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Editorial

Jennifer Fever in Academic Medicine

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In 1988, Barbara Gordon wrote a book entitled *Jennifer Fever: Older Men/Younger Women*.[1] Jennifer was the most popular girl's name at that time, and Gordon used it to represent younger women who attract the attention of older men. This attention, she noted, typically comes at the expense of a loss of interest in women of their own age whom Gordon refers to as "Janets," a popular female name from a previous generation. Janet was often the middle-aged spouse who had worked hard for years to earn status and equity. We have been struck by how often this phenomenon occurs in academic medicine.

Frequent examples of Jennifer fever occur in words and actions among middle-aged or older men in academic medicine, whom we call "Daves." For example, at a reception not long ago, one Dave, a senior administrator, said to one of us, "You won't have anything to worry about in terms of women in medicine; you should see the caliber of the women medical students who are entering medical school now." Similarly, in a local newspaper article on why the school was unable to keep senior women physicians on its faculty, a senior Dave's response to this query was that the young women in medical school would solve the problem. These statements are emblematic of the persistent disregard for women who have been entering medical school in large numbers since the early 1980s[2] and the inattention to senior women physicians who are currently members of the Daves's own faculty. We have observed that the experience and talent of senior women in academic medicine remain underused, and these Janets are often passed over for leadership positions when they arise in favor of frequently lesser qualified Daves.

We notice, with considerable regularity, that when the issue of the need for more women in academic medicine is brought up, the Daves generally begin to talk about students, residents, fellows, or very junior faculty. They are frequently quite supportive of women at these early career stages. These junior women physicians are pleased with the attention, as Barbara Gordon noted that Jennifers are pleased with the attention of older men. We have observed, however, that when women advance to more senior levels—Janets, if you will—where they have competence, experience, opinions they may wish to voice, and a legitimate claim over institutional resources, they are abandoned. This abandonment comes in the form of being passed over for promotional opportunities, relegated to such positions as being in charge of women's issues, or assigned organizational tasks in response to mandates from higher lev-

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els of administration (e.g., devising mentoring plans, sitting on child care task forces).[3] We have both had young women faculty members inform us that gender issues were a thing of the past in academic medicine. These same women have come to us in frustration years later when they were hit by the bias against Janets for the first time.

How do these bright, competent, hard-working women once viewed as promising stars by senior men then become marginalized? We have witnessed a pattern of what we call "mythologizing and justified distancing." If a Janet in any way threatens a Dave—requesting space for research, seeking a leadership position that would put her in charge of a Dave, making a scientific discovery that challenges a Dave's existing work—we note that the Janet begins to be described by one or more Daves as someone who is "difficult to work with," "hard to get along with," or "not a team player." Sometimes, more derogatory gendered descriptors, such as strident or bitchy, are used. Once this myth gains traction, it is used to justify distancing the Janet from those things she would need to succeed. She may be left off key decision-making committees, closed out of communication loops where important information is shared, and denied access to essential resources needed to sustain or advance her academic career. This behavior toward the Janet can of course be justified because of belief in the myth that "she is difficult to work with." Sometimes, the myth actually does becomes reality because the Janet in academic medicine begins to feel betrayed by those she assumed were supporters or colleagues and becomes frustrated or angry, further justifying the exclusionary behavior of the Daves toward her. These scenarios are familiar outside the professional realm, where the middle-aged wife is portrayed as nagging, unreasonable, and unexciting in order to provide some legitimacy for replacing her with a novice Jennifer who is impressed by Dave's stature and who is grateful simply for acknowledgment.

It is noteworthy that all NIH training grants must report their success in recruiting women and underrepresented minority scientists at the level of Jennifers, yet there is no such accountability for institutions in terms of advancing women and underrepresented minorities into senior leadership positions. The new Clinical and Translational Sciences Award (CTSA) from the NIH is a stark example of how individual academic medical centers and the major public research-funding agency can successfully collude to exclude Janets from participating in leadership.[4] These large awards have been made to 12 male principal investigators. The NIH mandates that the CTSA subsume some funded, peer-reviewed programs led by women and that their budgets be redistributed into the hands of the single powerful Daves who lead the CTSAs. An important part of the CTSA is, of course, recruiting young Jennifers into training grants.

Academic medicine exists in a broader culture where women have historically occupied low status positions. Women at early stages in their medical careers also occupy low status positions in the hierarchy of academic medicine. The power dynamic between senior male faculty and younger women imitates the gender roles occupied by men and women throughout most of history and still to a large extent in U.S. society. When the first wave of women physicians to be eligible for senior leadership positions found them to be unobtainable, they did what women so often do—they blamed themselves. This spawned multiple programs dedicated to "fixing the women." We saw the growth of conferences on mentoring, negotiation, effective communication, and the like. This resulted in even better prepared women physicians passed over for leadership positions.

Studies document multiple barriers to women's success in leadership in academic medicine. Among them are feelings of isolation, lack of role models, lack of formal and informal mentorship, an environment perceived as denigrating to women, frank gender discrimination, a lack of institutional support for family issues that continue to fall predominantly on women, and traditional models of pedagogy that negatively impact women's self-efficacy to lead a research program.[5,6] We suggest one additional barrier: Jennifer fever.

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