"Times are changing. The public expects communication with the physician."

A 1972 volume on prominent women doctors cites Mary Ellen Avery, "for her pioneer work in pulmonary diseases," as one of the medical luminaries "likely to emerge from the waiting room of history."

The prophecy is fulfilled. Three years ago Dr. Avery became the first woman to chair a major department at Harvard Medical School, where she is Thomas Morgan Rotch Professor of Pediatrics, and the first woman to be named physician-in-chief of Boston's Children's Hospital Medical Center.

Dr. Avery and her colleagues dramatically advanced the understanding of respiratory distress syndrome in the newborn while she was a research fellow at Harvard from 1957 to 1959, working with physiology professor Dr. Jeremiah Mead. Their discovery of the key factor in hyaline membrane disease carried her to the summit of world renown in neonatology.

Mary Ellen Avery was born in Camden, New Jersey, in 1927. She did her undergraduate work at Wheaton College and in 1952 received her M.D. degree from Johns Hopkins, where she served her internship and a three-year residency in pediatrics. After the research period at Harvard, she returned to Hopkins, becoming associate professor of pediatrics in 1964. Five years later she was appointed head of the pediatrics department at McGill University and physician-in-chief of Montreal Children's Hospital. In 1974 she moved to Boston.

A milestone for Dr. Avery was the establishment in Boston that year of the Joint Program in Neonatology, directed by Dr. H. William Taeusch Jr., an Avery recruit from Montreal. This seminal project, in which she was a prime mover, combines resources of Children's Hospital Medical Center with those of Beth Israel Hospital and the Boston Hospital for Women, Lying-in Division.

A fellow of the American Academy of Arts and Sciences, and a recipient of five honorary degrees and awards from Mead Johnson, the United Cerebral Palsy Association, and others, Dr. Avery has held twenty named lectureships and written or been co-author of more than a hundred scientific publications. She has served as president of the Society for Pediatric Research and on the World Health Organization's Technical Advisory Committee. She is frequently called to Washington to make her informed contribution to H.E.W. policy, one of numerous areas of social concern in which she is involved.

Asked about being a woman in a profession historically dominated by men, Dr. Avery replies, "It's not the major issue in my life, but I wouldn't be so naïve as to say it's a non-issue." There have been occasions when she's observed that a man has experienced less difficulty than his female counterpart in swinging decisions.

She seeks respite from her grueling schedule in fishing, golfing, and cross-country skiing. Occasionally she flies to the Arctic Circle to visit Eskimo friends for whom she provided health care as part of her work while at McGill.

In what she calls the "balancing act" of her diverse roles as administrator, teacher, clinician, researcher, and citizen—with their high degree of overlap—Mary Ellen Avery is a blend of zeal and wit. In one of the world's most respected hospitals, she is a leading figure—and something of a maverick.

— GEORGIA LITWACK

If you were to be remembered for one aspect of your work, what would it be?

There was one overriding discovery—the cause of hyaline membrane disease. That insight has been *the* single scientific contribution of mine which will live on. There were many, many other clarifications of the problem—variations and modifications—that extended the story. But there was one moment of insight. And that was it.

A "Eureka!" experience.

Yes. Everything else has been derivative.

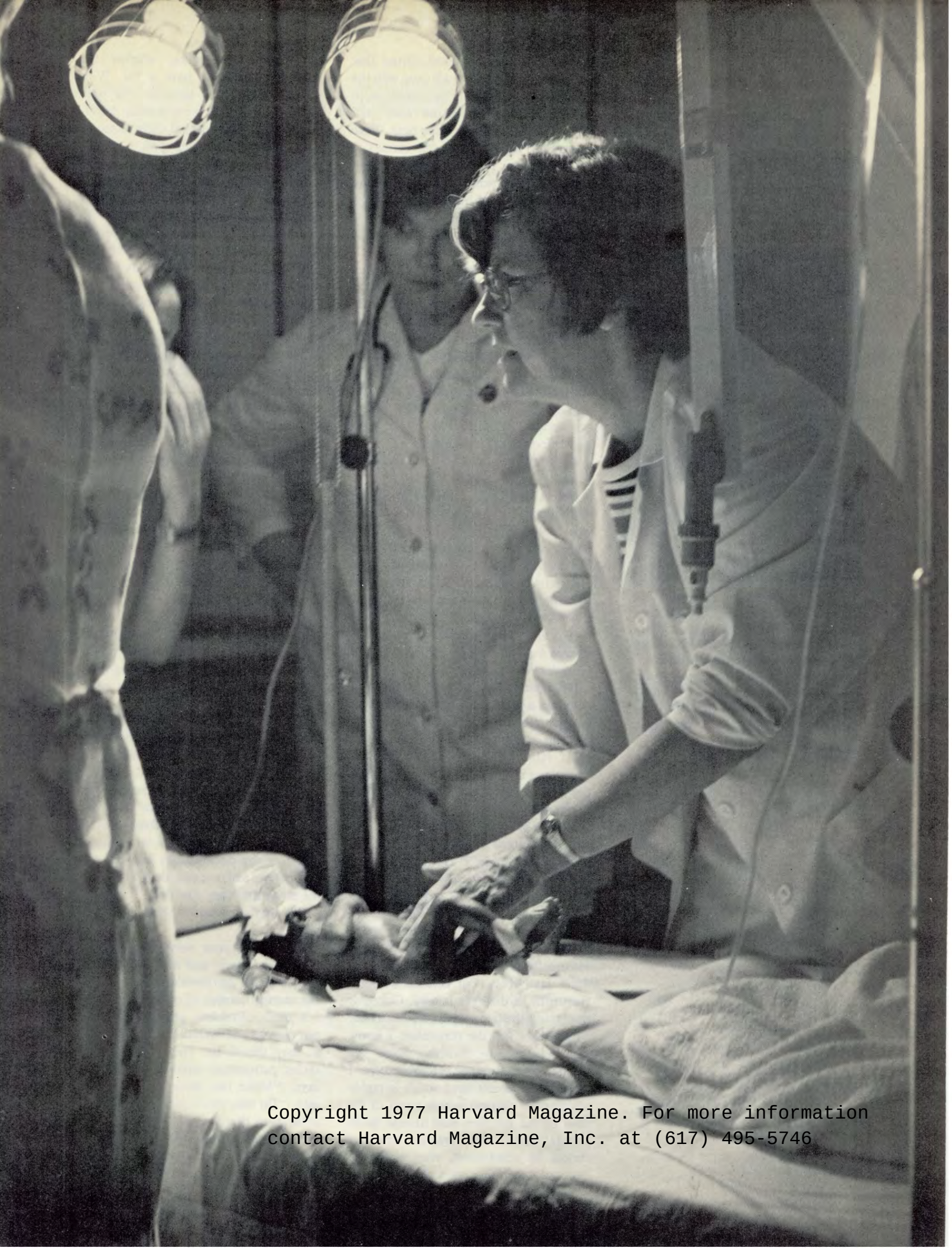
Your work obviously provides countless gratifications.

Medicine is so absorbing and has so many different facets. Sometimes I have to force myself to take time off, and I don't always enjoy it when I do, because I'd rather be back doing some of the things that are medically related.

There must be frustrations, too. How do you deal with them?

I'll answer that with an illustration. Recently I was attending in a situation where I was most uncomfortable. I was working mostly with older children and I'm more at ease with younger ones. Some of them really were adults, with whom I'm not at all at ease as a physician! Moreover, I was expected to exam-

Georgia Litwack, who interviewed Dr. Avery and took the photographs on these pages, is at work on a book of photo-biographical studies of women in various branches of the arts and sciences.



"I'll make a prediction. A third of Harvard Medical School students are now women. They'll have career patterns that are different. The system will be forced to bend. Medicine will become more of a forty-hour week—for men as well as women. And the men will like it." At left is Dr. Myriam Puig, a research fellow from Venezuela.

ine every patient admitted during that particular month and touch base with the parents and summarize each situation in writing. And teach house staff and medical students at the same time. Time constraints forced me to cut corners. I get tense when I have to cut corners—that's the perfectionist in me. The house staff was very good but I felt I was delegating rather too much, and I don't like to be in a position of not assuming my full responsibility.

What do you do when you feel all that discomfort?

I blew my stack once or twice, probably inappropriately. I had a little trouble getting to sleep a few nights. And when I feel that happening, I usually try to back away. I may sign out to somebody for a weekend and turn over the responsibility to someone else. That's one escape. Another, with me, is writing. I find release in writing.

Do you write about what's troubling you?

No. About other things. I'm always writing one book or another. If I can go write about cysts in the lung, get thoroughly absorbed and leave everything else behind, then I can meet my own expectations of excellence. I then have something that's my own, where I know I've done it just right.

An interesting solution. Sounds as though you turn more inward than out in such circumstances.

Not always. I do a lot of socializing, I entertain a great deal. In a case like that I sometimes turn on a dinner party or pick up a few people and go out for a good talk. Life can become simpler, sometimes even funny, after a good dinner and some good friends to share things with.

In each of your professional roles, can you step outside yourself and try to describe your "style"? How about your administrative function?

Here's an example of how I direct the department of pediatrics. We have sixteen divisions, each of which has a chief. We meet in my office almost every week. Informally. We don't keep minutes, we don't take votes. But because we meet frequently, a dialogue is easy. Concerns that affect the department are discussed. And then I feel the consensus. I know which issues are divisive, which are boring, which produce real excitement. I sense it. A current issue which is highly emotionally charged is how much of the time of the full-time staff should be in private, versus public, practice, how they should be reimbursed, who sends the bill, and, when they see a private patient in their hospital office, whether the hospital too should have a fee. With third-party payment agencies—the state and others—asking for a sharper definition of where the hospital dollar is spent, we've got to formulate policy in this regard.

I see this as potentially divisive. It can't just be tossed out over a lunch meeting. Obviously I'll now move to an "ad-hocracy," identify a few people who are centrally concerned with the problem, and ask them to study it with the administration and then make recommendations. I work up to these things, trying never to take anybody by surprise. I try to make sure that any action that's going to affect somebody be discussed openly with them and all the people to be affected *before* the action occurs. I think it's my job to try to anticipate all the waves that will be produced by any action, and forestall there being opposition mounted because of hurt pride.

You exercise a kind of deliberation laced with informality.

Yes. And then I can always punt, because of course I have some bosses. I can always take an issue higher up, and then I can say, "The administration says" or "The dean says" we must.

This whole issue of payment to physicians, in the instance you've just cited and generally—you've been heard to express some firm views on the subject.

I think doctors are overpaid. It strikes me as a little inappropriate for the healer or servant of mankind to be the biggest wage-earner of all professionals. Let me say I think there are a lot of people who are overpaid, like corporation presidents and hockey players. But I think doctors have carried this thing too far. I'm not sure that the discrepancies between one occupation and another ought to cover the range that they now do.

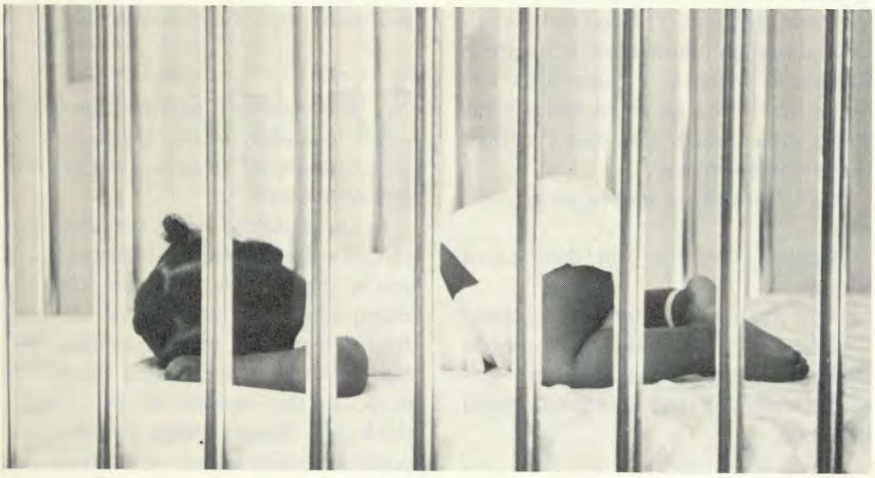
But that's a kind of social commentary.

But doesn't your work concern itself with social issues and therefore require you to make commentary? How about the soaring number of malpractice suits?

I think physicians traditionally have not been as communicative with patients as they should be. They've assumed a rather patronizing attitude. The patient says, "Make me better." The doctor says, "Do this, you'll get better." That's often been the level of communication, and the public wants more than that.

Litigation occurs because the physician never made it clear why this opera-

"A large proportion of medical teaching takes place at bedside."



tion or that course of treatment was necessary. Then there's a misadventure along the way and everybody hates everybody and sues and the price of medical care soars. It's the extraordinary cost of malpractice suits that has a lot to do with these increasing bed rates. It all gets passed on to the insurance companies and eventually to the patients.

Are today's medical students interested in greater humanization of the physician-patient relationship?

I think they perceive the need quite clearly. We have a group of students with an immense social concern, very receptive to producing an atmosphere of confidence with patients, not just looking at disease as a biologic aberration but as something that happens to real people in real life.

Was this attitude fostered during your own medical-school years?

It was there implicitly. I don't think it was always there explicitly. But every physician who's a fine clinician has this as part of his approach.

Do you perceive any difference in the way today's women medical students view themselves? Different from your generation?

Oh, this group is very different from my-age women. They're outspokenly women's-liberationists. They like to organize and change the system, just as the generation before me did. I rode, you see, on the shoulders of those early activists and was carried on the wave of thinking everything was fine. Now mind you, it wasn't fine, because I knew full well that when I was an assistant professor of pediatrics, I was getting paid at a rate significantly lower than someone exactly my age and level of training and responsibility who happened to be male.

But it never occurred to me to do anything about it. If I had stood up in 1960 and made a big issue about women never being made full professors, when I was then an instructor, I have a feeling I would have been pushed aside as a troublemaker.

Is there salary parity now?

Oh yes. But there's a factor I haven't heard anybody mention, although I'm convinced it's important. I think the major influence of more women in medicine is that the women probably will settle for generally lower incomes for physicians. In many instances family responsibilities will prompt them to be partly rather than totally committed, and this will become more acceptable socially, and I don't think women will demand, as the men do, that there continue to be the same over-all salary structure. Another question: When a third of all doctors are women, will this make medicine a less attractive profession for men?

Well, if you introduce the element of competitiveness, conceivably it could. How do you feel?

I don't know the answer to that one, but I think it's an intriguing question.

What has happened in other countries? Russia, for instance.

Medicine has a lower status and lower pay in Russia. I'm told the Russian woman doctor is more the equivalent of the public-health nurse.

Getting back to what I've called your style... how does it shape your teaching?

I'll use another illustration here. Pediatrics has been labeled a primary-care specialty by the government in its current health-manpower legislation. It's been decreed that medical schools have at least fifty percent of their residencies

"I've been fortunate—in having acquired genes that made science pleasant and easy for me, in being born into a setting where I could be really free, with no limitations on what I could study, what I could do, and in picking the people I worked for very carefully. I guess I can sniff quality from a distance."

and internships in primary-care specialties. That's internal medicine, family practice, and pediatrics. So *we're* asking, What do we want our residents to know? How to set fractures? Examine eyes? Be pretty good dermatologists? How can we insure they know these things? How do we satisfy what we read now as a mandate to promise that anyone who spends two years with us will be a competent generalist pediatrician, who may or may not elect to go on to subspecialties?

Then the formation of curriculum is an essential part of your teaching role?

Yes. Congressmen are not likely to tell us exactly how to proceed. It could be that a committee of experts would, of which one of us doubtless would be a member. And it's highly probable that academic pediatricians would have a major input into this nationally. I have to do my homework on this. Do we introduce block-time assignments? Do we inaugurate a system of electives? Do we have a test? Do we have a check list of objectives? This is functioning as an educator.

And also as a citizen participating in government.

When Mr. Califano calls, I go! It's obvious that a new Secretary of Health, Education, and Welfare would be consulting widely. There's a need now. Quote, serve your country in the broadest sense, unquote. This has to be a priority, although I must admit it's nothing I enjoy as much as I enjoy what I'm doing here. So I go down and say my piece, even though I'm sure I'm their token woman anyway.

Still? Haven't we moved away from that?

(Smiling) Oh, I'm still their token woman.

Were you a token woman at Hopkins?

Not at all. That's the place women medical students always have been welcomed, from the time the school opened its doors.

You decided very early, didn't you, to become a doctor?

A woman physician lived next door. She was nice enough to give me a fair amount of her time and attention. Took me into the hospital with her on occasion, talked about her patients. I became fascinated by what she was doing, and I'm sure by her, too. She was an exciting woman.

You were how old?

About twelve. I was looking around for role models and she was one.

Once you demonstrated this interest, how did your family respond?

With total support, and I expect that's very important. Both parents were perfectly willing to do whatever was needed, and they always had plenty of expectations that I could do whatever I wanted to. Seek as much education, try as many things. A free but very supportive atmosphere.

Was your mother a working woman?

She had been a schoolteacher, but stopped teaching when my older sister was born. She was not working while I was a child. She was *very* much at home, taking care of her two children. But I think in retrospect she was sorry she wasn't working. I think she looked back on the satisfactions of her working years and felt a little bored, a little lonesome. Housekeeping didn't provide the greatest satisfaction for her. In subsequent years I think she wished she'd kept teaching. That may have something to do with my chasing after a career.

How did your father feel about a daughter going into the medical profession?

He thought it was marvelous. He had his own business and had wanted me to take it over. It didn't worry him that a woman might not normally take over a business. He always assumed I could do anything I wanted to, including running a business. When I indicated I wanted a profession, that was fine with him.

Your parents' approval, then, was valuable. How important has approval been as you've proceeded further?

In the academic world you obviously run into a competitive situation, and if you're the one who gets the A on the exam, somebody pats you on the back for it. Now this isn't necessarily anything other than the luck of the genetic draw, so the capacity is there. But I think any human being acknowledges positive reinforcement. And when you pick up a few A's on a few exams, and somebody tells you that's good, you go ahead and do more of it if you can. It's my guess that's operated all through school and college and so on.

And of course you've received many honors in more recent years.

They please me, I rise to it. I don't lie awake wondering whether I'm going to win a prize or not, but if it happens, it gives me pleasure.

Although it appears you never chose to be primarily a practicing physician, you apparently do see some patients.

"Times are changing. The public expects some kind of reasonable communication with the physician and this requires the physician to learn to speak the layman's language better." Across the aisle from Dr. Avery is her predecessor, Charles A. Janeway, M.D., Children's Hospital Medical Center physician-in-chief emeritus.

How would you describe your manner in dealing with them?

I'm pretty compulsive.

Thorough?

Yes. Probably too much so. It's likely I couldn't have made a living as a modern pediatrician. And maybe I knew that all along. My style is to be the total physician, which means if it's a new patient I always spend a full hour, because it takes me that long to first know the mother and to learn a little about the mother's perception of the child, to gain a feeling that I understand the environment from which this child comes and to which this child's going, something about family interactions.

And then I like to be somewhat leisurely in my examination, because I think it is infinitely more informative than to have somebody else weigh, measure, and undress the child, and have me walk in, listen to the heart, and walk out. I can't do that. I undress them myself because I learn a lot while I'm doing it. I usually weigh the child myself because I like to use this as a desensitizing interaction between us before I get to those things which are a little more threatening. I'm pretty slow. And then I think hard about the next step, don't just automatically order things. I read all my own x-rays, in addition to having the radiologist read them. The result is I can't afford to have many patients; nobody can afford to if they work this way. Society can't afford to let me practice this way.

We've touched on your techniques as administrator, teacher, clinician. How do you operate as a researcher?

That's complicated. You start sort of solo-flying, doing your own thing at the bench, and you quickly mobilize help. You soon have a technician and a few fellows and others at the bench, so your contribution to research changes with your advancing age. Only a few years ago I was solo, then moved into being a manager of a research enterprise, with major government grants and a training program. These I had at Hopkins before I ever went to McGill.

At McGill the issue was whether I could maintain leadership in research and also head a department of pediatrics. The answer was clear: I did both. We set up a laboratory that did train people and was highly productive, and that was the trump card in my move here because I could bring along all those people! That became the Joint Program in Neonatology. I think I brought eight people with me from McGill and set up Neonatology here, people who had been in that training program in which I was engaged in perinatal medicine and research. My major input into research at present is at the idea level.

With reference to ideas, in what ways is Children's Hospital Medical Center pioneering?

In what ways! In almost every way you can name! There isn't a division of this hospital that isn't pioneering in a wide variety of things. Tumor therapy is one of our best known, through the Jimmy Fund activities. Congenital heart disease, operating on babies that nobody else in the world would touch. Treating cystic fibrosis. Prevention of hyaline membrane disease. Learning disabilities. I could name every division.

Constant movement forward. It occurs to me that society too is constantly moving, forever changing. I'm wondering if you feel that society's view of the physician is altering.

Probably you speak better for society than I do. I'd almost say, Why are you asking me that?

There's a lot of skepticism in the air today.

There are some funny signals here that are hard to read. I don't know the answer to your question but I can give you a few facts. More students than ever are trying to become doctors. The pressure on admissions to medical schools is astounding. Thirty-eight hundred applicants to Harvard Medical School for 165 places in the first-year class. If medicine is losing its prestige, why do so many bright young people want to be doctors? Question.

Secondly, I think the Congress of the United States must represent the public in some sense. The Congress is allocating more money to medical research than ever in the history of mankind—almost two billion dollars a year. And voluntary giving by the citizens of this country is at an all-time high. I view that as evidence they have confidence that we know what we're doing.

I think in their hearts, people are fully mindful that we know what we're doing because they have a lot of objective evidence. There is no polio in this country, and most adults remember when there was. The average quality of life for most people is improving tremendously—longevity and quality. Cancer is cured a good bit of the time. Little Teddy Kennedy would have died of his bone cancer ten years ago, and he's still very much alive and well, thank you.

That's modern medicine. I think people know those things. And I think their criticisms are perhaps because they want a Dr. Kildare or... who is the other one?

Welby.

Another Marcus Welby. They don't see many Marcus Welbys in this world. But if they are sick, they come to institutions like this with confidence that something intelligent is going to happen, and their chances of getting well are better than they've ever been in history. That's a matter of record. Somebody out there is feeling very positive about us. □