

## Women's Challenges in IR: #ILookLikeAnIR



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### Editor:

Susie Pitt, MD, a surgeon at the University of Wisconsin, saw the recent *New Yorker* cover illustrating women in surgery and challenged women surgeons to replicate the image with their female colleagues. The thread went viral (#ILookLikeASurgeon), with women all over the world sharing photographs in a show of solidarity. The movement comes at a time when hard-won women's rights are threatened. On March 27, 2017, President Trump signed an executive order revoking President Obama's 2014 Fair Pay and Safe Workplaces order, which had provided for paycheck transparency and banned forced arbitration clauses for sexual assault, sexual harassment, and discrimination claims. The *New Yorker* cover campaign is meant to promote women working in male-dominated fields and to dispute gender stereotypes in medicine—specifically in surgery. Indeed, the stereotype of men as surgeons and women as nurses is so strong that it persists when people are given evidence to the contrary (1).

The women in the Interventional Radiology (IR) Service at our institution were inspired to rise to the *New Yorker* cover challenge (Fig). Of 6,800 students who graduated from US-accredited medical schools between 2006 and 2008 and went into general surgery or surgical subspecialties, 31% were women (2). By comparison, in 2010, only 7% of IR faculty were women, and in 2012, only 15% of IR fellows were women (3). Survey studies have pointed to radiation exposure, career length, call responsibilities and long work hours, lower amounts of patient contact, male predominance, and lack of female mentors as deterrents to women choosing IR. It is therefore remarkable that a single institution has gathered 6 women attending interventional radiologists, representing nearly one third of the IR Service faculty. This accomplished group has 1–30 years of practice in IR and includes a former division head, National Institutes of Health grant awardee,

American Board of Radiology Trustee, and National Comprehensive Cancer Network Hepatobiliary Section member.

Why are there so many women in 1 IR group? Arguably, most important is the support one finds in numbers; for junior women physicians, a group of accomplished female colleagues offers support and mentorship. One drawback of IR is the wide variation in when the workday ends because of the unanticipated nature of a high volume of add-on inpatient cases. Our section channels inpatient cases to specified procedure rooms, with other rooms ending at more predictable times, enhancing the quality of life of male and female colleagues alike. Practicing in a liberal, cosmopolitan city is another draw, with a culture more likely to accept diversity and challenge stereotypes.

Although the experience of our group is encouraging, the underrepresentation of women in IR remains a problem in the United States overall, particularly in light of the recent report that female physicians may have better outcomes than male physicians (4). Only 25%–30% of medical students who choose a radiology residency are women, limiting the number of women available to subspecialize in IR. The transition to the IR/diagnostic radiology residency program may help address this problem and presents an opportunity to recruit women directly from medical school. At the 2017



**Figure.** The *New Yorker* cover challenge. Our IR Service includes 6 women attending physicians who replicated the April 3, 2017, *New Yorker* magazine cover, "Operating Theater" by Malika Favre. From 12 o'clock, clockwise: Karen Brown, MD, Amy Deipolyi, MD, PhD, Anne Covey, MD, Lynn Brody, MD, Duan Li, MD, and Yolanda Bryce, MD. Photograph by James Mulea, RT(R)(CT)(ARRT).

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Society for Interventional Radiology annual meeting (Abstract #45), Dr. LaBerge's group at the University of California, San Francisco, postulated that the barriers to women choosing to specialize in IR may stem from a lack of knowledge about our specialty. They surveyed students before and after a 10-week IR elective. However, despite the elective, almost half of students still believed that the field was inhospitable to female physicians.

Why would students who rotated through an IR division with outstanding female mentors believe the field to be inhospitable to women? Even if one day we overcome salary discrepancies and hiring inequalities, we are left with a subtle but ubiquitous chauvinism that is embedded in our male-dominated field. This is not the blatant *Mad Men*-like misogyny of the past, but because it is not blatant, it is more difficult to eliminate. Rivers and Barnett (5) describe the "soft war" that professional women are fighting today in their book, *The New Soft War on Women: How the Myth of Female Ascendance Is Hurting Women, Men—and Our Economy*. Women battle what New York University psychologist Heilman described as the "lack of fit" between the expectations of a successful professional and those of a nurturing woman (6). This conflict may manifest in male colleagues believing female colleagues less capable of performing challenging cases, resenting women who must balance work with responsibilities at home, or attributing a woman's success to favoritism and flirting rather than ability. This also plays out in challenging interactions between female physicians and nurses and between women physicians who ideally would support each other but instead are ensnared in a competitive dynamic as "tokens" who feel the need to contend for limited resources.

How can we overcome the chauvinism embedded in IR? Institutional policies defining and identifying sexist behaviors can encourage women to report harmful interactions, with potential disciplinary measures for blatantly disrespectful behavior. Respectful behavior toward colleagues can be incorporated into performance feedback, with direct influence on possible bonuses and promotions. On a national level, we challenge the leaders in IR to include women in sessions at meetings, to recognize and promote successful women, and to expose trainees to a more inclusive image of IR. These efforts are only a start. Responsibility rests on IR faculty to reinvent, or perhaps invent and/or define, the woman IR "ideal"—an intrepid, compassionate, dedicated team player who manages stressful professional situations while achieving and maintaining personal excellence; these attributes are prerequisite for anyone aspiring to specialize in this field. The onus is on us as female faculty to model these behaviors to potential trainees and to develop collaborative relationships with other women in medicine. By recruiting more women to IR, we hope to reinforce our positive image and conquer the belief that IR is inhospitable to women.

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## Diagnostic Reference Levels Will Not Lead Us to "ALARA"



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### Editor:

I read with great interest the paper by Heilmaier et al (1) on establishing local diagnostic reference levels (DRLs) in interventional radiology. Although DRLs can be a valuable tool for increasing awareness and alerting operators when defined thresholds are exceeded, it is important to remember that they are only a part of the process of optimizing radiation dose. Overreliance on DRLs can actually thwart the attainment of levels that are "as low as reasonably achievable" (ALARA), which is one of the guiding principles of radiation protection.

The Merriam–Webster dictionary defines "achieve" as "to get or attain as the result of exertion." This implies constant effort and striving for improvement toward true optimization. The DRL concept incorporates a static reliance on previously established values without challenging the operator to improve. This approach may well result in complacency and passing the important concern of minimizing patient and operator exposure on to the dose-management software. The onus to minimize radiation dose must rest on the shoulders of the operator himself or the supervisors of the training program for residents and fellows.

In 2015, my colleagues and I published a paper on radiation dose reduction in fluoroscopic procedures using left

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