



ORACLE

To further the achievements of women practicing thoracic surgery by providing mutual support and facilitating professional advancement

President's Corner



Virginia R. Little, MD

"Never better," was the common reply from an old college friend whenever I asked him how he was doing. I'd say that would be my reply too if asked how things are going with the WTS! I've been a member of WTS since 2004, when I finished cardiothoracic training at the University of Pittsburgh and began an academic career in general thoracic surgery. Every year the organization continues to evolve. It is growing in member numbers and level of engagement. The leadership has been diverse, attracting both cardiac and thoracic surgeons and trainees. Margarita Camacho was the first WTS leader to whom I was

exposed. A transplant surgeon, Margarita is surgical director of a top-performing heart transplant program in New Jersey. The next president Nora Burgess also is a practicing cardiac surgeon and an administrative leader at Kaiser Permanente, San Francisco. During her WTS tenure, Nora planted the seed for a collection of the gender-bias articles for each subspecialty of cardiothoracic surgery. During her presidency, Yolonda Colson watered the garden and allowed it all to blossom into a plenary session at the AATS in Philadelphia in May 2011. Yolonda fostered the collaboration between WTS members and male and female leaders in cardiothoracic surgery for publication of articles in the Summer 2011 issue of *Seminars in Thoracic and Cardiovascular Surgery*.

At the completion of Yolonda's tenure, we had a record turn-out this year at our 2012 STS reception. We also bade a sad farewell to Nancy Puckett, who was the Executive Director of WTS and our head cheerleader! Nancy coordinated our relationship with the STS and allowed us to grow from a grass roots organization started a quarter of century ago by Leslie Kohman and professional friends to an organization well-recognized within our cardiothoracic community. As a follow-up to our recent 25th year anniversary, Jessica Donington summarized a survey of the 204 living women with ABTS certification. (*Oracle*, Summer 2011, page 14 or <http://www.thoracicsurgerynews.com/issues/march-2012>). In the past year, we also began to foster a collaboration

with our cardiology colleagues. Emily Farkas, who practices cardiac surgery in St. Louis (See page 10), is our facilitator. She will return this year as an invited guest of the Women in Cardiology board meeting at the 2012 American College of Cardiology conference. We hope to learn from our medical colleagues and foster future collaborations with our pulmonary and gastroenterology peers as well.

As we move forward in the next two years, we will continue to increase our membership and to focus on the specific aims for 2012-2014: Research and Surgical Volunteerism. Two separate initiatives with seeds for growth within our organization. Aim One: Research. We have an outstanding cadre of researchers within our ranks covering a diversity of research efforts. Patricia Thistlethwaite, Yolonda Colson, Jennifer Lawton and Christine Lau are engaged in basic science and translational research. Leslie Kohman, Carolyn Reed and Gail Darling all have led intergroup clinical research trials. Shanda Blackmon and Shari Meyerson work well with industry to share technical advances with their thoracic colleagues. Blair Marshall is an expert in surgical education and simulation.

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President's Corner

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Aim Two: Surgical Volunteerism (SV). SV is often synonymous with international outreach. Although Dickens wrote that charity begins at home, in 2012, international efforts are laudable and should be recognized as well. Kathleen Fenton operates with an international foundation (babyheart.org), Carolyn Dresler led the tobacco unit and international cancer group in Lyon, France, and future CT surgeon Helen Mari Merritt volunteered with the Haiti earthquake relief effort. I have mentioned only a few members engaged in Research and SV because we need to know what the rest of you are doing! Please take time to answer our short surveymonkey survey (link: <http://www.zomerang.com/Survey/WEB22F4U2QFNKU>) to share your research and local and international volunteer efforts with us. We aim to facilitate intra- and intergroup collaborations and accomplish one of our organizational missions: to educate and mentor women cardiothoracic surgeons and recruit more stars to our field. The initiatives are set! Let's maintain the enthusiasm and continue to make OUR organization "Never better!"

Highlights from the STS 48th Annual Meeting

STS Presidential Address

By Iva Smolens, MD

The Presidential Address of the STS 48th Annual Meeting was delivered by Dr. Michael J. Mack. In his opening remarks, Dr. Mack expressed just how proud he was to be a thoracic surgeon and acknowledged that what we do is both challenging and fulfilling on a daily basis. He then went on to acknowledge the large responsibility that many of us may feel on a daily basis; when we make a mistake in the OR it can cost a life, yet could any of us imagine doing anything else? Would we be as fulfilled?

Dr. Mack continued to state how privileged we are to be in a profession that allows us to live at the intersection of science and humanity. No other profession has such an opportunity. Furthermore, he emphasized that this privilege comes with a huge responsibility, one that can dangerously lead to entitlement. Rather than letting a sense of entitlement take root, we need to take full advantage of our opportunities as thoracic surgeons and fulfill our responsibility to do even more. When we save a life we can change a life! When we change a single life, it, in fact, impacts on so many more lives.

Dr. Mack challenged us to all do more, to think outside of the box. He challenged us to be innovators. Dr. DeBaKey was one of the first innovators in our field; sewing a vascular graft with his wife's sewing machine, but so many of us can do more. For example, modern day innovators like Dr. Ed Bender, who is credited for creating a number of iPhone applications related to thoracic surgery, Dr. Billy Cohn, who has invented material like LeGoo, and Dr. John Stevens, the CEO of HeartFlow, are all thinking outside the box and leading the way into uncharted frontiers. We are all capable of being leaders. We just need to find a way to do so and to think outside of the box.

As presidential tradition dictates, the past president leaves the incoming president a letter addressing unfinished business. In his letter to Dr. Rich there are three areas of unfinished business that he addresses and shares with all of us.

First, we need to continue to improve our surgical outcomes. Many states have already established statewide initiatives to do just that. However, he points out that there are still 43 states not participating. We as an organization can work together to help each other achieve this goal. He goes on to state that we, as an organization, should have as our goal a drop in CABG mortality rate to less than 1% over 5 years, stroke rates post CABG to be less than 0.5% over 5 years, AVR mortality to be less than 0.5% over 5 years and incidence of mitral valve repair rates to double to 80% by 2017. These are all achievable goals.

Highlights from the STS 48th Annual Meeting

Second, he reminds us that we can't do it alone. He referenced Dr. Chitwood's presidential address in which he stated that we all need to "find a partner and buddy up". We all can follow Dr. Macks example, over the last year he partnered with Dr. David Holmes, president of the ACC. They have stressed the application of the "heart team approach" to cardiovascular care and he really applied this to TAVR over the last year. This approach actually yields the best possible care for our patients. He encourages us all to implement this approach into our own practices.

The last item of unfinished business in his letter actually asks that we all pay heed to the tremendous emotional investment we make as thoracic surgeons. He cites a talk he recalled from the archives about 20 years ago where it was stated "no one can understand what we do as a thoracic surgeon without walking in our shoes". He acknowledges our great responsibility to our patients, and acknowledged something that I think we all feel; when we have a complication or a death a bit us dies with the patient. The greatest gift we get from working in medicine is not what we learn about working, but rather what we learn about living.

At the outset of the talk Dr. Mack referenced Dr. Shumway's presidential address where he stated that presidential addresses were a waste of time. After hearing Dr. Mack's address, I too disagree with Dr. Shumway; this was certainly not a waste of my time. At a time when many of us may become dismayed with medicine in general, Dr. Mack did an outstanding job of reminding us that we do is a great and unique privilege and that our future is a bright as ever.

Highlights from the STS 48th Annual Meeting

Congenital Heart Surgery Highlights from the STS

By Kathleen Fenton, MD

The three day congenital heart surgery session of the STS 48th Annual Meeting in Fort Lauderdale, FL highlighted numerous excellent presentations and posters of the latest research and advances in the field of congenital heart surgery. Most notable among these are two award-winning congenital heart surgery papers, the J. Maxwell Chamberlain Memorial Paper for Congenital Heart Surgery: "Changing Expectations for Neurological Outcomes following the Neonatal Arterial Switch Operation," and the Richard E. Clark Paper for Congenital Heart Surgery: "Effect of Gender and Race on Outcomes in Congenital Heart Surgery Patients: An STS Congenital Heart Surgery Database Study," presentations by doctors Karamlou and Chen in adult congenital heart surgery, and doctors John Costello and Michael Wolf in pediatric cardiac surgery critical care, respectively. These will be summarized here.

Dr. Dean Andropoulos, well known for his work in cerebral protection for pediatric heart surgery, presented the J. Maxwell Chamberlain Memorial Paper for Congenital Heart Surgery, entitled "Changing Expectations for Neurological Outcomes following the Neonatal Arterial Switch Operation." In this paper, Dr. Andropoulos explained that mortality following arterial switch in newborns has steadily improved; at Texas Children's Hospital, 175 consecutive neonates have been operated since 2000 with no deaths. For this reason, attention is being shifted to improving neurological outcomes. The current study includes 97 neonates enrolled in a prospective neurological outcomes study, of which 31 had arterial switch operations. Brain MRI scans were performed preoperatively and 7 days postoperatively in all infants. Near infrared spectroscopy (NIRS) was used in the operating room and in the ICU postoperatively, and a drop in NIRS below 50% intraoperatively resulted in corrective intervention. Preoperative MRI was abnormal in almost 1/3 of patients, and postoperative MRI showed changes in 61%, though most of the changes were mild. Of the entire cohort, there were 2 early and 8 late deaths, all in infants with hypoplastic left heart syndrome. Bayley III cognitive scores were above the population mean at 12 months, but motor and language performance was low (by less than 1 standard deviation). Motor and language performance improved at 36 months. There was a new finding of an association between low postop NIRS and postop MRI changes with worse outcome.

The Richard E. Clark Paper for Congenital Heart Surgery, entitled "Effect of Gender and Race on Outcomes in Congenital Heart Surgery Patients: An STS Congenital Heart Surgery Database Study," was presented by Dr. Daniel DiBardino. The authors studied outcomes for patients within the STS database under age 18 years who underwent surgery between 2007 and 2009, and found a significant association between outcome and race. Caucasian children had the lowest rates of mortality and complications, and had the shortest length of stay. The odds ratios for death and complications in African American children, respectively, were 1.67 and 1.15. There was no effect of gender on mortality



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Highlights from the STS 48th Annual Meeting

Take Home Messages

- Dr. Lawton: plan and organize. Know what you need for promotion from the get-go.
- Dr. Colson: Focus, focus, focus! And develop a niche!
- Dr. Speir: You can be successful and engaged nationally without being at a university and ... develop a niche!
- Dr. Guyton: Be a team player, be clinically competent and have a mentor!

WTS MENTORING BREAKFAST SESSION AT THE STS

By Virginia Little, MD

WTS held its second ticketed breakfast session on January 31, 2012, at the STS 48th Annual Meeting in Fort Lauderdale, Florida, entitled: Managing Your CV: Tips for Career Planning. The one-hour presentation and question session included invited speakers Drs. Alan M. Speir and Robert A. Guyton, and WTS leaders Drs. Yolonda Colson and Jennifer Lawton.

Jennifer S. Lawton, M.D. is an Associate Professor of Surgery at Washington University School of Medicine and Vice President of WTS. Her presentation was entitled, "Optimizing Your CV for Academic Promotion." She reviewed the academic promotion process and different types of tracks, noting that they can vary between institutions. Dr. Lawton stressed the importance of mentors and introduced the concept of "mosaic mentoring," in which a network of people meets different mentoring needs of the individual. She also stressed the importance of planning and setting annual goals for the number of publications you want and specific journals you want to publish in. You cannot decide mid-stream that you suddenly want to apply for promotion when you haven't designed a path for accomplishment.

Yolonda L. Colson, M.D., Ph.D., is an Associate Professor of Surgery at Brigham and Women's Hospital and immediate past President of WTS. Her presentation was also geared toward the academic surgeon and was entitled, "Your CV as a Roadmap to a Successful Academic Career." Dr. Colson offered practical and experienced advice for the academic cardiothoracic surgeon with a dedicated research interest. Dr. Colson's initial point was that to be a successful academic surgeon you must be a surgeon first. Establish your area of expertise and build on it with publications and funding. She wrapped up her talk stressing the importance of mentoring as well: "Mentoring Matters."

Alan M. Speir, M.D., is a practicing surgeon and Medical Director at Inova Health System throughout the state of Virginia. He talked about "Managing Your CV: Tips for Career Planning, The 'Non-University' Perspective." He eschewed misconceptions about a "non-university" cardiac surgical practice, and he gave examples of successful authorship, presentations and research- all academic accomplishments by "non-academic" surgeons. Offering specific questions for the young audience contemplating professional practice choices, he reminded them to be "true to themselves."

Robert A. Guyton, M.D., Professor of Surgery and Chief of the Division of Cardiothoracic Surgery at Emory University, gave a presentation entitled: "Developing and Sustaining VALUE." He also emphasized that being an excellent clinician and a team player is integral to professional success and growth. Acting individually will hinder career growth, while being an active team member will create opportunities. He reminded the young audience members to be true to themselves when contemplating career and practice choices.

Please see our website for links to these thoughtful and insightful talks;
<http://www.wtsnet.org/>

EDITORIAL:**If There's a Will, A Way Can Be Found**

By Davida A. Robinson, MD

As I was preparing for the Oracle multidisciplinary interview, which included one of our cardiology colleagues from Women in Cardiology, I did an internet search to learn more about the organization. During my internet search, I came across an article published in their e-newsletter, the Heart. The very first paragraph of this article read as follows:

*"During a meeting at the American College of Cardiology (ACC) conference in Orlando, FL this year, Dr. Jamie B. Conti (University of Florida, Gainesville) related an anecdote. Explaining how females in the field of cardiology had gotten together to form a "women-in-electrophysiology" support group, she said: "My father [cardiologist Dr. C. Richard Conti (University of Florida)] made fun of us. He said, 'We should have a white male cardiologist group,' and I replied, 'You already have one; it's called the ACC.'"*¹

I laughed...hysterically. Firstly, because Dr. Jamie B. Conti's response sounds like the type of sarcastic, reflexive comment that I would make to such a statement, and probably to someone who wouldn't particularly appreciate it. Secondly, although Dr. J.B. Conti's response seemed so obviously true, I expect that many people would probably fail to grasp the depth of her response.

Women have made important inroads in medicine, politics, and business. However, although progress has been made, gender bias, sexism, and prejudice remain, and in some instances, thrive. In the age of political correctness, all of the evil "-isms" of modern society are frequently masked but present nonetheless... and its effects just as pervasive and harmful. This is not merely my opinion; it is grounded in facts.

Based on an AAMC survey, in 2010, total medical school enrollment comprised of 53% males compared to 47% females². Although the medical school enrollment is approaching parity among the genders, women in the subspecialties continue to be underrepresented. This underrepresentation becomes even more pronounced in academic programs and at higher levels. The higher you go in academia, the fewer women there are^{3, 4}. Furthermore, even if the number of male and female professors is similar, the criteria for promotion may differ. For example, according to the 1996 survey of cardiothoracic surgeons, although the number of male and female assistant professors were comparable, women were noted to have more years of experience than their male counterparts (13.2 years versus 8.9 years)⁴. Similar gender discrepancies were found in salaries reported among both cardiologists and cardiothoracic surgeons, with a significant number of women receiving lower salaries or reporting dissatisfaction with their financial compensation^{3, 4}. These differences persisted despite correcting for age, practice characteristics, or professional rank⁴. Finally, women report higher incidences of discrimination both during training and subsequent to training^{3, 4}. According to the survey of cardiothoracic surgeons, women were significantly more likely to experience discrimination from multiple sources, including male or female attending staff, male or female resident colleagues, medical students, nursing staff, hospital support staff, patients, and their families⁴.

Gender based discrepancies have the potential to negatively impact the professional and personal lives of fellow members of the medical community. Discrimination, whether conscious or unconscious, creates a culture within the medical community that may result in isolation and feelings of betrayal, anger, and mistrust. This, in turn, may hinder one's success, productivity, innovation, creativity, and interactions amongst colleagues. In a certain sense, it's a "vicious cycle."

These very real issues and experiences of women within the male dominated specialties need to be addressed in an honest and constructive way. The first step in doing this is to raise awareness that the problem actually exists. Unaffected physicians and surgeons, male and female alike, may ignore, deny, or minimize these gender disparities and discrimination in medicine. Since they have never experienced it, the problem in their mind truly does not exist. Many people firmly believe that the medical profession is immune to the values, morals, prejudices, and double standards of the broader society, but those who have experienced discrimination would argue otherwise⁵. Similarly, many may think

EDITORIAL:**If There's a Will, A Way Can Be Found**

that a problem doesn't exist because it is not discussed. However, people may suffer in silence out of fear of having to endure further retaliatory derision or contempt⁵. People who are aware of these problems and do not publicly speak out, particularly those in leadership positions, are as guilty as those who perpetrate the problems, as their silence allows the problems to be perpetuated. Alternatively, some may think, based on their perceptions and experiences, that if you are effective at doing your job, these experiences won't occur. This is not always the case.

People who find themselves having to address these issues may through their actions and responses have good intentions. However, they may just not quite get it... and if they do get it, may not quite know how to address it. Although it is imperative that we reach out to, engage, and form partnerships with other specialties, perhaps we must first reach out across gender, cultural, and racial lines within our own specialties. After all, how can we be expected to reach out to, engage, and partner with new persons outside of our group whom we don't know, when we haven't mastered doing this with all persons within the group whom we know? Our respective specialties are indeed "one big playground", in which everyone needs to get along. But in an actual playground, members of the playground community are safe guarded against injuries, abductions, and other calamities by the existence, observance, and enforcement of basic rules. Being a "team player" or "putting in your time" should not be confused with compromising one's right to equitable treatment, training, promotion, or financial compensation.

Having said this, it is certainly true that there are many pioneers in medicine who have had to overcome these and even greater disparities and discrimination in the medical field, beating incredible odds to go on to achieve personal success and to advance the field of medicine as a whole. So the lesson for us is to "woman up" (or "man up", as it may apply) and persevere just as our predecessors did for us, and create the change we want to see so that life will be better for future generations to come. If there is a will to ensure that all persons can fully enjoy the honor and privilege of working in the profession of their choice free from the stench of inequality, a way can be found!

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For details on practice focus, areas of advice, and levels of mentoring, please refer to the www.wtsnet.org website.

If you are interested in learning more about becoming a WTS mentor, please contact Dr. Rosemary Kelly at kelly071@umn.edu.

As the field of cardiothoracic surgery becomes increasingly interdependent of other specialties, and healthcare becomes increasingly managed, there is a greater need to build strong, symbiotic relationships with other related specialties. These relationships must be developed if the field is to remain relevant in providing optimal quality, efficient, and fiscally responsible care to our patients. In accordance to this mandate, WTS has encouraged its members to attend major national and international meetings of other specialty groups. Interacting with our interdisciplinary partners creates an avenue to engage women in other specialties, build bridges, and address issues and find solutions to problems that are mutually concerning. In addition, WTS Oracle will also conduct a series of interviews in the “Getting to Know You” segment, exploring issues that arise during early, mid, and late stage careers, from the perspectives of a cardiothoracic surgeon and a cardiologist. The Oracle recently conducted interviews with early career Drs. Rose Cohen and Emily Farkas.

A special thanks to both Drs. Farkas and Cohen for agreeing to be pioneers in this endeavor.

GETTING TO KNOW YOU:

The ORACLE INTERVIEWS with Dr. Rose Cohen and Dr. Emily Farkas

Dr. Rose Cohen is currently a clinical cardiologist at The Permanente Medical Group in Walnut Creek, California. Her clinical interests include adult general cardiology, nuclear cardiology, echocardiography, cardiovascular computed tomography, and cardiovascular disease in women. Dr. Cohen did her undergraduate work at Brown University in Providence, Rhode Island where she graduated with honors and Magna Cum Laude with a degree in Biological Sciences. She attended medical school at Columbia University College of Physicians and Surgeons in New York City. Following medical school, Dr. Cohen completed her internal medicine residency and cardiovascular fellowship training at Columbia University Medical Center. In addition to her clinical work, Dr. Cohen was an ACCF/Merck Adult Cardiovascular and Glorney Raisbeck Adult Cardiovascular research fellow and received a master’s degree in Biostatistics and Patient Oriented Research from Columbia University Mailman School of Public Health. Dr. Cohen is a council member of Women in Cardiology Council of the American College of Cardiology and editor of the Women in Cardiology e-newsletter.



Dr. Rose Cohen

Dr. Emily A. Farkas is currently Assistant Professor of Surgery at the Saint Louis University School of Medicine in St. Louis, MO, with clinical interests in adult cardiac surgery, aortic surgery, TMR, stem cell therapy, and cardiovascular disease in women. Dr. Farkas did her undergraduate work at Pepperdine University in Malibu, California, where she majored in sports medicine. She attended medical school at Rosalind Franklin University, The Chicago Medical School in North Chicago, IL and went on to complete her general surgery training at the Ochsner Clinic Foundation in New Orleans, LA and thoracic surgery training at Yale University, becoming the first woman to be accepted into Yale’s cardiothoracic surgery training program in its 50 year history. August 3, 2011 was designated as “Dr. Emily A. Farkas Day,” in the city of St. Louis, MO by mayoral proclamation in honor of her dedicated clinical service, as well as her numerous humanitarian efforts around the world, including Kenya, Tanzania, Uganda, India, Sri Lanka, Peru, Mongolia, and Vietnam. Dr. Farkas serves on the Board of Directors of the WTS and STS Workforce of Media Relations and Communications, and she is an honorary member of Women in Cardiology (WIC).



Dr. Emily Farkas

GETTING TO KNOW YOU:**The ORACLE INTERVIEWS with Dr. Rose Cohen and Dr. Emily Farkas****Oracle:**

Despite the increasing number of women entering medical school, the number of women in thoracic surgery and cardiology has not shown a corresponding increase. What do you think this is most attributed to?

Dr. C.

There has been some progress over the decade in increasing the number of women in cardiology and thoracic surgery, but perhaps not as much as needed. I think people are still concerned about the uncontrolled hours, particularly in cardiology. In addition to the unpredictability of the time factor in clinical cardiology practice, there is the reputation that these specialties are not friendly environments. The reality is complicated, but optimistic. According to the 2008 report of a survey by the ACC Women in Cardiology Council[†], a disturbingly high number of women (69%) compared to 22% of men ($p < 0.0001$) responded “yes” when asked whether they “experienced any effects of discrimination during [their] career”, although both groups reported having high levels of career satisfaction. I don’t think that we have done enough to reach out to medical students to show them role models, and I think the profession itself and society as a whole has not done enough to work out a way for people to have a more balanced lifestyle.

Dr. F.

It’s true that the percentage of females choosing CV specialties doesn’t parallel the dramatic increase in female med school matriculants, and I think that’s primarily due to the lack of exposure to female role models during training. Despite an increased female presence in both Cardiology and Cardiothoracic Surgery in the last decade, there will be some lag time before an appreciable difference is realized in medical school faculty. It’s also somewhat dependent on women choosing academic careers where they can interact most readily with students and residents. I feel strongly that one of our most important responsibilities as female cardiothoracic surgeons is to be visible to young women when they are in this decision-making stage. While establishing a formal mentor/mentee relationship with a female physician is an important part of pursuing a career like this, I think it’s even more critical to be exposed to someone in their daily environment and say, “Well, if she can be a successful surgeon or cardiologist balancing external responsibilities, a fulfilling career, and appears to be satisfied both personally and professionally, why can’t I do that too?”

continued...

GETTING TO KNOW YOU:**The ORACLE INTERVIEWS with Dr. Rose Cohen and Dr. Emily Farkas****Oracle:**

What do you think are the greatest obstacles facing women who enter male dominated medical specialties?

Dr. C.

I think that there are competing interests for a lot of women that most men aren't facing in terms of traditional family roles. When you have competing interests in your early career, that makes you a little less focused and able to compete with your colleagues who are not facing competing interests. People talk in hushed tones in hallways and stairwells about how women are side tracked in the early part of their careers when they're dealing with children, families, caring for aging parents, etc. and that women's careers take off in the later years. I think women have more on their plate and it's more difficult to stay focused. As an early career physician, I have observed that one must come in early, stay late, actively promote yourself in order to be recognized and be given more responsibilities and resultant benefits of career advancement. If you have competing interests, you're at a disadvantage. We need to have more solutions to overcome these issues.

Dr. F.

First and foremost in my mind, the biggest obstacle is thinking that being a woman in a male dominated medical specialty is an obstacle! Subscribing to that philosophy can oblige a pattern of overcompensation or unwarranted aggressiveness to overcome 'the obstacle.' There is simply no reason why effectiveness as a physician is superficially elevated or diminished based upon gender, or that accomplishments are more or less worthy based upon the number of X chromosomes. Once you acknowledge that reality, you realize that male or female: you have a job to do, you do it well, and you don't give anyone an opportunity to look for reasons why you are different from the doctor standing next to you.

Oracle:

What changes do you think need to be implemented in training that would increase the number of women in the field?

Dr. C.

I think promoting a career profile that is variable as it applies to an individual's needs would be attractive to potential specialty candidates. A career in cardiology doesn't have to be one size fits all (i.e. full time versus part time, this or that setting, or a set amount of work hours). This more varied profile of women gives potential applicants a sense of flexibility that would improve perception of the specialty as an attractive choice. There are clearly gender based concerns pertaining to cardiology (e.g. radiation exposure). Many women are looking at the whole picture and not just the distilled aspect of the [work of the] specialty, and they're not seeing enough people who are making it work and are happy with their lifestyle. Mentoring is paramount to gaining more equal representation in fields such as cardiology or cardiothoracic surgery. Over the generations of cardiologists, this seems to be more important.

Dr. F.

I'd like to think that the ACGME resident work-hour restrictions level the playing field to some extent. At least conceptually, surgical residencies and fellowships which were traditionally considered more time & labor-intensive than other specialties no longer have that flexibility or entitlement. The urban legends that characterize training programs like a neoplasm that is "malignant or benign" will linger, and certainly there are multiple variables that cannot be standardized across programs such as patient volume or physician personalities. But at least in regard to time spent on-duty during the training years, resident work hour regulations ideally remove that confounder from the equation to allow a more pure consideration of a particular specialty. While important to both men and women, females may classically have more concern over managing pregnancies and balancing family responsibilities.

GETTING TO KNOW YOU:**The ORACLE INTERVIEWS with Dr. Rose Cohen and Dr. Emily Farkas****Oracle:**

If someone encountered unequal access to resources or training opportunities, during the course of training or early in their career development, what do you think is the best way to address this problem?

Dr. C.

I think one should pick a particular trend that is bothering you or does not seem inherently right and have data/facts behind your concerns to support what you're saying, maybe even to speak to your chief, and have a solution ready. The most successful people that I've observed have come forward with a specific complaint with data and a proposed solution. I think that is the most effective way to change something. I think people are afraid of making people who are in charge of them upset, or angry, or think less of them, but sometimes I think you're more respected if you come to someone with a concrete problem and data behind what you're saying and not just complain because of a feeling that you're being shortchanged. Never convey a feeling of being shortchanged, even if you truly do feel that way. [Rather,] say "I've noticed this inconsistency; it's X, Y, and Z; and I recommend we fix this by doing 1, 2, and 3." I think this approach is much more respected, and it's part of the game. If this doesn't work, then that's a tricky situation. You generally do not want to go over your chief's head, but if you feel like you've addressed it at the level you're supposed to go to and there's no resolution and you feel like something very wrong is going on, then I think [you] need to talk to a neutral party. At every institution, there is an ombudsman. Speaking with an ombudsman is a good way to balance your concerns and to see what resources are available to you. Getting an outside/unbiased opinion is always a good idea.

Dr. F.

I think it's important to pursue the proper channels. Unless your direct supervisor is involved in the incident, begin there and give that person the opportunity to address it. If that individual is unwilling / incapable of handling it to your satisfaction, move up the line to the next level of authority. Although many people are unaware of them, most academic institutions have protocols/pathways/committees in place to assist with these exact issues, and additionally national societies such as the American Medical Association, the Association of Women Surgeons, or the Women in Cardiology section of the American College of Cardiology offer resources for guidance and suggestions through their members and on their websites.

Oracle:

What, if any, barriers to training and early career development exist that women may intentionally or unintentionally create or contribute to?

Dr. C.

I really don't think that women are perpetuating the problem. I think that we're dealing with more models and styles of work in an area of work that has been traditionally created for men and it is an evolving process. Our professions and society in general are trying to adjust to getting women involved in our fields. That being said, I think that some of the survival skills that women have learned to excel in male dominated fields is to not help each other out and I think that such a competitive spirit is complicated. I wish women were more cohesive and supportive of one another, rather than leaving each other in an environment to scratch out your own path to success. [This is] not necessarily constructive to the collective group and to increasing the number of women in the field, and I think we need to reprogram that a little bit. I would like to see a greater movement of women mentoring women professionally.

continued...

GETTING TO KNOW YOU:**The ORACLE INTERVIEWS with Dr. Rose Cohen and Dr. Emily Farkas****Dr. F.**

Again I would emphasize the importance of making gender a “non-issue” for yourself first, and instead making the quality of patient care, the mutual respect of your staff, and the maintenance of productive relationships with colleagues your focus. There is no benefit to feeling as if you will inevitably become a victim in the system or in assuming that you will be limited by anyone other than yourself in what can be achieved as a surgeon. I think that there really is a degree of accountability that is sometimes lacking in these situations by women themselves; I would never trivialize any inequality that a woman may have endured in the workplace by suggesting that the right attitude could have prevented it, but I think it’s important to recognize that you do have a great deal of control over the way in which you are perceived. It’s true for a man or a woman. Confidence in your own ability and setting a tone of professionalism will make antiquated gender polarity assertions seem even more ridiculous.

Oracle:

Do you think there is a role for shared residency or part time training positions for labor intensive specialties such as in cardiothoracic surgery and cardiology?

Dr. C.

I personally have the bias of having trained full time, but I did have to interrupt my training when I had my first daughter. I would want to hear more about it. I’m completely open to that, and I definitely think that we should be thinking outside the box. But I do think that training needs to be intense and demanding and of a certain prescribed duration and curriculum since that’s the experience I had. But sometimes you have to leave your bias behind and be able to consider alternatives. In order to increase women representation in such specialties as cardiology, I do think that we need to be progressive and think of progressive solutions, even at the training level.

Dr. F.

That’s an interesting question and I suspect that the popular answer would be yes, but in my opinion it would not be in the best interest of the trainee. I think many surgeons agree that not operating for even a short period of time can result in a noticeable difference in the flow of an operation, and that difference would be amplified in training. In addition, the value of continuity of care is real, not just for the patient, but for the education of the clinician. Becoming a physician requires commitment, focus, experience, and repetition. Developing a meaningful skill set upon which you will rely for the rest of your career takes time; there’s no way around that nor should there be. Limitations on maximum work requirements are justified, but the flipside of competency achieved via minimum requirements is also an important concern.

‡To view the WIC ACC survey report in its entirety, please refer to the following reference: Survey Results: A Decade of Change in the Professional Life in Cardiology, Women in Cardiology Council (Poppas et al, JACC 2008; 52:2215-260). This publication and other resources are available on the Women in Cardiology Council Website, www.CardioSource.org/WIC.



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Farewell Nancy



WTS would like to acknowledge the four-plus years of dedicated service that Nancy Puckett provided as Executive Director of WTS, and extend our well wishes as she moves on to new endeavors this year. Nancy first became involved with the WTS in 2007. She has been instrumental in its stewardship as it blossomed into a successful, ever growing, forward thinking and increasingly relevant organization in the field of cardiothoracic surgery. According to former WTS President Yolonda Colson, "WTS is forever indebted to her encouragement, her organizational skills and her ability to make 'magic' happen for the WTS. Without Nancy we would still be having meetings in a back hallway somewhere..."



In addition to serving as Executive Director of WTS, Nancy was STS Director of Marketing and Communications, Executive Director of the Southern Thoracic Surgical Association, and Executive Director of the Thoracic Surgery Directors Association.

WTS bids farewell to Nancy with great affection and gratitude as she embarks on her next chapter!

Find Us On Facebook!



WTS is pleased to announce that we are now on facebook!

Our link is:
www.facebook.com/home.php#!/pages/Women-in-Thoracic-Surgery-WTS/164495920267558.

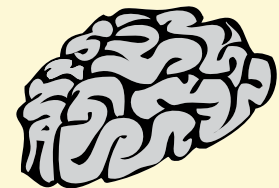
Or search for:
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Visit us today. Once you've experienced it, invite a friend!

What's On Your Mind?

We want to hear from you! Don't forget to submit any questions or topics of interest that you want discussed in our newsletter.

Please e-mail your questions and topics of interest to:
wts@wtsnet.org
 subject heading "WOYM".



Save the Date

WTS Networking Reception

Sunday, April 29 at 5:00 p.m. in San Francisco during AATS. Additional details will be posted to www.wtsnet.org in them coming weeks, or find us on Facebook. We hope to see you in San Francisco!

2012 Women in Thoracic Surgery Scholarship Winners



By A.J. Carpenter, MD, PhD

WTS is pleased to announce the recipients of the 8th annual Women in Thoracic Surgery Scholarship Program for 2012. This year's topic: "How do you believe that changing health care access will impact your future as a cardiothoracic surgeon?" generated a lively and varied discussion among the applicants! The scholarship covered meeting registration fees, hotel accommodations, up to \$500 in related travel expenses to attend the STS 48th Annual Meeting in Fort Lauderdale, FL, and most importantly provided the scholarship recipients with an invaluable opportunity to network and form potentially life-long mentoring relationships with leaders in the field. Thanks to all of the applicants and members for your participation!



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2012 Women in Thoracic Surgery Scholarship Winners

Mara Antonoff
University of Minnesota
General Surgery Resident

The move toward universal health care coverage has created significant market pressures for physicians. Seemingly contradictory demands – caring for more patients while further containing costs – pose a challenging paradigm for cardiothoracic surgeons. A resonating wave of change promoting increased emphasis on evidence-based practice and outcomes is washing into our surgical lives. Shifting the paradigm toward cost-effective, outcome-based care is a modern challenge. Surgeons must actively take leadership in organizational efforts to enhance our understanding of the components required to deliver quality care in an economy of finite resources.

Ann Gaffey
University of Pennsylvania
General Surgery Resident

The extension of insurance to 30 million people by the Affordable Care Act creates new research opportunities. The larger patient population with access to surgical care allows for re-evaluation of medical decision-making through collaborative ventures and comparative effectiveness research model. Thoracic surgery is poised to spearhead this shift from the current paradigm of anecdotal reports to one that analyzes comparisons among options for treatment, surgical approaches, and follow-up care. With my interest in epidemiology and economics, I aim to be a leader in this effort with the goals of innovating care and improving quality of life for patients in light of financial constraints.

Kimberly Holst
University of Michigan
Medical Student

Increases in healthcare access will be accompanied by increased monitoring of cost and outcomes. The vast difference in cost of cardiac surgery in the United States compared to other areas of the world was recently highlighted when Dr. Devi Shetty won the Economist Innovation Award. Financial reform will be mandated by healthcare payers and cardiothoracic surgeons must anticipate these changes to be a part of the process. Increased healthcare access and reform has the potential to maximize cost effectiveness and quality of care; however, if not performed in a conscientious way will lead to poor outcomes for patients and cardiothoracic surgeons.

Eva Richardson
University of Mississippi
General Surgery Resident

As a resident of Mississippi, one of the most medically underserved states in the nation, I am often overwhelmed by the number of patients with advanced cardiothoracic disease that could have been prevented or cured if they had access to healthcare. As policies change and access widens, there will be a need for streamlined, multidisciplinary clinics that eliminate multiple office visits and duplicated testing. I plan to work closely with cardiologists, pulmonologists, and gastroenterologists to provide fiscally responsible and efficient treatment plans for each patient. My goal is to accommodate the increasing number of patients without compromising excellent care.

Joanna Sesti
New York University
General Surgery Resident

I became a doctor to care for people. Unfortunately, 16% of Americans lack access to healthcare. This situation is challenging to all, including cardiothoracic surgeons, because it forces the system to increase services while decreasing healthcare expenditures. To ensure increased access doesn't come at the price of quality health care, I need to be more than a surgeon; I need to be a businesswoman, leader, patient advocate, and an active member of organizations like the STS. The STS database is an excellent example of the type of initiatives we will need in medicine to guarantee the care we provide to patients.

WTS Networking Reception

A WTS Networking Reception was held in Fort Lauderdale during the AATS 92st Annual Meeting. This was a great opportunity to network and reconnect with fellow WTS members and prospective members.



WTS Networking Reception



Acknowledgements

WTS gratefully acknowledges the generous support of the following companies and institutions:

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University of Pittsburgh Medical Center
University of Rochester
University of Texas Health Science Center, San Antonio
University of Virginia
Vanderbilt University

WTS Leadership Meeting – Save the Date!

Mark your calendar for the Spring WTS Leadership Meeting in San Francisco on Sunday, April 29 from 3:00pm – 4:30pm. A WTS networking reception will follow from 5:00pm – 6:00pm. If you are attending AATS please plan to participate. A meeting agenda and additional information will be sent in the coming months; if you have specific agenda items you'd like included, please forward them along!

Thank you,
Katie Bochenek

Authors Wanted!

By Katie Bochenek

Preeti John, MD, a critical care surgeon in Baltimore, is working on a new book compiling the experiences of women in the surgical field through stories, anecdotes, essays, biographies, poetry, and articles from women surgeons and surgical residents in-training from across the United States. For more information please see the full announcement in the General Surgery News link:

http://www.generalsurgerynews.com/ViewArticle.aspx?d=In%2Bthe%2BNews&d_id=69&i=March+2012&i_id=821&a_id=20272

If interested, you may contact Dr. John by email at preeti.john@va.gov. Original contributions have no specific guidelines and there is no word limit. The deadline for draft submissions is April 30, 2012.

Membership Update

If you have not paid your 2012 membership dues, please do so today! It is through your support that we are able to continue our outreach efforts to women throughout the world who have chosen this specialty, along with influencing young women interested in cardiothoracic surgery through our scholarship program.

Please also encourage your non-member colleagues to learn more about WTS and consider applying for membership. A listing of WTS membership categories and a sample membership application is included in this edition of the Oracle. Applications are also available at www.wtsnet.org in the "Become a Member" section.

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Women in Thoracic Surgery (WTS) is an international organization of thoracic surgeons whose purpose is to:

- Provide quality care to our patients;
- Mentor young women interested in pursuing careers in thoracic/cardiac surgery;
- Provide educational opportunities for our members;
- Educate the public, especially women, regarding cardiac and pulmonary health and disease.



WTS Membership Application

Name: _____
Institution: _____
Address: _____
City: _____ State: _____
Zip/Postal Code: _____ Country: _____
E-mail: _____ Phone: _____

PLEASE PROVIDE THE FOLLOWING INFORMATION

Your areas of interest in working with WTS (circle all that apply):

WTS Membership Outreach WTS Education WTS Scholarships
WTS Newsletter WTS Mentoring Other (please specify): _____

DUES PAYMENT INFORMATION

U.S. Active - \$150 International - \$75 Residents/Students - No charge
Associate - \$150 *Institution Benefactor - \$500 *Corporate Benefactor - \$1500

*For additional information regarding Benefactor membership benefits please contact WTS Headquarters at 312-202-5835

Make check payable to: Women in Thoracic Surgery (Tax ID#: 30-0003353)

To pay by credit card: Visa MasterCard American Express

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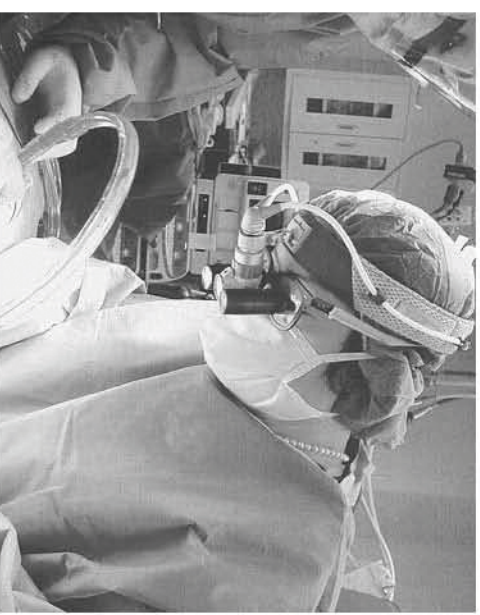
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If you have questions, contact WTS Headquarters at 312.202.5835 or WTS@WTSnet.org.

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