

Women in Oncology: Progress, Challenges, and Keys to Success

Katherine Reeder-Hayes, MD, MBA, Enriqueta Felip, MD, PhD, Debra Patt, MD, MPH, and Elizabeth Jaffee, MD

OVERVIEW

Women have an increasingly significant presence in the oncology physician workforce but remain underrepresented in leadership positions and at the senior levels of academic medicine. Initiatives to close these gaps are underway both in the United States and Europe. However, many areas for improvement remain on an organizational level and in the trenches of career development and mentorship for individual female oncologists in both community and academic settings. Solutions to advance women in the oncology workforce will involve policy initiatives by professional and funding organizations, individual initiatives by universities and practices to recognize and develop female leaders, an increased focus on teamwork and novel practice arrangements, and high-quality mentorship of young women entering the oncology field.

The presence and role of women in oncology is an issue of great practical importance in providing a large and vital physician workforce to meet the ever-growing need for oncology providers. It is also an issue of immense personal importance to women entering the ranks of oncologists, those who have served in those ranks for decades, and the men who have worked alongside them. In this manuscript the authors present the professional and personal insights of four female oncologists who span the range of career stages, practice settings, and research interests, discussing strategies to successfully bridge the gap between the current state of women in oncology and the future to which we aspire.

ELIZABETH JAFFEE: AN OVERVIEW OF WOMEN IN ONCOLOGY, PAST AND FUTURE

Women are now a substantial group within the medical profession, thanks to pioneering predecessors and the male physicians who supported them. It was only a generation ago that few women enrolled in medical school, and those that succeeded in becoming physicians had fewer opportunities in the job market and at a reduced salary than their male counterparts. Women now comprise about 31.2% of all physicians (2011) and are represented in most subspecialties, even those that were dominated by men in the past. In oncologic fields (hematologic, medical, surgical, pediatric, gynecologic, and radiation oncology) the number of physicians has continued to increase in the past 9 years by approximately 3% per year, mostly in pediatric and surgical oncologic specialties. The number of female oncologists has also increased from 22.4% (2004) to 28.4% (2011) of the total number of

U.S. oncologists. Women in oncology pipeline programs make up approximately 46% of physicians (44.7% in internal medicine, 81.4% in obstetrics/gynecology, and 72.7% in pediatrics), and this is about the same for women currently training in oncologic specialties.¹ Salaries have also equalized for women, although more women than men choose part-time positions, which sometimes skews the published data.

Although major barriers have been overcome and glass ceilings have been cracked, women in oncology still identify a number of challenges that are unique to women as well as one important challenge that is shared with their male colleagues.

First, although women in medicine and oncology have made major strides over the past generation, they continue to be under-represented in areas of leadership. Women often receive fewer invitations to speak at, organize, or chair national meetings and compete less often for major leadership positions including division/department chairs, cancer center directors, leaders of national committees, and president of national societies, when compared with men at similar stages in their careers. This is a complex issue and the outright inequality issues of the last generation do not apply here. Instead, the inequality is subtle, with male meeting planners forgetting to make a conscious effort to think of women who are as accomplished as their male counterparts to deliver a seminar at a national meeting or serve as an organizer of the meeting. In the case of leadership positions, women often are encouraged to apply for leadership positions but decline because the opportunities arise at inconvenient times, when their work life is competing with raising their family.

The key to succeeding at being invited to national speaking engagements is simple: women need to work towards being

From the Johns Hopkins University School of Medicine, Baltimore, MD; Oncology Department, Vall d'Hebron University Hospital, Barcelona, Spain; Texas Oncology, US Oncology Network, Dallas, TX; Division of Hematology/Oncology, University of North Carolina School of Medicine, Chapel Hill, NC.

Authors' disclosures of potential conflicts of interest are found at the end of this article.

Corresponding author: Katherine Reeder-Hayes, MD, MBA, 170 Manning Dr., Campus Box 3705, Chapel Hill, NC 27599; email: kreedr@med.unc.edu.

© 2013 by American Society of Clinical Oncology.

more visible on the national stage. A woman who is interested in talking at a particular national meeting needs to contact the organizer directly and share her work; even if the agenda for the meeting has been set, she will now be on the radar for future meetings. For example, when I recently organized a national meeting, five men emailed me with summaries of their latest work and requested an opportunity to share their work by giving a talk. Not one woman did the same. A few pro-offered short talk slots were still available, and three of the soliciting investigators were given the opportunity because their work fit into the program well.

The key to leadership success is more complicated. In medicine in general, fewer women than men pursue academic careers after fellowship. Studies conducted by the National Institutes of Health (NIH) as well a report in EMBO Reports have shown that the number of women who are in tenure-track positions in science has remained unchanged in the past 10 years. Although women make up approximately 45% of biomedical science fellows in training programs, they represent only 29% of tenure-track investigators, and less than 20% of senior investigators at academic institutions.² Therefore the pool of women available for leadership positions is much smaller than for men. Furthermore, fewer women than men want to take on this difficult task because they value the little time they have at home. In addition, there are too few women currently in leadership positions to serve as role models and mentors. Women often feel less equipped with the skills to take on these higher-level leadership positions, and there has been very little mentorship in this area for women. The key to success on this issue requires a larger effort. We need to provide more incentives to senior women to apply for these leadership positions. More local and national efforts to provide leadership training to women seeking these top jobs would provide additional training and mentorship to women thinking about these positions and would give women more confidence that they can take on these positions successfully. In addition, access to more

convenient child-care may help increase the pool of younger female investigators interested in pursuing academic careers.

Second, women still need to be more assertive in the workplace to have their input heard and to ask for what they need. This is often linked to lack of self-confidence. Although there is no easy way to explore the prevalence and consequences of this issue in the workplace, many women report that a lack of confidence can hinder them from asking for what they need from their leaders to facilitate their work objectives. Many women in oncology that I work with or have spoken to about this topic are afraid to ask for what they need and are often more hesitant to negotiate for what is important to them. The most successful women are willing to talk about their own strengths and contributions to make sure their value is appreciated, facilitated, and compensated. The key to success is to become less concerned with what others think, to believe in oneself, and to “wear” self-confidence for others to see.

Third, women need to learn to deal with adversity and criticism. Oncology is a competitive field that is changing rapidly. As technologies advance and information systems move more and more quickly, female oncologists need to embrace learning and realize that they cannot possibly master everything. They must learn to accept input even when it may seem negative. Many women tell me they feel threatened by many forms of criticism, especially when provided by male colleagues. Many women take this criticism personally. The key to successfully overcoming adversity and criticism is to accept it as part of daily business and to learn from it. And, when in the position of having to give feedback that may be viewed as critical, always be honest, give it to others with a positive spin as part of the learning process, and show respect for colleagues’ input. When one of my female faculty members is feeling frustrated about what she perceives to be negative feedback from a colleague, I always say, “Watch *The Godfather*.” No one says it better than Tom Hagen when he tells Sonny about his father’s being shot: “It is business, not personal.”

Finally, the biggest challenge is one faced by both men and women in oncology—learning how to balance work and a home life. There is a growing interest in understanding work-life balance among many Americans who struggle to maintain high-pressured jobs while raising a family, caring for aging parents, spending time with friends and partners/spouses, cultivating hobbies, and maintaining personal health. This issue is even more complicated for oncologists whose job it is to care for individuals who are in critical life situations and/or participate in high-pressured research aimed at understanding cancers and finding new treatments and preventions.

Achieving a satisfactory work-life balance is necessary to achieve happiness, well-being, and contentment in life and should lead to a healthier attitude and enhanced productivity at home and at work. The pressures to work harder and longer hours in all areas of oncology are increasing as reimbursements for medical services decline, costs of running private and academic practices increase, regulatory oversights of research continue to demand more time of the researcher, and

KEY POINTS

- Women are well represented in oncology training pipelines in the United States and Europe but continue to be under-represented in academic and leadership positions.
- Policy initiatives that incentivize women to remain in academic positions and that develop leadership skills among women can further reduce gender inequities in oncology.
- Interventions to promote work-life balance may help women find sustainable ways to advance professionally and make maximal contributions to their fields.
- Team patient care and team science arrangements maximize contributions from women in oncology while promoting sustainability.
- High-quality mentoring is a key tool to equip junior female oncologists for career advancement.

funding for research continues to decline. In addition, people are more connected than ever through multimedia devices that lead to addictive behavior and inhibit the ability to periodically “disconnect” from work. However, there are solutions that can solve this challenge as well.

As individuals we must prioritize. Some women are considering restructuring their jobs—either through part-time work or job sharing—or arranging for a more flexible work schedule. Other women have chosen either team-based patient care, working with other nonphysician providers in private practices, or team-based science, working with other investigators and researchers. Although technology has increased connections to work, members of the field of oncology need to make better use of technological advances to speed up work tasks, allow for faster and more efficient communications between physicians and patients or between researchers, and to save time for more important work-related and home-life issues.

Some agencies and employers are implementing policies to facilitate a better balance. In academics, in particular, the NIH has had innovative grant opportunities for women who became part-time employees during early child-bearing years, and some institutions provide modest research funding for junior faculty in need of flexible hours or job sharing opportunities. More employers are realizing the benefits of facilitating work-life balance, including less burn-out and increased health and productivity. Yet institutions can facilitate more. In particular, academic institutions can loosen criteria for moving rapidly through the tenure track, and clinical practice environments can be improved to facilitate patient care. However, most importantly, individuals need to step back and consider their priorities. Success will depend on choosing the right job fit, identifying mentors and role models, letting go of the type-A personality requiring perfection at everything, overcoming guilt, setting limits on time and use of technology, and finding the right life partner. Achieving work-life balance is an active process that requires active participation by the individual seeking this balance.

In conclusion, women have made great progress in pursuing careers in oncology and medicine. The big barriers inhibiting entry into M.D. and Ph.D. training programs no longer exist. However, less apparent challenges still exist but are difficult to quantify as a result of the lack of studies that are ongoing to identify and monitor these challenges. Although many women are succeeding at overcoming these remaining obstacles, continued research and proactive initiatives are needed to ensure that women fully succeed in their goals. Finally, we need to increase the pool of qualified female mentors who can serve as role models to attract and continue to increase the pool of women choosing a career in oncology. These role models are the key to success for women who need to learn how to work productively with others, become more inclusive in research, show generosity in acknowledgments, authorship, and on grants, and to become the future role models for the next generation of women pursuing a career in oncology.

ENRIQUETA FELIP: AN INTERNATIONAL PERSPECTIVE ON WOMEN IN ACADEMIC ONCOLOGY

Academic medicine is a process of continuous learning that has to serve three outstanding tasks: teaching, research, and patient care.⁴ The field of oncology offers opportunities for tremendous career satisfaction. Academic medicine in oncology encompasses the mission of educating the future generations of medical oncologists, discovering causes of cancer and establishing appropriate treatment approaches, and advancing knowledge of cancer care while caring for patients.

Although the majority of medical graduates are now women, available data indicate that women in academic medicine are not reaching the same levels of career advancement, leadership responsibility, and financial compensation as their male counterparts. An American study analyzed whether women who graduated from medical school from 1979 through 1993 are more or less likely than their male counterparts to pursue full-time careers in academic medicine and advance to the senior ranks of medical school faculties.⁵ In this study women were shown to be more likely than men to pursue an academic career and to become faculty members. However the proportion of women who advanced to the senior ranks of academic medicine was lower than that of their male colleagues.

A number of issues may influence the low proportion of women in academic leadership positions: potential gender discrimination with differential access to career-promoting experiences, lack of serious attention to female candidates in search processes, inability to acknowledge the contribution women make, lack of effective and willing mentors, and the impact of family and domestic responsibilities. Furthermore, during their career, women have to make conscious efforts to transcend gender prejudice (incompatibility of academic demands with family commitments, replication of traditional roles in the assignments earmarked for women, constraints on career-related choices) when negotiating their terms of employment.

It is unclear whether women themselves have different career expectations and professional skills when compared with men. The results of one survey of academic medical professionals showed that the intellectual challenge of academic medicine is as important to women as it is to men, but that achieving recognition as a physician or being viewed as a leader seems to be less important to women than it is to men.⁶ Effective collaboration, networking, and being a team player are essential in academic medicine. Carr and colleagues⁷ addressed how faculty experienced collaboration in regard to gender. They interviewed 96 medical faculty members at different stages in their careers and in diverse specialties. They found that female faculty expressed enthusiasm about the potential and process of collaboration; male faculty were more likely to focus on outcomes.

In Europe, in the latter part of the 20th century, the number of women going to university rose constantly and is, at present, higher than the number of male students in many European countries. In Spain, women comprise 54.4% of

university students and 61% of students who complete their studies. Nowadays over 60% of medical school graduates in Europe are women. In Spain, in the academic course 2010–11, 69% of medical students were women. Despite the clear increase in the number of women entering the medical profession, women continue to be underrepresented in the higher levels of European academic medicine.

Currently in Spain 954 of the 1,721 (55.4%) medical oncologists who are members of the Spanish Society of Medical Oncology (SEOM, www.seom.org) are women; there are 82 medical oncologist residents, of which 57 are women (69.5%). However, only 17 of the 91 (18%) heads of medical oncology departments are women. All 17 presidents of the Spanish Society of Medical Oncology, who are elected every 2 years, have so far been men. However, this precedent may be changing, as the present president elect, Pilar Garrido, MD, PhD, is a woman, and she will be the next SEOM president as of October 2013.

At present, the European Society of Medical Oncology (ESMO, www.esmo.org) has a female President, Martine J Piccart, MD, PhD, an exceptional academic medical oncologist, who has held numerous international posts. It is worth mentioning here that the ESMO executive board is composed of 11 members, only three of whom are women (including the President). An ESMO working group, the ESMO Young Oncology Group has 15 board members and, encouragingly, nine of them are women.

The present disparity between the proportion of female medical oncologists and the proportion of women in key academic oncology positions may discourage women from pursuing academic careers, thus having a negative effect on the hope of changing the situation in the foreseeable future. It is, therefore, essential to encourage women to pursue well-planned careers with the objective of achieving medical leadership. To reach such an objective, there is a need to ensure equal opportunities for women in accessing academic appointments and attaining promotions. Essential to this is the role of the mentor, which is crucial for career development. Unfortunately, outside of the U.S., the figure of the mentor is not always formally established, and junior doctors are often without the necessary support to project their careers. Young female medical oncologists should be encouraged to seek mentors who can empathize with their specific challenges, and women in key positions in academia should be aware of their responsibility to act as mentors. Oncologic medical associations also have a prominent role to play in ensuring equal opportunities in academic medicine for men and women. Data on the gender of association members should be gathered, and women should be encouraged to be candidates for key positions in the association.

A recent European initiative, the project “gender in science” (genSET), funded by the Science in Society Programme of the European Commission’s Seventh Framework, creates a forum of sustainable dialogue between European science leaders, science stakeholder institutions, gender experts, and science strategy decision-makers to agree on the gender dimension in science in order to produce practical guidelines

for implementing gender action plans within existing institutional mechanisms. The goal is to develop practical ways in which gender knowledge and gender mainstreaming expertise can be incorporated within European science institutions to improve individual and collective capacity for action to increase women’s participation in science. genSET focuses on five key areas in which gender inequalities and biases negatively affect women’s participation in science: science knowledge-making, research process, recruitment and retention, assessment of women’s work, and science excellence value system. The group gives several recommendations, and the report can be found at www.genderinscience.org.

In summary, in recent years, the presence of women in academic oncology has been slowly but steadily increasing and, at present, there are an encouraging number of women in key positions in academic oncology. These female leaders can act, not only as mentors to young women who want to build a career in academic oncology, but also as visible role models for women oncologists. However, we have a long way to go, and more should be done to improve career prospects for young female oncologists. Key actions should include, among others, ensuring that conditions for promotion are clear and explicit, making women’s professional contributions more visible, increasing women’s awareness of salary negotiation tactics, encouraging women to apply for clinical excellence awards, and supporting women who are considering leadership in academia as a career option.

DEBRA PATT: WOMEN BUILDING BRIDGES THROUGH TEAMWORK IN COMMUNITY ONCOLOGY

A great challenge within community oncology is learning how to foster collaboration between different groups to work as a team toward shared objectives. Although the strategy of teams delivering care and working toward common goals is not unique to community oncology, the ability to align interests and work in collaboration is of heightened importance. Community oncologists must work with the resources they have, as there is often an absence of larger institutions that can support their strategic initiatives to improve the quality of care and patient experience. Improvements are achieved on common ground shared between hospitals, practices, community support organizations, support services, political leaders, religious organizations, family, and friends. In this way the ability to build bridges and foster collaboration has greater direct impact on the ability to provide care to the community and the patients who live within it. As a woman and a mother, this idea of collaborative synergies has been instrumental to my personal and professional growth.

Building Teams

I manage my life by building bridges and teams to serve my various communities. Like most of my female colleagues, I lead or serve on many different teams: patient care teams, research teams, program development teams, policy teams, community teams, and, most importantly, my home team,

which I codirect to manage the development of three very charming social experiments: ages 10, 7, and 4 years old. The function of these teams working toward our strategic objectives lies in management within each team and integration between them.

Managing Teams

The successful management of these teams depends on group motivation, investment, and coordination. Motivation for shared vision is best achieved when a leader appeals to the personal, social, or structural motivations of the team so the team's goals are held internally by each team member. In medicine, many practitioners share common motivations that draw them to the path of patient care: the need to serve and improve the lives of others, integrity, and views on justice are commonalities among health care providers. Understanding and appealing to these motivations of team members will help them internalize the team's strategic goals with an innate drive toward a common purpose.

Personal investment develops and nurtures strong teams. Leaders invest in the professional development of their team members. This involves both mentorship and opportunity, and even the opportunity to fail. By building bridges with others and strengthening each pier and beam, the collaborative effort is stronger and more enduring.

Fostering Team Dynamics

In my novice oncology career path I am both a mentor and mentee, and I have benefited and continue to benefit greatly from exposure to strong leaders who continue to shape the way I interact with the world around me. Based on my experience in leading and participating in team development there are behaviors that foster beneficial team dynamics: set expectations for and meet expectations of others, be candid (with praise and, particularly, with criticism), listen and foster environments that allow open communication of ideas, learn from others, and encourage diversity and independence, as they breed innovation.

Why Teambuilding Is Important for Women

Experience, too, is a great mentor. Unlike my mother before me, I was reared in a household in which I was taught that my opportunities were endless. We have seen the proverbial glass ceiling rise, crack, and often break in this era of professional development, offering women unprecedented opportunities in medicine. What I learned only after the birth of my first child is that endless opportunity still exists in a system of limited resources, and that my most scarce resource is time. We do not have the ability to do everything on our own. What I learned with my second child is that we should not try to do everything on our own, and with my third (through experience and exhaustion), I learned that although our independent resources are limited, our collective team resources are rich. Reaching across and grabbing the hands of my partners is the only way to continue to move forward—in collaboration. My ability to manage my competing opportunities and priorities is only realized by managing time well,

building teams with common goals, and integrating teams that can act together in synergy.

Team Integration

In addition to healthy team management, as a woman with a family, my teams must be integrated. My professional partners are often guests in my home and understand that my family is the cornerstone of balance in my life. My children, by design, come to my office and do their homework about twice a month. They see (from a short distance) that I care for people who are sick. They understand well what I do when I am away from them and why I value it so highly. Their presence and integration in my professional life gives them insight and understanding that when I cannot be there with them it is only because I am giving a service to others that is also really important. My informatics and clinical content teams within my network are removed from direct patient care but have traveled to my office, in which they can see systems of patient care delivery in action. As opposed to being value-neutral, this integrative function actually strengthens each team. Resulting from this, these teams have developed clinical insight that fosters understanding of what they do from different perspectives and share in the motivation to improve patient care as they develop tangible insight toward that common goal. Similarly, bridging between local support organizations and our local hospitals for cancer resources improves the value of each organization and clearly improves care delivery within the community. Usually with integration of these disparate parts, synergies arise that add value to each independent system and tremendous value to the collective effort.

Defining Balance and Presence

I have the great pleasure of learning from and having close friendships with many strong women who are bright, leading in their communities, and share the need to strike balance between their work and family. It has been my experience that successful balance has a different structure for each woman and tends to evolve over time as their teams grow and mature. I also believe that our ability to balance is in part our personal choice, and in part our capabilities that are largely defined by the ability to rely on others. In comparison to my friends and colleagues, I have always had an easier time with balance because my husband (also a physician) is an equal partner in parenting our children. Although our home is far from perfection, I am certain that my family always knows they are loved and cared for.

In addition to learning balance, it is vital to be 100% present in each moment. Let teams know that when they are given attention it is enthusiastic, complete, and without distraction. This will make the time that can be given to each team exponentially more valuable.

I think understanding this balance of competing priorities makes women natural collaborators, and each community can benefit from women's contributions to leadership within them.

Ultimately, each person can make a difference as an individual, but greater change will occur only when dissimilar

stakeholders come together to collaborate, compromise, and form strategic synergies that innovate cancer care for the global community. Facilitating meaningful change within collective communities requires leaders to stand at the intersection between sometimes disparate stakeholders (pharmaceutical companies, payers, physicians, policy makers, large corporate partners, academia, private practice, professional organizations, etc.) and build bridges to conquer cancer.

KATHERINE REEDER-HAYES: BUILDING MENTORING BRIDGES FOR WOMEN IN ONCOLOGY

Not infrequently, I look around my workplace and wonder what I did to accumulate such talented mentors. Luck is part of the equation, certainly, but assembling an all-star mentoring team also requires thoughtful and diligent work on the part of the mentee. Persistence and self-advocacy in reaching out to mentors will almost certainly yield a large professional and personal payoff down the road, and there is widespread agreement that such a payoff is particularly critical for advancement among women in early career stages. There are a number of “mentor myths” and conversely “mentor truths” that should be identified when searching for good mentorship.

Mentor Myths

Your mentor should be the most approachable person in your department. During my internal medicine residency I sent an email to the oncology faculty seeking a project for a month-long research elective. Only one faculty member responded, and she was not the woman I wanted to hear from. This senior researcher was only slightly known to me from the clinical wards, and she was intimidating. It only took a brief encounter for one to realize that she was formidably intelligent, had an impressive fund of knowledge, and set high standards for everyone on the team from the medical students up. My knees were quaking a bit as I said “yes” to her invitation, but I could not have made a better decision. Those same qualities that made her intimidating on first meeting have served me well over a long mentoring relationship: high expectations, an acquaintance with a wide variety of research methods, and the ability to give direct and constructive feedback. Overcoming natural hesitation to collaborate with an accomplished mentor can make their strengths your own.

Your mentor should be the twin of your future self. We naturally seek out as mentors those whose example we would like to follow, and often this strategy is appropriate. However, particularly in the current environment of multidisciplinary and translational research, many people outside of one’s own immediate field of research interest can be excellent mentors, provided that there is at least some overlap between interests. In fact, working with a mentor whose interests only partially overlap with one’s own can foster the chance to become the “expert” in a particular area rather than being constantly in the mentor’s shadow. As my career has developed from resident to fellow to early-career health services researcher, I

have received wonderful career guidance from lab scientists, social scientists, health policy researchers, and physician researchers in other clinical specialties.

Mentorship should be a monogamous, longtime partnership.

What is true of marriage may not be true for mentorship. Over time, an oncologist’s career path is likely to change significantly as a result of shifts in research interests, the need to learn new methods, or a move from one institution to another. A mentor who is well-positioned to give guidance at one stage may not have the right expertise, time, or proximity to play a central role later on. Mentoring relationships tend to follow a natural progression of the “getting-to-know-you” phase, a period of maximal productivity, and then an “emeritus” stage, in which the relationship is hopefully still cordial and collaborative, but requires much less time and commitment by both parties. It is helpful to recognize these stages and seek new mentors as one’s needs evolve.

Mentorship is the responsibility of the mentor. Nothing kills a mentoring relationship like a passive mentee. Mentors in academia are usually busy mid- or late-career investigators who may be pulled in many directions even if they are truly dedicated to the person they are mentoring. Thus, time with a mentor will be dramatically more productive if the mentee has a defined idea of what he or she needs from the mentor at each encounter. I highly recommend regular, structured meetings with key mentors that show respect for the mentor’s other time commitments and give the mentee the access that is needed to receive thoughtful feedback. Individuals with a true passion for mentoring are energized by someone who appears in their office with specific needs, questions, and plans around which to center feedback. Some of my mentor meetings are as simple as a stroll down the hall, but even for these casual meetings I try to have a simple “agenda” with a list of topics for us to talk about. Of course, we often wander off-topic, but the agenda reflects what I most want feedback about and helps me clarify how I am progressing.

The best mentor for a woman is a woman. I strongly believe in the importance of senior female role models for women in academic medicine, particularly with respect to issues of creative career structuring during childbearing, if desired, and balancing traditionally female family roles such as caregiving for elderly parents. I have personally benefitted from the examples of such role models. However, wisdom regarding work-life balance and other important issues facing female junior faculty is not exclusive to women. Many important “ah-ha moments” in pacing my career and prioritizing commitments have been delivered by male mentors. In particular, I have found that male mentors have encouraged me to say “no” to inappropriate commitments and deliver critical feedback in a direct but professional way. These two interpersonal aspects of professional life are uncomfortable for many female junior faculty, and good examples can come from mentors of both genders.

Mentoring Truths

Choose the mentor who has the time and career capital to invest in you. The most important characteristic of a mentor may be altruism—the willingness to give of her own resources, whether it be time, expertise, lab space, or funding, to advance your career development. You should feel sure that your mentor is secure enough in her own career trajectory to be able to donate these resources. It is both unfair and unproductive to ask for mentorship from a colleague who is not sufficiently senior or well-supported to be altruistic toward you. There are many ways to repay your mentor's investment in you, but ultimately mentoring is somewhat of a “pay-it-forward” enterprise.

Choose the mentor who has the skills you would like to develop. Although you do not want to be the professional clone of your mentor, it is particularly important for women in oncology to identify mentors, whether male or female, who exemplify the workplace and personal values they would like to emulate. Does a senior colleague seem to have a talent for leadership? Does she share your priorities regarding work and personal commitments? Does she demonstrate assertiveness in faculty meetings or possess unusual ability in public speaking? Mentors can teach these skills in addition to research or clinical skills, and the best mentoring relationships model these vital competencies in both professional and personal life. My mentors' willingness to open their homes and personal lives, allowing me a peek at their children, pets, cooking skills (or lack thereof) and more, have been invaluable in helping me define the professional woman I want to be.

Choose the mentor who helps you “guard the plate”. Of all the skills a mentor can teach, this may be my favorite. The “plates” of female junior faculty, whose professional trajectories often compete for limited resources with intimate partner relationships, childbearing, and rearing young children, can seem to be constantly overflowing, yet saying “no”

is difficult. I am eternally grateful to mentors who encourage me to ask the following questions: (1) How will I benefit from saying “yes” to this activity?; and (2) What will I have to give up to meet this commitment? These questions have stopped many a promising addition to my to-do list by reminding me of a poor fit with my overall desired career direction, short term, or long-term priorities. If the answers clearly reflect that the activity is not a good addition to one's plate, a good mentor will also be there to back their mentee up if the “no” or “not yet” must be delivered to someone with seniority or other influence in the workplace.

Choose the mentor who supports you as a whole person. Over the course of my career from medical student to faculty member, I have also given birth to four children. That means 36 months of prenatal appointments, four maternity leaves, 48 months of “breastfeeding brain,” and all the rest. My mentors truly deserve some sort of award for navigating these stages with me! They struck the perfect balance between avoiding false assumptions (“she has a baby, so she will not take on any new projects this year”) and reminding me to develop my professional path at my own pace and in a sustainable fashion. By giving me both the space to say “no” and the opportunity to say “yes,” they enabled me to find my own formula for mixing my personal and professional obligations. This is a difficult balance in mentorship, as in life, and it is an immensely valuable asset in a mentor.

Conclusion

The mentor-mentee relationship can be an immensely satisfying brand of collaboration for both parties. Women bring special competencies to the table on both sides of the mentoring equation through their skills in team building, integrating input from diverse sources, and building social networks. A successful mentoring relationship is key to career development for women in oncology, so begin building those mentoring bridges today.

Disclosures of Potential Conflicts of Interest

Relationships are considered self-held and compensated unless otherwise noted. Relationships marked “L” indicate leadership positions. Relationships marked “I” are those held by an immediate family member; those marked “B” are held by the author and an immediate family member. Relationships marked “U” are uncompensated.

Employment or Leadership Position: None. **Consultant or Advisory Role:** None. **Stock Ownership:** None. **Honoraria:** None. **Research Funding:** None. **Expert Testimony:** None. **Other Remuneration:** Elizabeth M. Jaffee, Aduro Biotech; BiSante.

References

1. Key Trends in Tracking Supply of and Demand for Oncologists. A report to the American Society of Clinical Oncology (ASCO) from the AAMC Center for Workforce Studies (Association of American Medical Colleges, Washington, DC), 2012. Available at http://www.asco.org/sites/default/files/workforce_information_system_12.17.12.pdf. Accessed March 22, 2013.
2. Martinez ED, Botos J, Dohoney KM, et al. Falling off the Academic Bandwagon. *EMBO reports* vol. 2007;8(11):977-981.
3. Francis, Lanie. A Post-Modern View of Women in Hematology: A Focus on Work/Life Balance. American Society of Hematology. <http://www.hematology.org/Publications/Hematologist/2012/8566.aspx>. Accessed 2012.

4. Kanter SL. What is academic medicine?. *Academic Medicine*. 2008;83:205-206.
5. Nonnemaker L. Women physicians in academic medicine. *N Engl J Med*. 2000;342:399-405.
6. Brown AJ, Swinyard W, Ogle J. Women in academic medicine: A report of focus groups and questionnaires with conjoint analysis. *Journal of Women's Health*. 2003;12:999-1008.
7. Carr PL, Pololi L, Knight S, et al. Collaboration in Academic Medicine: Reflections on Gender and Advancement. *Acad Med*. 2009;84:1447-1453.