Conversations With Women in GI:

Talking with Dr. Grace Elta on "The Current Challenges of Being a Female Gastroenterologist"

By Jill Gaidos, MD, FACG

Between sessions at Digestive Disease Week in San Diego, Grace Elta, MD, FACG, and I sat down at a collection of tables in the busy convention center to talk about her career and the challenges of being a female gastroenterologist.

While doing your residency, where you were one of only seven women among the 40 interns in internal medicine, what attracted you to the male-dominated specialties of gastroenterology and, particularly, interventional endoscopy?

GE: I liked procedures, even back as an intern and resident and, obviously, GI is very procedurally oriented. I was at Tufts during my residency and all of our services were subspecialty, so we only rounded on subspecialty wards. I just enjoyed the GI field. I liked the procedure aspect of it and I liked that it's a fairly broad field. I always say, "Oh, they've only got one organ, those heart people," and we've got lots of organs. I always liked the breadth of medicine and yet I never wanted to be a general internist because I was too fearful you'd have to know too much. I always wanted to be an expert in a smaller area.

So, your second question is about interventional endoscopy. The way I got into interventional is I was at Tufts New England Medical in the late 70s. ERCP at that time was primarily a diagnostic tool because CAT scan was brand new and there was no MRI. CAT scan was very rudimentary compared to what you are seeing right now. The first two individuals in New England who performed ERCP were Richard Norton at Tufts, where I was, and Doug Howell in Maine. That established Tufts as a referral center for ERCP and so we did a lot. Now, if I told you what a lot was it would be nothing compared to the numbers trainees perform now. When I finished my fellowship, I went back to Michigan because my husband got a job there. When I came to Michigan, they had two individuals doing diagnostic ERCP, but nobody had ever learned sphincterotomy or stone extraction, whereas I had learned that during my fellowship. So, that immediately put me into, "Oh Grace, you know how to do sphincterotomy and stone extraction, you have got to be an ERCPist." So, that is how I started down the interventional track. It was never that I decided, "Gee, this is what I'm going to do." Remember, back in the early 80s and late 70s, all gastroenterologists did everything. In fact, in the mid 80s, I used to round on the new liver transplant program at the University of Michigan. Now, I haven't done hepatology in a long, long time. My ERCP training started me down that interventional path, and I stayed there.

In your editorial "Is the glass ceiling in gastroenterology gone?"[1] You mention that one reason there are still persistently fewer women in GI is because of the "training culture" in gastroenterology that makes female students and residents feel undervalued and unwelcome. Did you experience that in your training and, if so, how did you overcome it?

GE: I have to say that in my fellowship, no, I don't think I really experienced that. My division chief, Marshall Kaplan, was always very supportive. I think I was treated very fairly, as far as I could tell anyway. During my career, there were some issues along the way, particularly as an interventionalist, where I wasn't taken seriously. In general, it was subtle and not overt. It never felt like it was mean spirited, it was more just that they didn't accept me as one of them, couldn't believe

Photo Top: Grace Elta, MD, FACG
Photo Opposite Page: Jill Gaidos, MD, FACG

it. On the flip side of that comment, I certainly did see overt discrimination against women in medical school; I could tell some pretty bad stories, but I won't because those situations are gone. The outlandish things people in power used to get away with, they never would anymore. But I still think there is probably some lack of inclusion of women students and trainees, making them feel unwelcome.

I think the biggest obstacle women face is that, at that phase of their life, they are trying to combine career and family, which is very hard. In doing this, they try to protect their time and in medicine, protecting your time means you're "not a team player" and you're "not dedicated." How can you be a dedicated interventionalist if you are trying to protect your time? It is not recognized that they are protecting their time because they are trying to do two important jobs. So, I think that combining career and family is probably a bigger challenge now than overt discrimination.

You wrote in "The Challenges of Being a Female Gastroenterologist"[2] that in order to encourage more women in GI, family time and family responsibilities need to be respected by not scheduling conferences early in the morning or in the evening hours. How were you able to maintain a family friendly schedule when your children were younger?

GE: It wasn't easy. I remember when I was a junior faculty and Tachi Yamada was my division chief. We had a small faculty, there were probably only 10 of us at that time. By then, I had two or maybe three kids; I had one during my fellowship and two while I was junior faculty. At one of our faculty meetings, which was always in the evening, Tachi said, "We are having too much trouble getting people to come to conferences." Which was true, it's always hard because everyone is always so busy with clinical demands. He said, "I think we should move them all so they start at 6:00 pm and end at 7:00 pm" Everybody said, "Oh, that's a great idea." And, I said, "No, that's not going to work. I can't do that." We had conferences two or three days a week. I said, "I can't do that on a scheduled basis. I just won't come. You can't do that, that's family time." Everyone in the room was scoffing at me. They didn't make a decision but I was the only one who said, "I just won't attend." I thought to myself, "Fine, if they fire me, I'll find another job."

Were you the only woman on faculty at that time?

GE: There was one other woman there. She had kids. She never said a word. I think she just wasn't willing to speak up, but I was. Sure enough, Tachi thought about it and did not change the conference schedule. We were a small group, but I was the only voice against it and everybody else was in favor of it. He did not do it. He obviously listened and paid attention to that. I credit him for that. I applaud him for that.

Do you think that is feasible now with the increased focus on clinical productivity? How do women work around that?

GE: We have early morning conferences at Michigan, early being 7:30 and not 7:00. Even people with child care issues can make those meetings, not always, but usually. I think that we try to stick to that. We try to make sure nothing starts before 7:30 and everything ends by 5:30. Otherwise you can't meet the child care requirements. So, I think it's doable. I agree, with clinical demands and pressure on productivity, it's tough to carve out conference time.

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Do you think women need to pick and choose what they attend? Do you think that sacrifices your career? If you're not there, your department chair or practice CEO doesn't see you and you don't have any input.

GE: I think it's important to be there. I think it's important to fight for some protected conference time in academic medical centers even though academic medical centers are under the same pressures as private practitioners in terms of productivity. I think people in private practice don't realize that, but the truth is that we are all under the same pressures for productivity. It think we just have to carve out at least some time for educational purposes. I think it's good for all of us.

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What are ways that we can attract more women into GI? You have clearly thought about this reading your publications. Do we need to focus on the IM residents or the medical students to increase interest?

GE: I think it's already happening, first of all. The numbers are clearly increasing. It's slow, but everything in medicine is slow. I guess it's surprising to me how slow, because actually the dramatic increase in women in medical school started in the 70s, but then really leveled off in the early 90s. It's already been over 20 years where medical schools have been around 50% women. You think, "Wow, it's been that long. Why is it taking so long for GI and cardiology to catch up?" But they are catching up. I think it is happening, it's just slow. I think role models help, seeing that other women have done it. I think mentors help, having someone to talk to, to say "You can do this." I think that makes a big difference.

"To me, as I wrote in that 'Glass Ceiling' editorial, the biggest inequity that still exists is pay. In academic medical centers, pay is secret, and nobody knows what anyone else makes. And, when anyone does study this, women are paid significantly less. And, that is just so unfair because women are really not working less. "

In the "Challenges" chapter, you mention the challenge of the ergonomics of endoscopy as there is only one size of endoscope head. Do you think that will change in the future?

GE: I think the endoscope manufacturers have heard this and are interested. They are well aware that may be challenging, but I doubt that it's their highest priority. They are a business and their interest is market share, as it should be. I'm not sure "smaller ergonomics" will ever change market share enough to drive them to try to get endoscopes that are ergonomically better. I'm also not sure the endoscope is ergonomic for men either. You talk to senior endoscopists, like myself, and many of us have had hand surgery. It's definitely challenging on your joints and your arms.

In several of your previous publications, you talk about the lack of women in leadership positions in academic medical centers and professional societies, which you attribute, in part, to discrimination due to the "Old Boys Club" and, in part, to a "lack of personal promotion and drive in many women." You are a professor of medicine, associate chief for clinical programs, director of the medical procedures unit, former ASGE president from 2007–2008, to name a few accolades from your career. Can I assume that you don't lack this drive and the skill of personal promotion?

GE: (Laughs.) I do lack the same personal promotion. I never promoted myself the way men have. I never went in and said, "I need more salary," and therefore I was underpaid compared to the men on my faculty. But I never asked for it, and they did. I very much was the typical woman. The flip side that we haven't mentioned is that, in some ways, being a woman has helped my career. There was a point when, "Oh my gosh, every governing board member in the ASGE is male, we better get a woman in here," and I was appointed. Not to say that I didn't deserve it or I wasn't qualified. However, if anything, it has helped me along the way to be a woman in a male-dominated field. Sometimes minorities and women have been helped by the fact that people are starting to look around in the last 15 years and are noticing that we need to increase the diversity.

Do you see ways for women to improve their ability to promote themselves?

GE: To me, as I wrote in that "Glass Ceiling" editorial, the biggest inequity that still exists is pay. In academic medical centers, pay is secret, and nobody knows what anyone else makes. And, when anyone does study this, women are paid significantly less. And that is just so unfair because women are really not working less. At least not at my medical center, they aren't working less. My guess is that's true at most. That is the one thing that I think that women really need to ask for–salary equity. They should also ask for the things they want in their career. I think that's just not part of the female culture. It wasn't for me either though, so I can't say I did it and that other people should.

Since salary is such a secret, is there a way to figure out if you are being paid less than the new guy who was just hired?

GE: The answer to that is probably no. I've been on the faculty at Michigan for over 30 years. Annually we get a letter telling us what our raise is going to be and then, two months later, you see it in your check. Three different times my check was more than what my letter said my raise would be. The first time it happened, I called and said, "You guys made an error. You made a mistake, you're giving me too much money." I didn't want to have to pay any money back. They said, "Oh, well, that came from the equity office on central campus." Central campus? Pretty far away from us. We have nothing to do with central campus. But obviously, even back then, they had an equity office that said I wasn't making enough compared to my male peers. And then it happened to me a couple more times. Of course, by the third time, I was like, "Oh, I bet this is equity again." It still makes you mad because you realize that they were going to pay you a lot less than what is fair. I guess you have to hope that your medical center or your central campus has an equity office that is doing their job. I'm not sure they totally did the job, probably not, but at least got me closer to the range that I deserved. This is not the way it should be run.

Even in private practice, women also make less than men, although the inequities are

greater in academics. Women sometimes do decrease their work schedule because they have another important job, raising a family. But even per hour worked, women are still making less. The reason the inequities are larger in academics than they are in practice is that salaries are not secret in most practices. If you are in a big group practice, everybody knows what everybody makes or it's based on the number of RVUs you earn, which is all pretty clear. But in academics, salary is very secret.

In your biography from 2003,[3] which needs to be updated, by the way, you mention that you found time for only two activities in your life, your children and your career. Is that the kind of focus that women need in order to have a successful career in gastroenterology?

GE: It's true of me at that time. I didn't resent it. I had my first child when I was 30, so I had a lot of years where I didn't have kids and I really wanted them and I enjoyed them so much. And I enjoyed my career. So, I wasn't resentful. It might have sounded resentful, but I really wasn't.

No, not at all.

GE: I remember that I always loved to read novels. I read them all the time now because I have a lot more time, the kids are gone. Back when I had young children, I only read one or two novels a year, and that was when I was on vacation. That's it. I never read anything other than journals because I didn't have time. I didn't resent that. Maybe some people would. I also didn't take time to exercise. I didn't do any of those things for myself. That's probably not good for you. I guess that men would say the same thing, to a certain extent. Although there are very few families still in this day and age where the woman doesn't take more of the household/children responsibilities. I think it's getting better, but still a lot of that falls on the women. I do think having dual-career couples, where the husband and the wife are both physicians, will help because the men will understand the demands. They will have to be the ones rushing out to pick up the kids from child care. That awareness will help. When I was a junior faculty member, none of the men that I worked with had wives working outside the home. Not one. So, that even made you more different. Now, that's not true.

Now it's hard with the focus on work-life balance and the importance of "you time." If you keep yourself healthy, then you are better for your family and your patients. Now, that becomes an extra stress, so if you don't have that "you time," you aren't keeping up.

GE: Yeah, to a certain extent, I say do what makes you feel good and don't worry about the guilt or what you should be doing. As long as you are happy and you're content, I'm not sure I would worry too much about "you time"; there will be other times of your life for that.

You mention in the "Training in Interventional Endoscopy: Current and Future State"[4] article that interventional endoscopy is associated with long hours and higher complication rates, which are two characteristics associated with high rates of physician burnout. How have you prevented burnout during your successful career?

GE: I'm not sure; maybe I haven't. I can tell you that the older I get, the more complications bother me. Complications occur in GI no matter what you do, but interventionalists certainly see more of them. I find that I take them very seriously. I take them home with me. I fret about them. If I were the patient, I wouldn't want a doctor who didn't fret about a complication. So, from the flip side, it just shows that you care, that you're concerned, and that you're rethinking about what could have been done differently.

In terms of long hours, interventional endoscopy doesn't have to be long hours. If you hire enough people and you have enough space, the duties can be shared. Individuals need enough volume to be good at it, but the procedure volumes that individuals are doing at some institutions are much more than they need for competency. Maybe that should be ratcheted back a little bit so it's not quite as draining.

One thing I have seen is women who change their career or move to a different location to take on different responsibilities to avoid burnout. But you've maintained a career at one academic center.

GE: I do much more administrative work than I used to, although I still have a fairly high clinical load. But, I agree, moving into administration or into education gives you something different. Something different helps burnout because it's interesting and adds more variety. That's one of the things that I always loved about gastroenterology in general is that we have a lot of variety in our job. Academics adds even more variety because then you have the teaching aspect and the lectures, even though they can be burdensome at times. That diversity in your job helps with burnout. Doing the same thing every day long term, especially if it's in the patient-care treadmill, leads to burnout. Patient care is so unrelenting even if you are good at it and like it. ACG

[1] GIE 2016;83(4):734-735.
[2] Gastroenterol Clin N Am 2011;40:441-447.
[3] J Clin Gastroenterol 2003:36(1):1-2.
[4] Gastroenterology 2015;148:488-490.

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