Are women residency supervisors obligated to nurture?

Laura D Hirshbein

Scholars in medical education have been increasingly aware over the last few decades of issues of women in medicine, particularly the ways in which women move through medical school and residency, and eventually become faculty. Much of the literature has focused on ways in which women are at a disadvantage in a male-dominated medical culture. But how can they overcome this disadvantage? Should women act like the men around them, emulating their practice patterns, research endeavours and teaching styles? Or do women need to behave differently from men in order to succeed? Isn't this an outrageously stereotyped way to think about the dilemma? Unfortunately, there may still be embedded gender stereotypes in academic medical centres, particularly in teaching relationships. How can we understand these stereotypes and overcome them?

MY EXPERIENCE

I was fortunate enough to join the psychiatry faculty of a reasonably prestigious university the very day after finishing residency. I was told that my job would include seeing patients, doing some research and educating residents. I was given a small course in my area of research interest, which I taught to second year residents, and I also provided clinical supervision for residents rotating on our adult inpatient and emergency room services. I was not given any particular instruction about teaching residents, but I didn't notice the lack of information. I assumed that, as I had just finished residency, I had a good handle on what residents wanted. My plan was to imitate what I thought was good about my supervisors (information, direction) and improve on what I had experienced that was less helpful (faculty who would not help with the work that needed to be accomplished).

When I started out, I thought things were going fairly well. My inpatient team was running smoothly and I had a good feel for what was going on with the patients. When the residents asked me for advice, I told them what I thought. I made no secret of the fact that I had 2 small children, and so I worked to make the whole team efficient so that everyone could get their work done and go home. I made my expectations for the residents clear and told them how they were doing. I also made sure that I covered for residents while they attended lectures and educational activities.

I was not given any feedback about my teaching during my first 2 years on the faculty. When I finally received a series of teaching evaluations, they were brutal. The residents complained that I was dictatorial, claimed that I had threatened them, that I was more focused on getting the work done than on teaching, and accused me of caring more for my own children than I did about the patients. What was striking was that the evaluations for my didactic lectures in my research area were very good and the residents rated my teaching very highly in that setting. So whereas my direct interactions with the residents were evaluated extremely poorly, my lecture style got high marks.

What went wrong? Why was there such a disconnection between what I thought I was doing and what the residents experienced? Why did they like my lecture style and hate my supervision? These were not just academic questions for me – I was supposed to go up for promotion the year that these evaluations came out, but our department's promotions committee pulled my packet from consideration after seeing the overwhelmingly negative comments. I still do not have a complete answer about what happened with the residents, but as I talked with senior faculty about my experiences, I discovered a number of things I had been unaware of previously. First, the supervision style I had been emulating – that which I had

Department of Psychiatry, University of Michigan, Ann Arbor, Michigan, USA

Correspondence: Laura D Hirshbein MD, PhD, 9C UH 9151, 1500 E. Medical Center Drive, Ann Arbor, Michigan 48109-0120, USA. Tel: 00 1 734 936 4960; Fax: 00 1 734 936 9983; E-mail: lauradh@umich.edu

doi: 10.1111/j.1365-2929.2006.02635.x

experienced during medical school and residency with my own (male) supervisors – evidently did not fit with what the residents expected of me. Second, I discovered that we still do not have much good information about how to supervise and teach residents appropriately and how to adapt supervision and learning styles for particular groups of supervisors and trainees. Third, I discovered that residents have different expectations of faculty, some of which seem to be determined by gender assumptions. One of my senior (women) colleagues explained to me that the residents expected me to act like their mother – that the residents' complaint that I cared more about my children than my patients was their way of saying that I cared more about my children than about them. This observation led me to a fundamental question about women in academic medicine: do women faculty who teach residents have an obligation to nurture their trainees?

WHY MIGHT A WOMAN SUPERVISOR BE EXPECTED TO NURTURE?

As historian Regina Morantz-Sanchez describes, women began to enter medicine in the middle of the 19th century and had reached significant numbers within the medical profession by the beginning of the 20th century.[1] Women doctors argued that women's nature, including their propensity to nurture, was essential for the practice of medicine.[1,2] In the first half of the 20th century, as historian Ellen More points out, women struggled to reconcile women's unique contributions to medicine with an increasing trend toward assimilation into mainstream (male) medical practice.[3] But although women continued to enter medicine throughout the 20th century, the numbers of women applying to and being accepted by medical schools dropped to very low levels in the first half of the century and did not increase until after the first wave of the feminist movement in the 1970s. During the beginning of the feminist movement in the 1970s, activists argued that women in medicine deserved equal rights with men.[4] By the 1980s, however, some had returned to the idea that women's contribution lay in helping to improve and humanise medicine as it became increasingly technical and inhumane. Women thus found themselves expected to be both pioneers in achieving equality with men and champions of female values in medicine, a dual role that was uncomfortable for many.[5]

The presence of increasing numbers of women doctors has clearly changed the dynamics of many medical specialties, especially those in which women have a significant numerical presence, such as paediatrics and obstetrics and gynaecology.[6] But the tension between equal rights and the celebration of female values continues to be very awkward for many women doctors, particularly in academic settings where they are expected to serve as teachers and role models for the next generation. Do we emphasise that we are just as capable as our male colleagues? Do we show that we are more sensitive to the role of women in lower status occupations and take on more responsibility for things such as our own typing and our own procedure clean-up? Are we doctors or are we women doctors? Is there a difference? Should there be?

Women doctors continue to both benefit from and be hampered by assumptions that women in medicine are going to change the quality of interpersonal relationships in the medical system. Certainly, there is evidence that women in general have different communication styles than men – as has been abundantly described (and caricatured) in the popular media.[7,8] But how much of the difference in communication styles is due to social and cultural assumptions and specific dynamic roles? One of the issues that complicates inquiry about gender and academic medicine is that many researchers conflate 2 very different concepts: sex and gender. Sex refers to the biological group to which an individual belongs (male or female), whereas gender refers to the complex set of social and cultural assumptions that govern individuals in a system. As historian Joan Scott points out, the concept of gender is intimately connected with power: for much of history, the dichotomy between male and female has been used to denote relationships between the powerful and the powerless, the active and the passive, the dominant and the submissive.[9] How does this complex system of power relationships affect teaching, particularly the dynamic process of resident supervision? What does it mean to have a woman supervise a man? Or a woman? What are the gender expectations for both supervisor and supervisee?

THE END OF MY STORY

My own story of resident supervision appears to have a happy ending. After a lot of soul searching and discussion with senior women faculty, I completely changed my approach to resident supervision. I stopped trying to help the residents get their work done and focused on trying to be supportive. I tried

to open up dialogue with the residents about their educational needs: although none of them ever told me what he or she wanted out of supervision, I did emphasise that I was trying to adapt my supervisory style to what it appeared that they wanted (i.e. more or less direction) and that they needed to tell me if the style did not match their expectations. I made a point of trying to get to know the residents – their educational backgrounds, their social and personal contexts, whether or not they had pets – and tried to balance being interested without being too intrusive. I also brought in food (especially baked goods) on a regular basis during the times I was attending on the inpatient unit (this on the advice of a senior woman colleague). I'm not sure what made the difference, but my supervision evaluations since my transformation have been good to excellent, and I finally got promoted.

As I made the decision to change my supervision style, I did not try to turn myself into someone I am not. I did make a conscious decision, however, to show parts of my personality I had previously kept only for my personal life – particularly with a more nurturing approach in supervision (in a way that is distantly similar to how I treat my children). But this has been a big adjustment and represents a complete departure from the way I was trained. At a particular point during my own residency, I was on an inpatient unit rotation when I was 8–9 months pregnant. My supervisor (an older man) appeared not to notice that I was pregnant and made no efforts to change his rounding style, which had all of us standing for several hours at a time. At the time, I didn't think this was unusual or inappropriate (although it was certainly uncomfortable), and I remember the supervision in this setting as being very high quality. Last year, when I supervised a resident who was on the unit during her last month of pregnancy, I made a special effort to make sure she could sit down whenever possible and changed the structure of rounds to make sure she wasn't standing for long periods of time. My male colleagues did not make similar accommodations for this pregnant resident, but I don't know if she would have expected them to – and I don't know what their teaching evaluations look like.

Medical education as a whole appears to be moving away from the traditional, top-down model of instruction and authority in all areas, from classroom teaching to supervision. Yet how do these new teaching styles and methods of interaction work within our existing (and sometimes competing) patterns of interaction based on medical tradition and gender? Are women expected to embody the more collaborative approaches just because they are women? Do men (and women) trained in more traditional methods of teaching face a disadvantage in terms of their evaluations as teaching systems change around them? Are there other complexities besides nurturing that are incorporated into assumptions about women and their teaching styles? How can we tease apart issues of gender role expectations and good teaching? And, on a more personal and practical level, will the quality of my teaching evaluations decline if I stop bringing in baked goods?

Acknowledgements: none.
Funding: none.
Conflicts of interest: none.
Ethical approval: not applicable.

REFERENCES

1 Morantz-Sanchez RM. *Sympathy and Science: Women Physicians in American Medicine*. New York: Oxford University Press 1985.
2 Abram RJ, ed. 'Send us a Lady Physician': Women Doctors in America, 1835–1920. New York: W W Norton Co. 1985.
3 More ES. *Restoring the Balance: Women Physicians and the Profession of Medicine, 1850–1995*. Cambridge: Harvard University Press 1999.
4 Walsh MR. *Doctors Wanted: No Women Need Apply: Sexual Barriers in the Medical Profession, 1835–1975*. New Haven: Yale University Press 1977.
5 Morantz-Sanchez R, Pomerleau CS, Fenichel CH, eds. *In Her Own Words: 2,446 Histories of Women Physicians*. New Haven: Yale University Press 1982.
6 Hayashi TT, McIntyre-Seltman K. The role of gender in an obstetrics and gynaecology residency programme. *Am J Obstet Gynecol* 1987;**156**:769–77.
7 Tannen D. *You Just Don't Understand: Women and Men in Conversation*. New York: William Morrow 1990.
8 Gray J. *Men are from Mars, Women are from Venus: a Practical Guide for Improving Communication and Getting What You Want in Your Relationships*. New York: HarperCollins 1993.
9 Scott JW. Gender: a useful category of historical analysis. *Am Histor Rev* 1986;**91**:1053–75.