

Women In Thoracic Surgery



ORACLE

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

President's Corner



By: Jessica Donington

When I assumed the Women in Thoracic Surgery (WTS) Presidency, I became introspective about leadership and the qualities associated with outstanding leaders. I was reminded of the 2014 Society of Thoracic Surgery Presidential address by Dr. Doug Wood and the discussion of The Athena Doctrine: How Women (and the Men who Think Like Them) will Rule the Future. This work from John Gerzema and Michael D'Antonio describes the traits which are valued most in leaders throughout the world. The majority of these traits are considered feminine rather than masculine, including

patience, expressiveness, loyalty, flexibility, intuitiveness, selflessness, empathy, passion, compassion, and the ability to collaborate and plan for the future. I cannot help but think that these are the same traits that makes one a good friend, parent, spouse, and person in general. These are traits instilled prior to kindergarten (and unfortunately variably learned), but their mastery is clearly associated with greater lifelong happiness and security. These are also the traits that the millennial generation compared to other age groups values most in their leaders.

2016 is the 30th anniversary of the WTS and an opportunity to review the tremendous strides that women have made in cardiothoracic surgery since the inception of this organization. There are nearly ten times as many female cardiothoracic surgeons as there were in 1986. Women surgeons are no longer an oddity, and

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female trainees are common. Unfortunately, women in positions of leadership within our national organizations and academic departments remain rare. It is unclear if this represents a glass ceiling or simply a reflection of the small current number of senior female surgeons. Either way it is an important issue to overcome.

At the American Association for Thoracic Surgery meeting in Baltimore this May, the WTS and the Johns Hopkins Department of Surgery will be co-hosting

a special symposium on Sunday evening. This event will be held at the Center Club, is open to all, and will focus on the importance of diversity in leadership. I encourage you all to attend.

I am optimistic that we are in a period of transition and that the void in female leadership in thoracic surgery will disappear over the next decade. Gerzema and D'Antonio describe femininity as "the operating system for the 21st century" and consider the inclusion of the feminine voice in leadership

essential as our society becomes more social, open and interdependent. Cardiothoracic surgery is a highly specialized field that has made unbelievable clinical and scientific strides over the past century and has benefited millions of patients. The field would not be where it is today without incredible pioneers and leaders with analytic, decisive, and resilient behavior, but its continued growth and success will be enhanced with greater inclusion of the feminine voice.

WTS Leadership 2016

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Happy 30th Anniversary to the WTS!

We had a huge party in January to celebrate 30 years of women striving to break the glass ceiling in cardiothoracic surgery! Our special session on Monday afternoon at the STS was a packed house. The session was a celebration of "Innovations and Contributions of WTS and

STS members." Talks included: The Untapped Potential of Women as Leaders; Pioneers and Significant Contributions in Congenital, Adult Cardiac and Thoracic Surgery; Changes in the Demographics of the American Board of Thoracic Surgery Diplomates since

1961; Mentoring Female and Minority Surgeons; and Diversity in Cardiothoracic Surgery and the Future: What will the Face of CT surgery be? Leaders from all disciplines delivered great talks that motivated the audience.

During the STS Annual Meeting, Drs. Lawton,

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1961 - American Board of Thoracic Surgery (WTS) established

1966-1968 - ORACLE magazine established

1986-1991 - [Milestone description]

1992-1995 - [Milestone description]

1996-1998 - [Milestone description]

1999-2001 - [Milestone description]

2003-2005 - [Milestone description]

2007-2010 - [Milestone description]

2011-2015 - [Milestone description]

2016 - Celebration of the 30th Anniversary of Women in Thoracic Surgery

NUMBER of AMERICAN BOARD of THORACIC SURGERY CERTIFIED WOMEN per YEAR

Year	Number of Certified Women
1970	0
1975	1
1980	2
1985	3
1990	4
1995	5
2000	6
2005	7
2010	8
2015	9

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Baumgartner, Carpenter, Donington, and Antonoff sat down for a great roundtable discussion about the WTS 30th Anniversary. [Click here](#) to watch the video.

The celebration continued later that evening at the WTS Networking reception/30th Anniversary celebration.

Nora Burgess delivered an eloquent talk on the history of the WTS to another packed crowd. [Click here](#) to view the talk, in case you missed it. If you would like to learn more about the history of the WTS, please [click here](#) to read the feature recently published in the Annals of Thoracic Surgery.

The evening celebration

continued by honoring the past WTS presidents. The accomplishments of all women in thoracic surgery were celebrated with a wall mural, graciously donated by the Mayo Clinic. The evening was capped off with a champagne toast and cake! We can't wait to see what the next 30 years brings for the WTS!



Resident's Feature

By: Jennifer Wilson, MD

Dr. Wilson is a graduating cardiothoracic resident at Beth Israel Deaconess Medical Center in Boston.

"Practice is funny that way. For days and days, you make out only the fragments of what to do. And then one day you've got the thing whole. Conscious learning becomes unconscious knowledge, and you cannot say precisely how."

- Atul Gawande,
Complications: A Surgeon's
Notes on an
Imperfect Science

To: The surgeons, who trained me, This is a thank you letter.

The end of 7 years of training is approaching in a few months. The true beginning of my career is about to arrive and it is an indescribably good feeling. If I pause for a microsecond to reflect on the journey, I am immediately overwhelmed with gratitude for the surgeon-teachers who invested in me.

More than ever, I now realize the extreme patience that it took to teach me how to perform what to my instructors had become mundane tasks, starting with closing skin and graduating to complex fellow-level cases. Some mentors let me *fly free* with an attitude of *'I can fix*

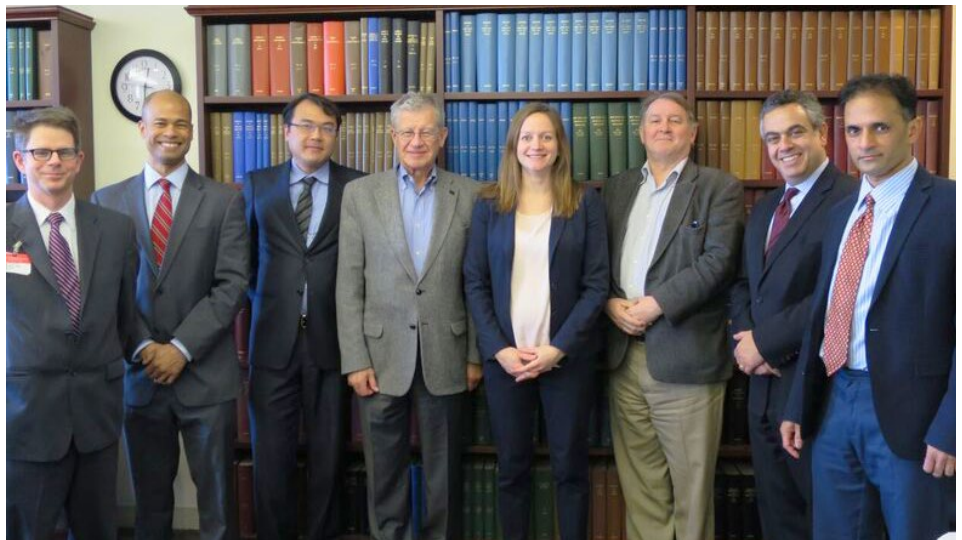
anything you can screw up' while others scrutinized every element of every maneuver aiming for technical flawlessness.

For those that gave me extreme independence, I was tortured and humbled by the mistakes that I was allowed to make. These missteps taught me not to let my guard down and will translate into independence as an attending when there is not someone directing every micro-maneuver. Equally beneficial, was training under the perfectionists who taught me priceless technical pearls that can never be translated into a textbook. These pearls have now become muscle memory to me and I will have the opportunity to pass them along to my future trainees. My teachers have given me a broad and well-balanced cache of knowledge that I will draw on throughout my practice.

Moving forward, I hope that I can emulate the generous men and women that were committed to molding me into a surgeon. Going back to the basics and teaching a student how to tie a knot reminds me where I started, which can be surprisingly easy to forget and humbling. The greatest privilege of academics by far is the unique and priceless opportunity to pay it forward to the next generation of surgeons.

Sincerely and gratefully,
Jen Wilson, MD
Cardiothoracic Surgery
Fellow PGY 7
Beth Israel Deaconess
Medical Center-Boston, MA

General Surgery Residency:
Swedish Medical Center-
Seattle, WA (2009-2014)
Cardiothoracic Surgery
Fellowship: Beth Israel
Deaconess Medical Center-
Boston, MA (2014-2016)



Michael Kent MD, Sidhu Gangadharan MD, David Liu MD, Sidney Levitsky MD, Jen Wilson MD, Richard Whyte MD MBA, Kamal Khabbaz MD, Senthil Nathan MD

Surgical Citizenship – How to be an Outstanding Peer Reviewer

By: Lisa M. Brown, MD, MAS
and Katie S. Nason, MD, MPH

Journal editors rely on peer review from physicians, biomedical researchers, and biostatisticians to critically examine study aims, design, and methodology, and ensure that analysis and conclusions are appropriate prior to manuscript publication. Given the importance of this process and clinician reliance on the published literature to guide clinical practice, we sought to provide Peer Reviewers guidance for performing outstanding reviews.

What are the steps of the editorial process?

Following submission, the Journals editor selects peer reviewers, emails invitations and uses the feedback to guide publication decisions. Journals typically set deadlines for reviewers to: 1) respond to the invitation and 2) submit the review. A prompt response from reviewers is vital to moving the process forward. The peer reviewer is expected to make recommendations to the Editor, based on their comprehensive review of all sections of the manuscript, as to acceptability for publication. Outstanding reviews provide the editor and authors clear, concise, insightful and constructive

feedback which accurately reflects manuscript strengths and weakness. They also provide specific recommendations for revisions that will significantly improve the manuscript. The following can be used as a step-by-step approach to producing an outstanding review.

What are the goals of the Introduction?

The introduction succinctly defines the scope of the problem and justification for further investigation. It should be no more than 2-3 paragraphs and briefly introduces strength and limitations of prior research. The final paragraph should include a clear statement of the study hypothesis and aim(s).

- Elements of the study hypothesis and aim(s):
 - Cohort to be studied
 - Intervention, prognostic factor, or exposure of interest
 - Comparison group or alternative intervention
 - Outcome to be evaluated

What elements are necessary in the Methods section?

This section describes how the study aim(s) were tested and include the elements below. Outstanding reviews

provide authors feedback when these requirements are not met, including sufficient information for each element such that independent investigators could replicate the study.

- Type of research study and study participants
 - Population and study setting
 - Inclusion and exclusion criteria
 - Study time frame
- Data source
 - Methods for data collection
 - Prospective or Retrospective
 - Whether the data abstractors were blind to the study question or intervention
- Predictor variables
 - Any novel, complex, or key study predictor variables should be defined in detail
 - Variables should be consistent with published literature or justification provided for alternative definition
- Outcomes
 - Primary and secondary outcomes clearly defined, including how they were measured
- Statistical Analysis
 - Sufficient detail provided such that an independent investigator could replicate the

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- analysis
- Institutional Review Board
- A statement of IRB approval or exemption and informed consent (if indicated) is required

How should the Results be presented?

The results section presents the analysis of the primary and secondary study aim(s) and any additional hypothesis-generating analysis of interest. Study findings are not interpreted in the results section. As a rule, the first paragraph of the results summarizes the study population and highlights differences in baseline characteristics between the two comparison groups. It is customary for the first table of a clinical paper to provide a descriptive summary of the population characteristics, stratified by comparison groups.

Results should proceed logically, presenting the findings for the analysis of the primary aim and then work through the secondary aim(s). Tables and Figures are clearly labeled and referenced within the text to direct the reader to them in a sequential fashion. Results presented in Tables and Figures are complementary to and not a reiteration of findings already presented within the text.

What does a comprehensive Discussion section include?

The discussion section

provides an opportunity for the authors to explain the study importance to the reader. As a general rule, the first discussion paragraph should summarize the study hypothesis, aims and key findings. Subsequent paragraphs are used to discuss the findings relevance in the context of the existing literature.

Additional components of the discussion include:

- Discussion of the relevance of the results in the context of the existing literature
- Paragraph on strengths and limitations
- Study generalizability and any precautions in result interpretation are noted

The final paragraph reiterates main study findings and ends with take-home message for the reader. The authors note why the study findings are relevant to their practice, where research needs to focus, or recommendations for data collection and analysis in future studies.

Once the review of the manuscript is complete, how should the reviewer submit recommendations?

Outstanding reviewers are not shy about telling editors and authors what is great (or not) about the manuscript. Constructive and specific feedback is key. Reviews that are too critical or inconsistent are of limited value, as are reviews that are superficial and do

not suggest opportunities for improvement. Reviewers are typically asked several questions about the scientific value, originality, and analysis integrity, and whether biostatistical review is needed. Most journals offer three categories of recommendations:

- 1) Accept as is;
- 2) Revision and Re-review; and
- 3) Reject.

Manuscripts are rarely accepted as is – outstanding reviewers can always offer the authors suggestions to strengthen a manuscript. Major and uncorrectable flaws with the study design, inadequately powered studies or uncorrectable problems with study measures are reasons for rejection.

Most editorial sites include a 'Comments to Editor' section; outstanding reviewers use this section to explain their recommendation to the editor. These 'Comments' should reflect a clear understanding and accurate critique of study strengths and weaknesses. Statements should not be arbitrary or unsupported; they should provide the Editor unbiased and objective justification for the recommendation. In the 'Comments to Authors' section, the review briefly summarizes overall findings and study quality and then continues with an in depth evaluation of the manuscript, section by section.

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Outstanding reviews identify study deficiencies and recommend corrective action, request clarification and detail specific suggestions for manuscript improvement.

By implementing the elements of outstanding Peer Review, new and seasoned

reviewers will ensure that the published literature is accurate and meaningful so that subsequent clinical practice changes contribute to ever increasing quality care and excellent patient outcomes.

An extended version of this article is available at www.wtsnet.org/

References:

Browner, WS (2006). Introduction. Publishing and Presenting Clinical Research (pp 21-26). Philadelphia, PA: Lippincott Williams & Wilkins.

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Is your institution a member of the WTS?
 If not, [click here](#) for more information.

WTS Scholarship Programs



WTS has seen enormous growth in our scholarship programs in the last few years! We currently offer three scholarship opportunities for female surgeons, trainees and medical students.

The TSFRE/WTS Carolyn E. Reed Traveling Fellowship

is now in its third year. **Drs. Daniela Molena** and **Elizabeth David** have been selected as honorees. Dr. Molena will be spending her scholarship at the Oregon Clinic honing her endoscopic skills including ablation, resection of early stage tumors, submucosal dissection, and peroral endoscopy myotomy (POEM). Dr. David will be spending time at the University of Wisconsin with Dr. Gretchen Schwarze developing her qualitative research skills. Congratulations ladies!

The Scanlan/WTS Traveling Mentorship Award

is continuing this year as well. This award provides an opportunity for a trainee who does not have exposure to a female CT surgery mentor at her own institution to travel to spend a week with a WTS Mentor. **Robin Boyer** from Ross University School of Medicine was selected to spend time with Dr. Tara Karamlou at University of California San Francisco gaining more exposure to congenital cardiac surgery and academic medicine. **Dr. Kyla Joubert** from University of Arkansas for Medical Sciences was selected to spend time with Dr. Mara Antonoff at MD Anderson gaining exposure to thoracic surgery and academic medicine. We hope you have an enriching experience ladies- congratulations!

The WTS Scholarship Program is now in its 12th

year! We were thrilled to have additional support from the STS again this year, which allowed us to offer 10 scholarships to interested female medical students and trainees. The scholarship included meeting registration fees, hotel accommodations, \$500 in travel expenses, and provided the recipients with a dedicated mentor to help them navigate and network at the STS 52nd Annual Meeting in Phoenix, AZ. Thank you to all the applicants and members for your active participation in an activity that helps not only the recipients but also our field by helping to recruit the best and brightest!

Enjoy the winning essays! This year's essay topic was: ***"As health care costs are driven by more complex and expensive procedures and pharmacotherapy, how does society decide who gets them?"***

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Jennifer Burg MD, General Surgery Resident, University of Oregon

As health care costs become prohibitive, personal responsibility for health-impacting behaviors will become more important. When considering patients for complex, expensive procedures and pharmacotherapy, especially those with long term medication and follow up requirements, preference should be given to patients committed to maintaining good health through sustained lifestyle changes. For example, patients demonstrating the ability to quit smoking, lose weight, maintain good diabetic control, and take prescribed medications as directed would be favored over non-compliant patients. Patients committed to improving their health will maximize their potential benefit from costly interventions.

Betsy Colwell MD, Integrated Thoracic Surgery Resident, Medical College of Wisconsin

To influence medical resource stewardship, Society will need to create a model where healthcare practitioners are encouraged and rewarded for consistently delivering efficient high-quality care. Creating accountability to this future model could combine many of the tools available to healthcare

today. For example systems can place emphasis on triple-aim oriented care, establish value-based contractual relationships with payers, or fund new research in areas of efficacy/cost. Success will be determined by incrementally reducing practice variation and improving value, while maintaining the autonomy of medicine to make the most informed patient specific care decisions.

Vicky Dhooghe MD, General Surgery Resident, University Hospital of Antwerp, Belgium

Being a health care provider I strongly believe that every person should have access to medical treatments, without taking their socio-economic status into account. In Belgium a "sugar tax" was introduced for unhealthy foods like soda, fast food, etc. The tax revenue will lower the health care costs and people are motivated for a healthier lifestyle. From an economic point of view we can reimburse costs for the patients receiving treatment according to evidence-based guidelines. Health care providers need to be encouraged to follow these guidelines to treat patients who will actually benefit from these procedures and new technologies.

Catherine Gilbert, Medical Student, University of Michigan

There are two factors

that I think should play a role in who receives health care procedures: urgency, and the likelihood that the procedure will have a lasting, positive impact on quality of life. Assessing and prioritizing these two components will ensure that those who receive the scarce healthcare resources are the patients who require the care the most and can benefit from the care the most.

Taylor Hodge, Medical Student, University of Louisville

As the field of medicine is constantly evolving and innovation drives the field forward, the centrality of the patient-physician relationship remains constant. While costs rise in correlation to advancement, ultimately decisions concerning patient care should remain primarily between doctor and patient. What is considered "best practice" should be better defined and updated more often, and socioeconomic strategies should be discussed more openly. These conversations should involve physicians; society should not dictate who is worthy of receiving sophisticated care. There is no blanket solution to determining the allocation of resources, which is why the conversation should remain in the exam room.

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**Alcina Lidder,
Medical Student,
University of Rochester
School of Medicine**

Allocating complex, expensive treatment should be based on patient need and cost-effectiveness. Patients with the fewest alternative cost-saving therapies and the greatest likelihood of positive outcomes with minimal morbidity should be given priority, especially when the need for intervention is emergent. More expensive treatments should be justified by substantially improving quality of life or by saving future expenses. The risks and benefits of evidence-based options should be reviewed to select the most appropriate treatment given the cost. This method of distribution will minimize health care expenses, maximize patient outcomes, and improve quality of life.

**Mansi Shah, General Surgery
Resident, UNC Chapel Hill**

Studies show that the main negative impact of reporting surgical outcomes is avoidance of high-risk patients. This is unlikely to impact cardiothoracic education. As more research is performed, physicians are becoming aware of this potential avoidance. With awareness, there will hopefully be efforts to risk adjust reporting of outcomes to improve the issue. Also, given the volume of cases

at most cardiothoracic programs, the education will still be broad, even if a small percentage of high-risk patients are treated non-operatively. Hopefully with continued improvement towards risk-stratification, public reporting of surgical outcomes will improve surgical results without any negative impact.

**Joyce Loh, Medical Student,
University of Michigan**

Allocation decisions should prioritize cost and benefits while still promoting equity. The cost effectiveness of health care can be partially measured with metrics such as quality-adjusted life years but should also take into account costs and benefits that are not financial in nature. To help promote justice, clear and transparent criteria on the decision process for allocating resources should be used and stakeholders and affected parties should have an opportunity to provide input. Resource allocation processes and priorities should also be continually re-evaluated to reflect changing values and new technological advances.

**Jessica Luc, Medical
Student, University of Alberta**

Health care systems face an increasing demand for expensive health care services in terms of limited financial resources. Fair allocation of resources should be

based on the principles (1) that each individual's life is equally valuable; (2) patient autonomy should be respected; (3) patient welfare should be enhanced; (4) access to care and consideration for eligibility for procedures should be available for all; (5) treatment should be based on likelihood for benefit and evidence-based-medicine; (6) the duty of health care providers to treat an individual patient has limits when doing so unfairly compromises the availability of resources needed by others.

**Natalja Rosculet,
Medical Student,
University of Michigan**

No matter how extensively we "reform" the American healthcare system, allocation will remain a problem. Basic economic principles cannot be blindly applied to healthcare decisions; human lives cannot be weighed appropriately using cost versus benefit models. As evidenced by the shockingly callous comments issued by the "God Committee" tasked with selecting dialysis recipients in the 1960s, no physician or task force is equipped, emotionally or ethically, to bear such responsibilities. Allocation of healthcare resources must be based on objective, uniform criteria that are consistently reviewed and revised to match the

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pace of innovations and changes occurring within the healthcare system.

Emily Tibbits, General Surgery Resident, University of California - Davis

Healthcare is based on exchange of goods and services. A wealthy few

will always seek expensive new services. Instead of shifting the paradigm of capitalism, we need to work within our means. Asking how to distribute million-dollar treatments to a hundred people is the wrong question. Instead, we should ask how to develop ten-dollar treatments to

distribute to the billions. As a society, we must incentivize development of affordable therapeutic options to increase availability without compromising standards of care. As surgeons, we need to help empower visionaries to develop sustainable equipment solutions to make our services more accessible.



Getting to Know You – Dr. Kristine Guleserian

By: Julia Swanson, MD



Dr. Kristine Guleserian

When first asked to write this piece for the *Oracle*, I jumped at the chance to get to know Dr. Kristine Guleserian – a congenital heart surgeon who I have admired for years. I was a bit intimidated by her impressive CV, but when we spoke on the phone, she put me at ease and was eager to share the adventures she has had in her illustrious career and the lessons she has learned along the way.

Dr. G, as she is known to her patients at Children's Medical Center in Dallas, is the Surgical Director of Pediatric Heart Transplantation and Adult Congenital Heart Surgery, and Associate Professor of Cardiothoracic Surgery at the University of Texas Southwestern Medical Center. I got a bit of insight into her life by watching *Children's Med Dallas*, a documentary series that films the lives of physicians

and their patients. The show highlighted one of Dr. G's patients from presentation with a failing Glenn through Berlin Heart implantation and, ultimately, to successful transplantation allowing her to return home to her family's ranch in Central Texas.

Dr. G may be from Boston but she is clearly passionate about the care of our littlest Texans. Dr. G is the daughter of first-generation Armenian-American parents; the Guleserian family owns the Sheraton Commander Hotel in Cambridge, MA currently run by her brother Michael and where she lived until she was 8 years old. Although her career path led her away from Boston, she remains extremely close to her family, speaking to them daily. As a little girl she always knew she wanted to become a physician but also considered becoming an Olympic figure skater or Hollywood actress. Perhaps somewhat telling is the Guleserian family's photo of Kris "examining" her father Edward while her little brother watches. She was undoubtedly headed for a career in congenital heart surgery—confident by her exam that

her father had dextrocardia. Kris' brother Michael was born with Tetralogy of Fallot, and she remembers his "Tet spells" during their childhood. She accompanied her mother to appointments with world-renowned pediatrician Dr. T Berry Brazelton and pediatric cardiologist Dr. Donald Fyler. She remembers his hospital stays after his Blalock-Taussig shunt and, four years later, following his full tetralogy repair. One of her future mentors, Dr. Aldo Castaneda and his fellow at the time, Dr. William Norwood, performed the repair. Kris played in the halls of Boston Children's Hospital, where, years later, she would return to complete her Congenital Heart Surgery training. She again visited those same halls, back in the role of sister, when Michael returned for his pulmonary valve replacement in 2015.

She attended The Winsor School, an 'all-girls' independent school in Boston. While in high school

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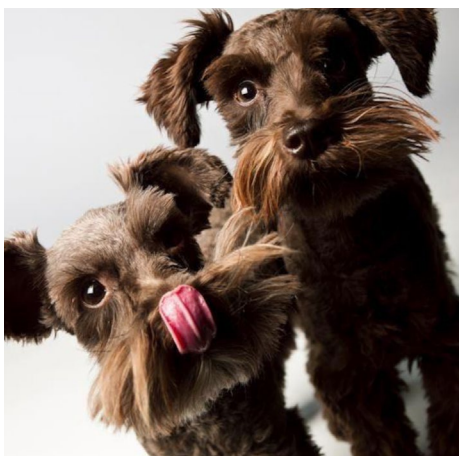
Dr. G. with her father Edward and brother Micheal

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she listened to Olympic Gold figure skater, general surgeon and Winsor alumna Dr. Tenley Albright, give a talk about her career; this was perhaps the first time Kris realized that women could be surgeons.

Kristine attended Harvard for college. After finishing her first semester and returning home for the holiday break, she was met by a letter from Harvard informing her that her college admission had been an unfortunate mistake and that she would not be allowed to continue with her studies there. After painstakingly informing her family during what was a very unsettled weekend, her Dad, a prankster, let her in on the joke. He had written the letter and passed it off as official Harvard communication.

Dr. G remembers her late father fondly. Not only a prankster, he was a loving father and "grandfather" to her two chocolate miniature schnauzers (Gigi and Gus,) who summered on the shore with her parents in Scituate, Massachusetts to avoid the



Gigi and Gus

Dallas heat. Her Dad was an avid Red Sox fan; a love that he passed on to his daughter. Their family has season tickets to the Red Sox right behind home plate. When Dr. G returns home to Boston to visit her family she always finds time to make a trip to Fenway.

At Harvard, she concentrated in Greek Classics, despite being told by her physician career advisor that she would never be accepted into medical school with that choice. She was undeterred. Dr. G feels strongly that one should understand fundamentals. Noting that "Bios" and "Logos" mean life and the study of, thus "biology," the study of life, she points out the relevance of her major. She feels strongly today that her Greek Classics education gave her the underpinnings for her ultimate career in medicine.

Dr. G obtained her medical degree from Boston University where during one of her outside surgical rotations she met one of the surgeons who would become the key mentor and influence for her ultimate career. She made an appointment with Dr. Aldo Castaneda, Chief of Cardiovascular Surgery at Children's Hospital Boston, who recalled meeting her when he operated on her brother and remembered that as a child she had loved figure skating and drawing. Dr. Castaneda remained a mentor to Kris as she navigated her way

through training.

She completed her general surgery residency at Brown University, where she loved all surgical subspecialties. The life-and-death aspects Trauma Surgery appealed to her and she was always prepared for an ED thoracotomy. She recalls one 13-year-old boy who was stabbed in the chest by another teen in hopes of "winning the girl." With ongoing CPR she opened the boy's chest encountering a right ventricular laceration. With no cardiac surgical instruments available, Dr. G put a Foley catheter through the laceration stemming the bleeding long enough to get him to the OR. He survived, and, when she rounded on the wards, he looked at her and asked, "Nurse, will you pass me my puke bucket?" Upon graduation she received the Outstanding Chief Resident Award and perhaps most fittingly the "Energizer Bunny" award in honor of her tireless work ethic.

She was not able to take time during her surgical training for research due to a lack of manpower during her residency; so, she chose to follow her interest in cardiovascular tissue engineering and its potential for growing heart valves after completing her Chief year. She returned to Boston and joined Dr. John Mayer's lab, where she earned an impressive \$25,000 salary

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and had the opportunity to live at home to offset her living expenses.

Not having made strong contacts in cardiac surgery during residency, she worried that she would not be competitive for CT Surgery Residencies and, thus, applied all over the country. Perhaps surprising only to her, she was offered 22 interviews. She took full advantage of this opportunity. She traveled around the US and met many of the Thoracic Surgery giants. She ultimately matched at Washington University in St Louis, Missouri. Not only did this mean leaving New England — this was a National League city! When asked whether she experienced culture shock leaving Boston for the Midwest, her answer was an unequivocal “Yes!” She recalls the first time she and her mother Nancy arrived in the city. “We went grocery shopping together and my mother walked around the store saying ‘Look honey, they have all the same types of fruits and vegetables we have back in Boston.’”

At Washington University, Dr. G met another key surgical mentor, Dr. Alec Patterson, whose influence nearly converted her into a general thoracic surgeon. She started off on his service and, for the first two weeks, while her senior fellow was on paternity leave, Dr. G took full advantage, logging all of her ABTS esophageal numbers,

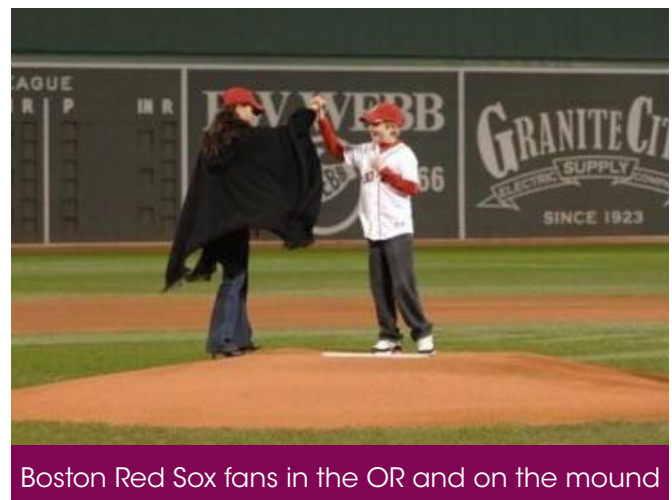
completing multiple major lung resections, and four double lung transplants. When she returned from one lung procurement Dr. Patterson asked whether she would like to stay to sew in the lungs. She didn’t hesitate. Forgetting her OR clogs at home she spent the next 6 hours at the OR table in 4-inch Prada heels, remarking afterward that, “If you can’t operate in heels, you can’t operate.” Dr. Chuck Huddleston, another key mentor, took her under his wing, aware of her interest in congenital heart surgery and helped her with her first Blalock-Taussig shunt.

After two years away from Boston, Dr. G returned to Boston Children’s to complete her Congenital Cardiac Surgery fellowship. During her training, she made a point to study the fundamentals from the extensive preserved heart collection in the basement at Harvard’s Cardiac Registry. She learned about cardiac development and morphology spending endless hours with Drs Stella and Richard Van Praagh. She now is a passionate member of the International Society for Nomenclature of Pediatric and Congenital Heart Disease.

She completed her Congenital

training at a time when jobs were scarce, but found a spot for herself at UT Southwestern Medical Center in Dallas, where she has been on the faculty for over a decade, building and leading the Pediatric Heart Transplant and Adult Congenital Heart Surgery Programs. She is one of the few women inducted into the American Association for Thoracic Surgery and Congenital Heart Surgeons’ Society.

One of the best stories I learned about Dr. G while getting to know her is perhaps the most telling about who she really is. Late in the summer of 2007, Dr. G met a 13-year-old boy with end-stage heart failure secondary to idiopathic cardiomyopathy. Prior to his rapid decline, he played baseball in rural Midland/Odessa Texas. He then found himself in Dallas, meeting with Dr. G and learning that he would need a heart transplant. It turned out that he was a huge Red Sox fan, as of course is Dr. G. As

Continued...

Boston Red Sox fans in the OR and on the mound



Deep sea fishing with brother Michael and enjoying the French Riviera

Continued...

they waited for a heart, they bonded over their passion for Red Sox ball. She gave him a Red Sox hat for good luck one Saturday while making rounds. A donor became available that night, and ironically he would be the 100th heart transplant at Children's Medical Center. This garnered the interest of the local media, who filmed him going to the OR in his Red Sox cap; not only had Dr. G agreed that he could wear the cap to the OR, she was also wearing her own Red Sox scrub cap. She told him it was good karma—something the Red Sox really needed that late in the season. The media learned about their friendship, and an off-hand comment about her one day taking her patient to a Sox game became a promise to go to the World Series together. Three weeks later, against all odds, the Red Sox made it to the World Series against the Colorado Rockies and Dr. G and Andrew Madden ended up on the pitcher's mound

at Fenway Park, with Andrew, powered by his new heart and in front of a cheering crowd of over 35,000 fans, throwing out the first pitch! An incredible story for both patient and surgeon, made even sweeter when the Red Sox went on to win the World Series!

Outside of the OR Dr. G makes time for yoga, tennis, downhill skiing, kite surfing, and deep-sea fishing. She is a self-proclaimed foodie and wine connoisseur – see image of her in Eze on the French Riviera. She lives by the adage that life is not measured by the number of breaths you take, but by the moments that take your breath away.

Finally, though it is hard to imagine that Dr. G, winner of the Energizer Bunny award, sits still long enough to read, when asked for book recommendations, without pausing she answered, "Anything by Malcom Gladwell." Speaking about David and Goliath (Gladwell 2013), she expounded on her interest in learning how

people overcome adversity and take advantage of the opportunities afforded to them. Dr. G certainly has made the very most of every opportunity she has encountered and has become a much beloved surgeon to many families in Dallas and Boston.

Her upcoming book *A Surgeon's Story* is due out in the Fall 2016.



A SURGEON'S STORY

Inside OR-6 with a top Pediatric Heart Surgeon

by **MARK ORISTANO**
with
KRISTINE GULESERIAN, MD

Upcoming book being written
about Dr. G

STS Networking reception 2016



STS Networking reception 2016



STS Networking reception 2016



Elizabeth's Editorial

Innovation is Inherent in All of Us!

By: Elizabeth A David, MD

"Innovation for Life" was the title of Dr. Mark Allen's presidential address at the 52nd Annual Meeting of the STS and it was a theme that was carried throughout the meeting. As we celebrated the 30th Anniversary of the WTS, I was struck by the idea that creative and pioneering women, recognized the need for the WTS, and had the fortitude to start it.

Dr. Kohman set a great example of innovation for all of us to follow.

We can't all start the WTS or develop a surgical procedure that revolutionizes

patient care, but we all can innovate. Innovation includes the application of better solutions that meet new or unarticulated needs. So how does this apply to the WTS? Over the last 30 years we have seen the first women become ABTS certified and become STS and AATS members. We have all been mistaken for any medical professional other than a surgeon and we have all been drastically outnumbered both in and out of the operating room.

The pendulum is beginning to swing. More and more

women are achieving ABTS certification each year and we are seeing dramatic increases in the number of female cardiothoracic residents. We are even experiencing cardiothoracic operating rooms where none of the staff have a Y chromosome! So what do we need to be innovative about?

Despite the successes we are enjoying, women are still underrepresented in cardiothoracic surgery leadership. The leadership challenge is two-pronged. First, we must have

Continued...



The UC Davis General Thoracic Surgery Operating Room filled with women!



Women fill the UT Southwestern Pediatric Cardiac Operating Room!

Continued...

opportunities to lead and perhaps more importantly, we must have candidates who want to lead. It is unlikely that women will ascend the ladder in the "traditional" way because there are very few women on the ladder right now! As WTS members we can be innovative by being aware of both issues and take positive steps to address both.

Keep an eye out for leadership opportunities and recommend and encourage a woman who would suit the position when the opportunity arises. It is important to acknowledge that not every woman is going to want to ascend to

leadership. We all have a lot to juggle in life between our "day job" and home life. We may want to consider ways to share leadership opportunities with other women rather than saying no. We need to continue to innovate – consider creative, "non-traditional" solutions.

We have all had to innovate to arrive where we are in life today. Whether it was to find a creative solution for childcare or dinner preparation when an operative case went long or finding a way to balance extracurricular interests with the demands of cardiothoracic surgery. Generally speaking, women

in today's workplace are faced with this balance dilemma more so than our male counterparts and have proven to be exceptionally creative in arriving solutions. Our profession is no different. Dr. Kohman set a wonderful example of innovation for all of us when she started (the WTS) Look around you; identify areas that can be improved in patient care, hospital processes, and life! Then put your intelligence, creativity, and perseverance to work to come up with an innovative solution that will enhance cardiothoracic surgery for generations to come!

Do you wonder what it is like to be a CT Surgeon? Check out this [candid video](#) featuring some of our family members describing their impressions of our lives! Enjoy!

In case you missed the celebration at STS, please join us at the AATS Annual Meeting:

WTS 30th Anniversary Johns Hopkins Symposium

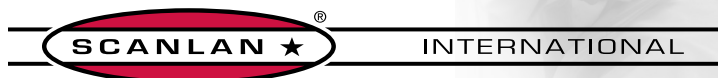
The Center Club (100 Light Street, 16th Floor)
Sunday, May 15, 2016
7:00pm - 9:00pm, ET



Additional information will be posted about the event as soon as it's available at www.wtsnet.org/meetings

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Become a Member of Women in Thoracic Surgery

Women in Thoracic Surgery (WTS) was founded in 1986 with a mission to enhance the quality of medical care given to patients of its members, to mentor young women thoracic surgeons, to enhance the education of patients about heart and lung diseases, and to enhance educational opportunities for women thoracic surgeons.

Today, WTS represents a majority of the more than 200 women who have passed their American Board of Thoracic Surgery exams since 1961.

WTS is making great strides in advancing the cause of women thoracic surgeons. Through our mentoring program we provide one-on-one teaching, support, and encouragement to our junior colleagues, and since 2005 the organization has awarded nearly 50 scholarships to female residents with an interest in thoracic surgery.

WTS has six membership categories for individuals and institutions.

Active Membership

Active Members are women holding their MD or DO degree, or the international equivalent, who have completed specialty training in thoracic surgery and whose primary activity and interest is cardiothoracic surgery.

Candidate Membership

Candidate Members are women enrolled in a general or thoracic surgery residency training program in the United States or Canada, or the international equivalent, or women who, in the course of their secondary and college educations, have expressed an interest in cardiothoracic surgery.

Associate Membership

Associate Members are individuals of all backgrounds, including members of allied health professions, who wish to demonstrate their support and dedication to the WTS mission.

Institutional Membership

WTS Institutional Members are organizations, institutions, or industry entities that wish to demonstrate their support and dedication to WTS by underwriting its mission.

Honorary Membership

Honorary Membership is reserved for those persons deemed worthy of such honor due to their support and dedication to the WTS mission. Honorary members are elected by a majority vote of the membership.

Emeritus Membership

Any Active Member age seventy (70) years or older, or who has retired from employment in the field of cardiothoracic surgery, is eligible for Emeritus Membership.

To become a member, complete the application (see reverse) and send to:

Women in Thoracic Surgery

633 North St. Clair Street, Floor 23

Chicago, IL 60611

Phone: 312-202-5864 • Fax: 773-289-0871

wts@wtsnet.org • www.wtsnet.org

www.wtsnet.org

WTS Membership Application

Name: _____

Institution: _____

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Zip/Postal Code: _____ Country: _____

E-mail: _____ Phone: _____

ADDITIONAL INFORMATION FOR CANDIDATE MEMBERS

Status: Medical Student General Surgery Resident CT Surgery Resident

Anticipated Graduation Date: _____

PLEASE PROVIDE THE FOLLOWING INFORMATION

Type of practice: Academic Private Practice Other

Area of practice (select all that apply): Adult Cardiac Pediatric Cardiac Thoracic Other

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

WTS Membership Outreach WTS Education WTS Scholarships WTS Newsletter WTS Mentoring

DUES PAYMENT INFORMATION (select one)

U.S. Active - \$225 International Active - \$75 Associate - \$225 Institutional - \$750

Candidate - \$25

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

To pay by credit card visit www.wtsnet.org/paydues or complete the bottom portion of this form and return it to WTS via fax (773.289.0871) or e-mail (wts@wtsnet.org)

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If you have questions, contact WTS Headquarters at 312.202.5864 or wts@wtsnet.org.

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