasion, two residents played "dropkick," one by one, with a stack of dirty restaurant dinner plates, splattering shards of broken ceramic toward a huddle of terrified waitresses. One of the women had sinned by not accepting the advances of a drunken resident surgeon, and this was the doctor's way of getting even. Having drunk more than was good for me, I thought it hilarious, and giggled nonstop, experiencing exhilaration from the wanton, destructive behavior that would have been shocking to me, and others, had we been sober. There was an amazing freedom in having the balls (literally!) to act out that way. I do not believe any of the physician participants or spectators that evening felt the actions were deliberately cruel. Outrageous, yes, but not meanspirited. After all, outrageous behavior was a God-given right for this group of men—not just men, but surgeons, the elite of the medical world. And boys will always be boys. It never occurred to me to join or even protect the frightened women.

All of us were lucky to have returned to home or hospital in one piece after some wild, wake-the-town-up drives down El

Camino Real. I realized this medical world was as it was, and I could take it or leave it. Impulsive, at times antisocial behavior was an integral part of that world, and frequently was excused as being necessary to reduce the constant stress in our day and night lives. If certain actions were disrespectful to women, so be it. The institution and the culture it engendered simply did not take women or their feelings into account. There was no need to. As very special beings, surgeons were protected—and the institution paid the bills. Had I voiced any objection, I would have derailed my career in surgery almost as rapidly as I would have by becoming pregnant. What else was there to do but join in—and have a good time?

On the work front, some faculty surgeons enjoyed testing me by giving me difficult cases, such as a gallbladder or splenectomy, as opposed to hernias or hemorrhoidectomies, which are the cases usually done by those with the least experience. This turned out to be an advantage: by the time I finished two years of general surgery, I had done more difficult cases than had my male resident peers and the operative experience has served me well. Mostly, however, I do not think I was taken seriously by the surgeons who taught me, and many treated me like "a cute little piece of fluff," more suitable for romance than for blood and guts. I was often asked, without a trace of subtlety, when I planned to start a family. I had the distinct impression that few thought board certification as a surgeon lay in my future. At the end of a six-month general surgery rotation at the VA, the Chief of Surgery, a professor, told me I was a good surgeon, but way too aggressive for his tastes. My future would be easier for everyone, including me, he said, if I could develop restraint and a degree of feminine shyness. It was impossible to think his advice was in my best interest. My successful compatriots were anything but shy. I saw a pushy assertiveness as being the best way to get ahead. Yet I could ignore being patronized and accept it with grace because I believed if I developed good talent as a surgeon, that alone would be sufficient to conquer old ingrained prejudices. I was not about

to let others limit my dreams, and thus copied the behavior I thought would allow me to realize them.

Phil's life probably would have been easier had I stuck with my original intent of becoming a plastic surgeon. Unfortunately, when I rotated on to plastic surgery for the required month during my internship, I had found the subject boring—the surgery itself is great fun, but the basic subject matter was not intellectually demanding enough for my taste. There was an ugly scar on an arm, the breasts were too small, or the nose was too big. Taking care of burn patients in that era was a truly hideous experience. Even today I can smell the silver nitrate solution, used to clean the burn, mingling with the scent of scorched, dying flesh, the silver paradoxically turning everything it touched black, except for the yellow-red depths of the wound itself. After morning rounds with the attending plastic surgeon professor, it fell to the intern to return for a daily torture session of cutting dead tissue from the burn, the anguished cries of pain never sufficiently dulled by Demerol or morphine.

Unexpectedly, during my month as the neurosurgical intern, I found neurosurgery to be the most exciting discipline I had ever encountered. It had everything. In the pre-CT, pre-MRI scan era, a neurosurgeon had to be an exacting diagnostician, asking where the nervous system was hurt; why or what was causing the incapacity; and what, if anything, could be done to reverse the damage. Unlike neurologists, who spend as much or more time intellectualizing about neurologic dysfunction as they do attempting to treat it, neurosurgeons have the technical ability to reverse many devastating neurologic deficits with surgery. A paralyzed patient walks, a mute stroke patient talks, a tumor patient borrows extra time. I knew then this was what I wanted to do with my life.

But in the 1960s almost no surgical programs were taking any women into their ranks, let alone into neurosurgery. There were no prohibitive written policies in place—women were just not expected to have any interest in surgery, and certainly did not

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.

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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