quality of care but do not substantially reduce costs among a broad array of patients. As more empirical evidence comes in, it may become easier to identify specific ways to reduce costs; for now, the possibility and scope of the savings remain unclear.

One approach that might improve the cost-effectiveness of disease-management and care-coordination strategies involves more accurately targeting these efforts toward the patients who would benefit the most. Indeed, the concept of better targeting is inherent in all the options considered here, from enhanced research on treatments to the designing of financial incentives. As medicine moves toward increasingly targeted therapies, the options for shifting insurance designs in the same direction merit consideration as policymakers grapple with the serious financial challenges faced by our public and private health insurance programs.

**An interview with Dr. Orszag can be heard at www.nejm.org.**

Dr. Orszag is the director of the Congressional Budget Office (CBO), where Dr. Ellis is a senior analyst. CBO is a nonpartisan agency that provides budgetary and economic analyses to Congress.


Climbing through Medicine’s Glass Ceiling

Nancy C. Andrews, M.D., Ph.D.

Earlier this year, I was named the first female dean of the Duke University School of Medicine, an event that National Public Radio summed up in the headline: “Andrews Makes History at Duke Med School.” Why should the appointment of a woman dean still be big news in 2007? Perhaps because, with a few localized exceptions, there has been little change since the 1970s in the barriers to women’s full participation in academic medicine.

I happen to believe strongly that diversifying all levels of academic medicine is not only politically correct, it is also the way to make our institutions better. The history of Harvard University, for example, where I spent many years before moving to Duke, is one of gradually increasing diversity, which I see as a necessary ingredient of an outstanding institution. When the university was young, 300 or so years ago, its faculty and students were Puritan men from good local families. Over the centuries, the Harvard community gradually became diversified in terms of geographic origin, religion, socioeconomic background, sex, race, nationality, and other personal characteristics. It has always seemed to me that it was only by choosing to recruit the individual scholars whom it viewed as the best, regardless of such characteristics, rather than limiting itself to a narrow circle of candidates, that Harvard was able to build a world-class faculty and student body worthy of the reputation it now enjoys. After all, brilliance and ability are not restricted to certain groups, so it seems logical that if they draw from the widest possible talent pool, the very best institutions will naturally have diversity at all levels.

And yet most do not, despite efforts to begin with a diverse population of students. Given that the proportions of men and women in medical school classes have been similar for some time, it seems puzzling that there are not more women in leadership positions in academic medicine. I suspect that some of the reasons for this disparity are the same as those that apply at the entry level for physician-scientists — concerns about balancing work and family, perceptions that women need to be better than men at their professions in order to be considered equal, and a dearth of female role models. But I also believe that if we are to have more female deans, we must be able to envisage female deans.

There was a riddle that was
To accelerate the emergence of female deans, institutions will need to consider women who have not stepped on every rung of the traditional academic career ladder.

Part of the answer for universities aiming to pursue such benefits is to work harder to identify and recognize women who are leaders. The Rosalind Franklin Society (of which I am a founding member) was recently created to draw attention to leading female scientists, on the premise that “there still exists a prevailing perception that women do not have the same talents and abilities as their male colleagues and that the contributions of women scientists are not as important.”

The goal of the group, made up of prominent scientists of both sexes, is to ensure that outstanding women are recognized in ways that its namesake, Rosalind Franklin, was not.

It is also important not to make assumptions about what women will and will not do. After my appointment at Duke was announced, many people told me that they’d assumed I would not be willing to move out of Boston — that I would not leave Harvard, that I would not move my children before they finished high school, that I would not uproot my husband. Obviously, all those assumptions were incorrect. My own choices notwithstanding, however, the “two-body problem” — finding a position for a new appointee’s spouse — remains a major obstacle to the recruitment of women in particular and of academic leaders in general. Though Duke found a creative solution in my case, many academic institutions do not do as well on this front.

Some of our counterparts in the corporate world may do better, for they are beginning to recognize that women are an under-valued resource. The teaser for a recent Boston Globe article began: “Hungry for talent, big companies have started to pursue women who have dropped out of the workforce. How this could redefine the whole notion of a career.”

The article described a partnership between a large financial institution and a prominent business school designed to recruit gifted women who had taken time off for motherhood. It argued that women (in this case, mothers) are an important, untapped pool of talent. At the moment, it appears that corporate pursuit of profits may be more powerful than academic initiatives in leveling the playing field for women.

As I look to the future, I wonder what my 15-year-old daughter thinks about all the publicity surrounding my new deanship. Until recently, she had been telling peo-
Becoming a Doctor, Starting a Family — Leaves of Absence from Graduate Medical Education

Reshma Jaggi, M.D., Nancy J. Tarbell, M.D., and Debra F. Weinstein, M.D.

Two decades ago, researchers studying pregnancy among women who were training at Harvard teaching hospitals concluded that, though pregnancy and childbearing were “a natural and expected part of all our lives,” most Harvard-affiliated institutions “were unprepared for pregnancies among members of the house staff” — as evidenced by the fact that four fifths of the training programs had no maternity-leave policy. Family-leave policies have since been developed at both institutional and national levels. Most teaching hospitals now provide explicit parental leave (often with pay), and the federal government and member boards of the American Board of Medical Specialties (ABMS) have developed relevant regulations (see the Supplementary Appendix, available with the full text of this article at www.nejm.org). Nevertheless, the issues surrounding parenting during training continue to challenge educators and policymakers, as well as residents and fellows. The personal and educational needs of trainees with children often collide with their colleagues’ expectations, their hospitals’ workforce needs, and the requirements of the ABMS and the Accreditation Council for Graduate Medical Education (ACGME).

With women now accounting for half of all medical students (see graph), and with training in many specialties now extending well into the fourth decade of life, the problems have become more pressing. A study of matriculants at Yale University School of Medicine showed that before