Ruth Adewuya, MD (host):

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I am your host, Dr. Ruth Adewuya. This episode is part of our Women in Medicine miniseries, and today I'm chatting with Dr. Michele Barry. Dr. Barry is the Drs. Ben & A. Jess Shenson professor of medicine and tropical diseases at Stanford University. She's the director of the Center for Innovation and Global Health and senior associate dean for global health. A leading voice for advancing women's leadership in medicine and global health. Dr. Barry founded the Gates funded international nonprofit Women Lift Health. She's also an elected member of the National Academy of Medicine, Council on Foreign Relations, the American Academy of Arts and Sciences, chair emerita of the Board of Directors for the Consortium of Universities for Global Health, and a past president of the American Society of Tropical Medicine and Hygiene.

She has most recently written on the exclusion of women climate scientists from COP meetings and leadership roles, and also published in the areas of climate's impact on mega cities, tropical diseases, human and planetary health, as well as global and refugee health. Thanks so much for chatting with me today.

Michele Barry, MD (guest speaker):

A pleasure to be with you, Ruth.

Ruth Adewuya, MD (host):

I am really excited to chat with you as part of our Women in Medicine series. What ignited your passion for a career in medicine and how have your motivations evolved throughout your professional journey?

Michele Barry, MD (guest speaker):

Oddly enough, I started out dancing with the Metropolitan Ballet Company, but I very much got caught up in the Vietnam War, particularly the protests, and I felt like I needed a skillset to help refugees in underserved populations. I had a real desire to get through college and medical school quickly to get the skillset I needed. I actually dropped out of college to go to med school and then I left med school to work on a Native American reservation with underserved indigent population.

I then spent the next 25 or so years at Yale, where I founded a refugee clinic and a homeless outreach fan. You asked me about how my motivations evolved. They really haven't changed. Many of the priorities in global health have shifted from tropical diseases to climate, to even women leadership, but honestly the moral imperative for me has always been centered on underserved populations and the political issues of the day.

Ruth Adewuya, MD (host):

Thank you so much for sharing that. I didn't know you started in ballet.

Michele Barry, MD (guest speaker):

That was my desire, to become a ballet dancer, yeah.

Ruth Adewuya, MD (host):

And so different, but also the other thing that I heard from you is how even though the application might look different, you've stayed true to serving underserved populations. Your work has spanned various

areas, from climate's impact and mega cities to tropical diseases. How do you see these interconnected issues shaping the landscape of global health and what connections do you find most compelling?

Michele Barry, MD (guest speaker):

My work's always centered on vulnerable populations, but there's a very close interconnection between the environments that people live in and their health. So, when you think about what's important, it's about equity, community health, land use, all of these are interwoven. I can give you actually an example of a project that I'm involved with called Health in Harmony in Borneo, where one of my students actually built a hospital next to an orangutan park, which was being logged. And she managed to do some really radical listening what the community needed to stop their logging and they really needed healthcare. So, she gave free healthcare to stop the logging, and we managed to not only stop logging by 70%, but we diminished tuberculosis, malaria, diarrhea. So, everything to me is interconnected, health and environment.

Ruth Adewuya, MD (host):

It's a really great example of the interconnectedness of things and how one feeds into another. Reflecting on your experiences, what challenges have you observed for women in the medical field and how did these challenges drive you to become an advocate for women's rights?

Michele Barry, MD (guest speaker):

I think it helped that I was only one or four women in my internship group in internal medicine, but I became very upset when it was clear that there was no maternity leave at all. There were tremendous disparities in pay. I'll tell you a interesting anecdote. My husband is a year ahead of me. We met in residency and when we started in academics, he got promoted a year ahead of me because he was a year ahead. Then I got promoted and it may not sound like a lot of money now, but they paid me $5,000 less.

They didn't think I would ask my husband about how much he made, but that set me off and then I realized there was no pay transparency, no maternity leave. I pulled together with another woman named Shirley McCarthy, a group of senior women to actually write a bill of rights for women to talk about maternity leave, transparency and pay, a whole listing of what we felt were the rights of women in medicine.

Then you asked me for challenges. Tell you some challenges for women. US is the only high income country without a national paid maternity leave. I think there are a few island nations that don't have it. Women in our sector, the health sector, earn 24% less than men, and this ranges in different subspecialties. It could even be more than some of the surgical specialties. And even though there's a 50/50 ratio now of medical students, female to male, only 27% of full professors are women. Many women suffer from the impostor syndrome and research has shown it's actually worse for minority women. They wait much longer for tenure and promotions, both in minority and white women. Research shows, I can't believe this, that 40% of women physicians go part-time or leave medicine within six years of completing their residency.

Ruth Adewuya, MD (host):

That's intense.

Michele Barry, MD (guest speaker):

Now, is it because they're often on the front lines? They are on the front lines. They're on the front lines of sexual reproductive health education, breastfeeding, hand washing. 73% of the essential workers in COVID were women, that got sick. So, I'm a big believer of collective voice. That's why we got all of our

senior women together. It really makes a difference. To anyone listening to this podcast, your unique voice does make a difference. It's better to be collective, but don't dismiss the power of your voice.

Ruth Adewuya, MD (host):

What a powerful statement. And just reflecting on some of the things that you said, the data, it's quite staggering in terms of the number of women that leave. It's not a surprise that you have these numbers in the forefront of your mind and that it's central to you because now you spend a lot of time promoting women's leadership. Having served in leadership roles that prestigious organizations, how have these experiences influenced your perspective on global health and your efforts to promote women's leadership in the field?

Michele Barry, MD (guest speaker):

Ruth, I'll start with, it's probably cliched, but I really believe in it, that women actually need to be at the table and if they're not at the table, they're probably on the menu. And I'm sure you've heard that, but I really believe that. And the word leaning in has gotten somewhat controversial, but I do think if you lean into a leadership position, you can actually change policy, or advocate for change. I did not want to run for presidency of the American Society of Tropical Medicine and Hygiene, but I had my arms twisted a little bit and it wound up being a great thing.

There were no certification exam in tropical diseases and I was able to start the first certification and help seed training programs. When I wanted to train in tropical diseases, I couldn't afford to go to the London school. There were no programs in the US.

I actually, ironically, because you heard how I started my career about the Vietnam War, I ironically went to Walter Reed because if you looked at who was doing tropical diseases, it was the military. So, there's a great picture in Walter Reed, everybody's in uniforms, I'm in cutoff shorts because I was the only civvy in the class. But I think if you take on these leadership positions, you actually can make a difference. You can use your platform to elevate other women by sponsoring them to be on committees, or to actually role model or convince them to take leadership positions. I hope in a small way, I've been able to do that.

Ruth Adewuya, MD (host):

What do they say, it's a small drop that makes the mighty ocean?

Michele Barry, MD (guest speaker):

I'm on many women's backs, you know?

Ruth Adewuya, MD (host):

Stand on the shoulders of giants. Medicine in some specialties is still a very traditionally male-dominated field. As an advocate for gender equity in healthcare leadership, what are some practical strategies that can be most effective to break down barriers and foster inclusivity for women?

Michele Barry, MD (guest speaker):

I think many women are the sandwiched generation. They're taking care of their children and they're often taking care of their elderly parents because we're living much longer. So I think you need to have childcare, home care, child-rearing care, and elder care all subsidized. There need to be flexible policies. You need to get paid enough to be able to cover that work.

I'm in the midst of doing a study now looking at male allyship because I don't think you can get into that leadership position unless you have male allies, so that you need to really look for those mentors. If you can, get some executive coaching, elevating minority women is particularly important because they're

very underrepresented. Authorship, when you write a paper, make sure that you're included there and if possible as a senior author, or as a first author, if you look at the five of the most prominent surgical journals, 80% of first authors are male. That's astounding.

I give a talk about ending what I call manels. These are panels with all men. For underrepresented women, you have to take away the minority tax. Don't put them on every single committee. You need to let folks, particularly women, have access to research funding. Who's getting those NIH grants? There're not as many women as men. So what's happening? Is it the home care? Is it the elder care? Is it access to support and that male allyship? Those are all issues that I think are really important.

And then lastly, because I always believe in collective voice, you need to have networking cohorts. I think women who network together can often be more effective leaders.

Ruth Adewuya, MD (host):

Those are really great practical strategies. You talked about how you want to elevate minority voices, but you also talked about the minority tax and don't put minorities on every single committee. And unfortunately, the world that we live in right now, diversity, equity, inclusion has now become somewhat of a bad word. And so, decisions made with that lens are sometimes reversed or sometimes not taken positively by communities. How do you balance those three things, to ensure that minority voices are elevated in a way that is not performative, but also in a way that is protective of them?

Michele Barry, MD (guest speaker):

I think it's all about women being good mentors, women actually helping other women and also men, as I was talking about, male allies. I think when you get into a leadership position, you need to be sensitive that you're not putting women or underrepresented minorities on every committee. You need to really step up to the plate. The difference between being a mentor and a sponsor.

A mentor is somebody that tells you how to navigate the path, but a sponsor is someone who puts you up for that authorship, or tells you you should be the editor on the editorial board, not me. I think that you really, in your question of how to do, it's a lot about sponsorship, allyship, and mentorship.

Ruth Adewuya, MD (host):

That's a great segue to my next question for you to talk about the Women Lift Health Initiative. Can you tell us a little bit more about the program, its origins, and what inspired you to illustrate such a transformative effort?

Michele Barry, MD (guest speaker):

It all started with my being in a conference in Nairobi. It was the medical partnerships for the future, and they had every African dean on the dais and they were talking about how Africa is going to lead into the next century, and I looked up at the dais and I said, "Oh my God, they're all men." So, I actually raised my hand and I was one of not many white people in the room and I raised my hand and I said, "It behooves you to look who your leaders are." And when I said that, I got a standing ovation from all the women in that room.

I realized that it's not just a problem in the US, it's a problem globally. When we set up the first conference at Stanford, it was interesting because the head of NIH was there, Francis Collins. And he said to me, "You should do something about this." I said, "No, you should do something about this. Give me some money to do something about it."

So that was the seed money to start the conferences, which led to a leadership program, which we now have over $30 million invested in it by Gates, to put women into CEO positions globally over the next 10 years. These are women working in global health and I don't care if they're academics, the public sector,

the private sector, we really want to lift those women. That's why it's called Women Lift and that's how it started.

Ruth Adewuya, MD (host):

That is so exciting and so powerful, and you talk about the focus of the program being on leadership development. Our office has been doing some work in leadership programs for physicians, for advanced practice providers, and we always have this discussion around what qualities make a good leader. And so, I'm curious from the lens of setting up such a program, can you share some examples, or skills or qualities that you believe are crucial for women in leadership roles, in the context of global health, but also generally?

Michele Barry, MD (guest speaker):

I think you need to embrace your identity and actually become authentic. I don't think that there's any cookie cutting. There are definitely leadership skills that you can learn and in Women Lift, we give you one year of leadership training, and skill building and networking, and we give you a personal coach and a mentor. Those are all important.

You need to embrace your own identity, develop your voice, and hopefully that voice can highlight inequities. I think it's really important for women leaders. You need to work at being a leader. You need to find a skillset that you bring to the table that's impactful, a niche area that you become the expert in. That is very helpful when you're trying to get onto that road of leadership.

You have to know how to navigate conflict in the right way. You have to learn how to influence the nuances of developing others to make change, because you're not the only person that's going to be able to make change. And then lastly, you need to be aware of your privilege and power and the power dynamics that are around you.

Ruth Adewuya, MD (host):

I'm wondering if you can reflect on the work that you're doing, and share a story or an example that illustrates some of the positive changes that you've seen through your involvement in this global women's leadership program.

Michele Barry, MD (guest speaker):

There are so many stories. To give you a CDC story, Center for Disease Control, one of my Women Lift cohorts just actually saw the first all-female cohort from the training program in Uruguay. It's around 40 years and it was dominated by men and completely men. And then this year the group finally graduated with an all female cohort of 10 very talented women who will be looking for disease outbreaks and threats to public health in Uruguay.

Ruth Adewuya, MD (host):

That is amazing. It speaks to the intentionality of your program to lift these voices and bring them in.

Michele Barry, MD (guest speaker):

It's not only about a personal voice, it's really about institutional change. If they can just nudge it a little, I don't expect them all to change their institutions, but they can become a part of transforming it.

Ruth Adewuya, MD (host):

Yeah, exactly. You also recently talked about the exclusion of women climate scientists. What prompted you to delve into this issue and how do you believe addressing gender disparities in leadership roles is critical for the intersection of climate change and health?

Michele Barry, MD (guest speaker):

I got interested in it because if you looked at COP 27 and COP 28, those are the climate summits, for those on the podcast listening. There are absolutely no women in leadership positions. Even though if you look at who's moving the needle, it's women. Whether it's Greta as a young woman, or the women out in the front lines. Actually, women have been the long behind scenes ... the first person to actually discover carbon dioxide as a warming gas was Eunice Foote. I can't remember the year, in the 1800s. But she was not allowed to present her data, actually write about this in a paper. Her supervisor actually had to present the data because women just didn't present data.

I think women have valuable and different perspectives to bring. I think they're more likely to build consensus. So, I think they are really important in the climate discussion, but they're not in leadership positions yet. And so, I did write this paper to actually shine a light on this.

Ruth Adewuya, MD (host):

It's unfortunate that we still live in a day and age where you still see this gender disparities in leadership roles. There's a theme in what I'm hearing in our conversation collectively as women, we can move the needle and put women in these leadership roles and really for the world to acknowledge the power that women have in affecting change.

You've had the opportunity to work in different cultures and communities, and there are unique challenges to working in those spaces. How do you approach building trust and fostering collaborative partnerships in diverse settings?

Michele Barry, MD (guest speaker):

That's a really good question. I think you have to listen to those folks that you're trying to set up a collaborative partnership with and prioritize their needs, not your agenda. Too often I see my medical students or my younger faculty go in with their agenda, or their research project, or their medical gadget and not really responding to the need in that community. I think you need to have cultural humility, not necessarily competency because I personally think you never become competent in somebody else's culture, but you need to have some humility about their cultural and sensitivities to it, and then understand the implicit power dynamic. And as I talked early, that you need to be upfront about authorship and data control and money, and I'll end with you need to avoid the white savior model, which in global health is a really big problem.

Ruth Adewuya, MD (host):

As you look into the future, how do you envision medical education evolving to better prepare healthcare professionals for some of these challenges that we will continue to face?

Michele Barry, MD (guest speaker):

I personally have shifted my priorities. I started out in tropical diseases. The biggest challenge now in global health is climate change. So, I think that medical education has to address this. We just develop, and it's free open access to anybody who wants to go to anybody who's a health practitioner. It's called Medicine for a Changing Planet. It's on the web and it's case-based vignettes that really teach you about some of the educational aspects of climate's impact on health.

I think we need to, in medical education, address one health, this concept that we need to have animal health as well as human health, because if you look at what these pandemics are coming from, almost 60% of all emerging diseases are coming from animals, whether it be HIV, Ebola, COVID, influenza even comes from avian or pig, nipah virus, which is a horrific virus that is associated with pigs and even anti-microbial resistance is really related to antibiotics used to raise poultry and fish. So that again, we need to think about animal and keeping our animals healthy, our planet healthy, and then we'll get a healthy human at the end.

One last thing, Ruth, controversial, which is years and years, public health schools have been siloed off from medical schools. And I think public health should be integrated into medical schools and not siloed off into separate schools. I'm probably going to get 1800 nasty from my public health colleagues. I adore, I just think it all should be integrated.

Ruth Adewuya, MD (host):

I really liked what you said about the one health and looking at all of the components, from our planet to animals and the impact on human health and not thinking of them as separately. Finally, as you look ahead, are there specific initiatives or projects that you are currently excited about to pursue in this space of global health or women's leadership?

Michele Barry, MD (guest speaker):

There's really three things that I've been working on most recently, male allyship. I think most men want to be allies, but they don't know how to do it, the best way, or they don't have the tools. So I had a small grant, where we're trying to survey best practices in how to be a male ally, and then maybe I'll come back to you on how to disseminate that.

The second thing is I got a very nice grant to bring African scholars to Stanford to learn a skillset, but what I'm excited about is they actually go home with $50,000 to implement that skill. So, nobody ever does this bidirectionality. I'm very excited about that.

And then the third is that One Health, Animal Health, Medicine for a Changing Planet, putting that education out into the world. So those are the three things that I've been working on.

Ruth Adewuya, MD (host):

These three things are exceptional. I would be honored if you had come back to share more about your efforts there and how we can be involved in disseminating the results of your work. Thank you so much for chatting with me today on the podcast and sharing your passion in all of these interconnected areas of health and women's leadership. I appreciate your time today.

Michele Barry, MD (guest speaker):

Thank you, Ruth.

Ruth Adewuya, MD (host):

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