



ORACLE

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

Summer 2019

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WTS ORACLE

Designed and Published by
Scanlan International



President's Corner



**Shanda H. Blackmon,
MD, MPH, FACS, President,
Women in Thoracic Surgery**

It has been a tremendous honor to be the President of WTS for the past year and a half. We have accomplished so much in so little time. Looking back on the past few years, I thought it might be nice to review some of these accomplishments so we can take a moment to pause and be grateful.

Ongoing Growth

There were a record breaking 27 new American Board of Thoracic Surgery-certified women this year. WTS developed a new logo and successfully recruited 106

new members over the past two years.

Success at the STS

We had a very successful session at the Society of Thoracic Surgeons meeting with a [TED Talk-style](#) symposium on gender bias and sexual harassment. We have started to collect areas of interest of women members to develop a list of expertise among women surgeons for circulation among Program Committee Chairs to be mindful of potential women to moderate sessions, give targeted talks, and serve as invited professors to individual institutions.

WTS Going International

WTS has reached out to various regions around the world. A Latin American Thoracic Surgery visiting Fellowship was established, there was a WTS-Brazilian meeting in Belo Horizonte, a WTS-Taiwanese Women in Thoracic Surgery gathering in Taipei, a WTS-European Women in Thoracic Surgery

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meeting in Dublin, Ireland at ESTS (led by Dr. Leah Backhus), WTS gathered on behalf of women in Chennai, India at the ASCVTS, and have a Japanese Women in Thoracic Surgery meeting planned for November.

Growing Support for WTS

At the Women in Thoracic Surgery Membership Meeting and Reception at the 2019 AATS 99th Annual Meeting, I was proud to quote one of our newest Honorary Members, Dr. Ara Vaporciyan, when he said "I am not necessarily a fan of women, I am a fan of talent. Anyone who ignores 50% of the talent pool is doomed to fail." And with that, we were able to induct several new Honorary Members, who happen to be men, who have been unrelenting supporters of women throughout their careers. The men inducted as Honorary Members include Drs. Ara A. Vaporciyan, G. Alexander Patterson, Thomas

K. Varghese, Thomas D'Amico, Robert S.D. Higgins, and Walter H. Merrill. In addition to supporting women, we also recognize the incredible support that WTS has received from multiple industry partners, including Scanlan International, Edwards Lifesciences, Ethicon, Medtronic, and Intuitive.

Learning Through Mentorship and Scholarship

Both Ethicon and Medtronic generously supported our WTS receptions in 2019, and Intuitive offered seven new scholarships for women to train in robotic thoracic surgery. We were also able to establish the Thistlethwaite Scholarship to allow a female thoracic surgery resident to attend the Western Thoracic Surgical Association's (WTSA) Annual Meeting held in June. We also continue to offer the WTS Carpenter Scholarship which allows a female medical student, general surgery resident

or cardiothoracic surgery resident to attend the Southern Thoracic Surgical Association's (STSA) Annual Meeting held in November. Applications will open this summer. In 2013, WTS helped launch the Carolyn E. Reed Traveling Fellowship Award. To date, 12 women have received the fellowship. WTS has helped TSF to raise over \$200,000 for this grant. Carolyn would be so proud. In addition, TSF awarded 28 surgeon awards earlier this year, in the areas of research, education, and surgical outreach grants. Of these 28 awards, 14 were issued to women cardiothoracic surgeons. This is an incredible accomplishment for Women in Thoracic Surgery: 50% of TSF awards were granted to women! Thank you for your contributions to these many successes for Women in Thoracic Surgery. We are making a difference.

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STSA 66th Annual Meeting & Exhibition

Meeting Dates:

November 6th - 9th, 2019

Exhibition Dates:

November 7th - 8th, 2019

JW Marriott Marco Island
Beach Resort
Marco Island, FL

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A Special Thanks

Without our leadership members, we would not have accomplished so much in such a short amount of time. I would like to thank all of the people on the WTS Board of Directors and the membership body who have generously donated their time and coordinated all of the wonderful activities that we now offer. I especially want to recognize Dr. Mara Antonoff who has helped to maintain our social media outreach and website. Also, Dr. Erin Gillaspie for writing the Oracle. Of course, we wouldn't be anywhere without support from STS and Laura Medek, Beth Winer and Rachel Pebworth. We also were very excited to welcome Elaine Weiss, the

new Executive Director of STS, who has already started mentoring many of us.

Looking to the Future

Looking ahead, we look forward to our retreat, which will occur just before the STSA 66th Annual Meeting in Marco Island, Florida in November. This will give us an opportunity to network, have fun, strategize, refine our goals, and renew focus. During that retreat, we will also have a video blog established whereby people can sign up to create a video that will be posted on the WTS website. The goal of this project is to reach out to young women who may be interested in a career in science and discuss the challenges, opportunities,

and develop insight. We look forward to these frank conversations that are both engaging and inspiring.

Closing Remarks

Finally, I would like to invite all women who are interested in a career in cardiothoracic surgery to join us and sign up for mentorship, attend our receptions, and continue to engage so that we can make each other stronger and continue to grow. I am so proud of the work that we've been able to accomplish together. This has been one of the most positive experiences of my entire career, and I am proud to have been able to work with such amazing people.



Interview with Living Legend, Dr. Valerie Rusch



By: Melanie Edwards, MD

Dr. Valerie Rusch was the 21st woman certified by the American Board of Thoracic Surgery and is currently Professor of Surgery at Weill Cornell Medical College and Vice Chair for Clinical Research in the Department of Surgery at Memorial Sloan Kettering where she has practiced and educated scores of thoracic surgeons since 1989. Dr. Rusch is also President-elect of the American College of Surgeons (ACS), having served as Chair of both the Board of Regents and the Board of Governors.

ME: Can you provide some background for how you decided to become a thoracic surgeon and what your motivating factors were, and how you evolved to become who you are today?

VR: Serendipity. You know how some people wake up when they are five years-old and they decide they are going to become a cardiac surgeon

and they become a cardiac surgeon? I can't say I've been remotely as organized. And I do actually think this speaks a little bit to the mentoring issue. Certainly, I came up in the era when there was no mentoring. So anything that's happened to me career-wise has happened because I was interested in doing it, intellectually, and then somehow managed to navigate my way to doing it. And so I really do think that the mentoring issue is a very important one, where there are a lot more opportunities to be mentored now than there were in my era, but it's still perhaps more an issue for women than it is for men. That's at least my subjective impression.

My father was a physician, he was an otolaryngologist in private practice here in New York, and through a number of generations of the family there were other physicians, so there's some family tradition in that regard. However, in the broader extended family, I'm the only one who went into medicine. I have a brother and a sister who do stuff that's completely unrelated to medicine. Because I am part Swiss by family background and went to French School here in New York which really gave me a strong liberal arts background - I've thought about lots of other things in life besides medicine. I don't think it was a decision for

which I was predestined, but ultimately seemed to fit my interests and personality.

Regarding the issue of surgery versus some other specialty, I worked for three summers in hospitals, when I was in college. Two of those summers I worked as an OR tech so I got a lot of exposure of what it was like to be in the operating room before I went to medical school. That's also really interesting; to see what it's like to be an OR tech dealing with surgeons. It was an informative experience: there were some surgeons who were really professional and some surgeons who were the "throw the instruments around the room" type, especially in an era where that was more tolerated than it is today. By the time I got to medical school I had an inclination to consider surgery and I liked the combination of cognitive skills and technical skills coming together.

I did not start out my surgical training with any preconceived notions. In fact, in medical school I thought that neurosurgery was pretty interesting, that is until I did my neurology rotation. Then I thought maybe vascular surgery was interesting. I did two months back-to-back on the surgery service at the VA doing amputations, and that sort of became disenchanting. Speaking to the mentoring aspect, the division chief of CT at the

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University of Washington was someone who had been the cardiac surgery fellow when I was a third-year medical student at Columbia, and he was an excellent clinician, a very engaging person, and very good about clinical mentoring. He persuaded me to consider going into CT surgery at a very late point in time when I was a fourth-year resident. Nothing thrilled me more than the fact that he personally helped me close an ASD as a fourth-year resident. It was a secundum defect, a very simple thing to do, but you know what that feels like when you're a resident and someone helps you do a procedure.



Dr. Valerie Rusch

ME: It's interesting, and I guess this is a good segue when you mention the issue of mentorship. There is a series of articles in *Thoracic Surgery Clinics* published in 2011 on career development, one of which contained advice from leaders to which you contributed. In your section you highlighted some of the points just referenced, and you laid out eight steps in that article with some core, practical advice:

1. Select an academic focus.
2. Acquire the correct skills to pursue your academic focus, even if this requires some retooling after the end of clinical training.
3. Become a world's expert by studying your chosen

academic topic to an unparalleled degree.

4. Build the correct infrastructure for your research because you cannot do it all yourself.
5. Develop collegial and productive collaborations.
6. Seek mentors.
7. Carefully guard your most precious commodity: time.
8. Develop a 5-year plan.¹

ME: Is there anything that you think has changed now versus 10 or maybe even 30 years ago? Do you think it may be more challenging or easier for young surgeons

and women who seek to progress through surgery and academic surgery?

VR: Well, I think that in general whether you're male or female the pressure to produce clinically has steadily increased and that really puts all of us, but especially surgeons starting their practice, in a very difficult position. When I was what we call the service chief, but is a division chief here, I decided to recruit a faculty member whom I really wanted to be predominantly a laboratory investigator at 75% translational research and 25% clinical. I absolutely insisted that he have only one OR block day and one half-day clinic. In his first two

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years, even though he fully understood the importance of growing his lab effort to the point where he could become an independent funded investigator, he was in my office frequently complaining about clinical volume. And I said, "I don't want you doing more than 170 cases per year, period." I've got all these other faculty members who can crank out cases in a very expert manner. Now he's at the professor level still working here, and he gets it. But I felt it was my personal obligation to make that happen and to take any heat that I might get about this, and not have him get that heat. But that almost never happens.

I think that young faculty members often get conflicting messages to develop a busy clinical practice, and be a sterling educator, and get a funded lab effort, and produce all these fantastic papers but there are not enough hours in the day. And hospital administrations do not recognize that there is an importance and a richness to having a blended faculty. I think they are beginning to recognize it a little bit and are seeing more the importance of having surgeon educators. The translational science and the basic science are fading because investigators do not have enough mentoring and time and structure to do it right. And so I think that is a universal problem and it is even worse than it was when I started out.

I do think that there continues to be a mentoring issue that's specific to women. And that younger women have an idea that they can do it all, that they can be Wonder Woman who has three kids at home and they have a career and they're climbing the academic ladder and they have a busy clinical practice, and that actually isn't right either. I was just reading on our ACS community online forum and a number of women leaders were talking about these issues and also identifying programs around the country or employment environments that create good structure for women. And I thought to myself "how many times do women surgeons get paid maternity leave?" I was just looking at the *New York Times* about the paternity leave suit that got settled at JP Morgan that is going to accord parent's paternity or maternity leave to an equal degree, and that's unique.

I've watched other women faculty members struggle [through this problem]. I don't have kids. I knew that in my era that if you thought you were going to have children it was not going to all be possible, so you'd better make that decision up front. But for younger women who want to have a life, and have a family, it is not yet being made possible, and I do think that needs to change. It really needs to change. Having an explicit approach to time off, and paid maternity/paternity leave is something that

needs to be dealt with and eliminating compensation disparities needs to go away too. Those still exist and I've encountered that problem.

So I think, two things: one is the expectations for clinical productivity that are universal across genders and the second is, for women this sometimes unspoken expectation that they can and should do everything without having the infrastructure that makes it possible.

ME: As incoming American College of Surgeons President, what priorities are you planning to champion and can you speak to the importance of the ACS for cardiothoracic surgeons?

VR: Well, let me start with the latter. The ACS plays a very important role because it crosses surgical specialties. The late Tom Russell always used to talk about "the house of surgery," and I do think that's a phrase that represents it very well. As we all get into our subspecialty silos, there are overarching issues in the world of surgery that relate to many different aspects of what we do every day: quality of patient care, healthcare policy and advocacy, dealing with underserved populations, either nationally or internationally, educational needs that go across the specialties, such as, leadership courses, education courses, simulation courses. So, there are cross-

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specialty needs that the College meets especially well because of the structure and resources.

A great deal relating to surgical quality of care is done by the College, and a lot that we do every day could not happen without that backbone. For instance, staging of cancers is done by the AJCC through the Commission on Cancer housed by the ACS. Trauma centers are verified by the ACS, as is the quality of pediatric surgery. The ACS verifies cancer centers and places the "Good Housekeeping" stamp of approval on 1500 programs nationally and internationally. All of those things affect what all of us do in all specialties every day. The ACS has the largest and most robust healthcare policy and advocacy office that interfaces with all the other healthcare policy advocacy specialty focused offices in Washington, D.C. That is not to the exclusion of what many of the big specialty societies do. It is a very important part of the "house of surgery." More recently, the ACS has been dealing with issues of firearm injury protection affecting anyone who knows someone who has been involved in a mass shooting. So, the portfolio of the College is vast. While each President who comes along has maybe some aspect of what they are interested in, it is a one-year position, and my real job is to represent the interests of

the College nationally and internationally in all of these areas. I have a personal interest in underserved populations, and particularly in what the College can do internationally. L.D. Britt, when he was president, focused on the underserved populations nationally as an African-American leader and has an NIH-funded grant funded through the College studying how we can address those problems. That's a personal interest, but that's not really my main mission. These are the reasons that specialty surgeons should remain interested and active in the College.

ME: I'd like to switch gears and ask you about your former trainees. What are the things that they take away from their time with you and are there any phrases or "isms" that echo over and over in their heads?

VR: Gosh, I don't know, you'd have to ask them. In patient care I think it's a level of personal responsibility and a meticulousness in terms of both perioperative care which is really important to what I do where in general thoracic we do an enormous amount of longitudinal care, and we are personally responsible for the correct selection of patients for surgery and the preoperative evaluation. So, I think the meticulousness in terms of perioperative management, meticulousness in the operating room, I think I'm

kind of known for being finicky about those things, annoyingly finicky (laughs).

ME: In the shifts toward more minimally invasive surgery, you've stayed on top of new technology where some of your contemporaries may have left this to their younger colleagues to take on, say, robotic surgery for example. What motivates you to stay engaged with these changes and continual learning?

VR: Avoiding boredom. I think that's one of the things that's most interesting about medicine in general, and surgery in particular, is that we have a constantly and rapidly evolving body of cognitive knowledge, and a constantly evolving technology in CT surgery. One of great opportunities is that you're not going to wind up doing the same thing 30 years later that you were doing in residency. And I would say only a small fraction of what I do today bears any relationship to what I was taught as a resident, both technically in the operating room, and also in terms of cognitive knowledge. It's a completely different ballgame than it was in the 1980's.

Now it is painful to acquire new skillsets, and there's a distinction between what I call incremental skills versus paradigm-shifting skills. In cardiac, the analogy would be catheter-based skills, those are paradigm-shifting. And in general

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thoracic, two things have been paradigm-shifting; first was the introduction of VATS anatomic lung resections in the 1990s. It took the specialty more or less a decade for that to filter into practice and become a routine part of what we do and to recognize that we could achieve the same oncologic outcomes for patients. And then the second one is robotic resections, some are lung, mediastinal and esophageal etc. The incremental things are things like laser bronchoscopy, and endobronchial ultrasound. There are smaller steps that do not require the acquisition of an entire skillset.

But all of these things, I think are tools. Robotics gets treated as a new discipline when in fact it's a tool just like catheter-based therapy is a tool. So, to me, this is part of the continuum of lifelong learning. And if you dedicate yourself to lifelong learning, you recognize that is part of, not only of the responsibility, but the pleasure of being in the world of surgery. Then it's no big deal, and it's an obligation to our patients. I conversely believe that we have an obligation not to just adopt the next fancy interesting tool, but to adopt it thoughtfully and responsibly. Part of adopting new technology responsibly is to figure out how to do it well and who can benefit from it. For instance, I don't do robotic esophagectomies, but 90% of what I do in the lung and mediastinum, I do

robotically. I don't do robotic esophagectomy because my personal anastomotic leak rate for open procedures is <1%. And if I can't offer patients a better result, then I'm not going to do it. What gets lost in the discussion on minimally invasive esophagectomy (MIE) is that if you do an MIE and have an anastomotic complication such as a leak, stricture or both, it doesn't matter what the size of the incisions are. We have a responsibility to talk about outcomes and not to worry about whether it's a great new technology.

ME: What are some things that are not widely known about you that you think our readers might find interesting? I know you're fluent in French, for example, and enjoy the ballet.

VR: (laughing) Well, I like to garden too.

ME: In New York City? Wow!

VR: I live in a building that has a landmark building in front and a high-rise in back and a garden in between the two and I'm one of the individuals that maintains the gardens.

ME: In closing, are you optimistic for the future of our specialty? Where do you see us heading in the future and what are you excited about?

VR: Oh absolutely. I think it's a much more exciting time to be starting your

career in cardiothoracic surgery than when I started. And the reasons for that are new knowledge and new technology, to come back to two themes. Our ability to understand the basis of disease, whether cardiovascular disease or what I do in oncology is transforming at an unbelievable rate. The opportunities for research and changes in clinical care are absolutely enormous, and if you embrace that as the broader portfolio in the specialty, it's a very exciting time to be involved in CT surgery. I would say that while I think it's really important, I don't see as many women per se going down the path of doing original, important research and I think that's because they get lost in competing agendas and don't get mentoring. And that is something that we need to promote more and not lose sight of. And I say that as someone who if I had to redo my career, I'd go back and become a translational scientist academically, as opposed to what I've done. I think there are great opportunities academically and clinically.

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ASK WTS: Let's Talk Books!

Summer is here and it's time to take a break and do some reading for FUN. Here are some of the books the Women of Thoracic Surgery members and friends have been enjoying lately!!



Erin Gillaspie

I am a bit of a bibliophile and love to try different genres and topics. Two great books I have read recently are *Educated: A Memoir* by Tara Westover and *Where the Crawdads Sing* by Delia Owens. This weekend I started *The Woman's Hour: The Great Fight to Win the Vote* by Elaine Weiss.



Joan Delto

The Seat of the Soul by Gary Zukav. This book was published in 1989 but has been a great inspiration for so many, including Oprah Winfrey!



Monisha Sudarshan

Factfulness by Hans Rosling and *The Order of Time* by Carlo Rovelli.



Shanda Blackmon

Servant Leadership Characteristics in Organizational Life by Don DeGraaf, Colin Tilley and Larry Neal.



Elizabeth Stephens

Becoming by Michelle Obama and *Alexander Hamilton* by Ron Chernov.



Vika Maslova

The Orphan Master's Son by Adam Johnson.

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Some Popular Reads for Book Clubs:

Hello Sunshine Bookclub (Reese Witherspoon)

The Cactus by Sarah Haywood

The Unlikely Adventures of the Shergill Sisters by Balli Kaur Jaswal

Parnassus Book Club

(Ann Patchett – author and book store owner)

The Tattooist of Auschwitz by Heather Morris

Walking on the Ceiling by Aysegul Savas

I Miss you When I Blink by Mary Laura Philpott

A few more book club favorites and New York Times Bestsellers:

The Clockmaker's Daughter by Kate Morton

Eleanor Oliphant is Completely Fine by Gail Honeyman

The Guernsey Literary and Potato Peel Pie Society: A Novel by Mary Ann Shaffer

Normal People by Sally Rooney

Ask Again Yes by Mary Beth Keane

How to Do Nothing: Resisting the Attention Economy by Jenny Odell



Lessons Learned (the hard way) From Infertility

By: DPC

We have all had bad days. I mean, after general surgery and cardiothoracic surgery residency, we have all had bad days for one reason or another (unexpected patient outcome, difficult operations, shark bite from a senior). But we like to consider ourselves resilient, and there are few days that were so bad that one would do anything not to relive it. Mine was October 15, 2011; it was my brother's 40th birthday. But instead of celebrating it with him, I was an inpatient in Labor Delivery... in very early preterm labor... at

23 weeks, 4 days... after 11 weeks of bed rest... after six months officially (1.5 years unofficially) of trying to get pregnant, one cycle of injections/intrauterine insemination (IUI) and one fresh cycle of in vitro fertilization (IVF). And all I could think was "please don't let me ruin this day for my brother." The contractions subsided (for some unknown reason) after an epidural was placed and I did not go back into labor until the next day. The sanctity of my brother's birthday was saved, but our twins were not... at 23 weeks, five days. Baby A could not be saved, and after the stress

of deciding whether or not to medically delay the delivery of Baby B (putting me at risk of sepsis and both of our lives at risk) the decision was made for us (despite the massive doses of magnesium that made me uncontrollably and incessantly vomit). My water broke and Baby B was delivered. They both had heartbeats; and I counted at least 2 breaths from Baby B (a girl).

I mention all of these details not to make reading (and writing) this story excruciatingly painful, but because anyone who has remotely been through infertility knows exactly

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the significance of the details I brought up. One year is typically how long people wait before they seek assistance from a reproductive endocrinology & infertility (REI) specialist; after six months is the recommendation for couples of advanced maternal age. Twenty-four weeks marks viability for a fetus, which means I was put on bed rest upon completion of the first trimester (when most pregnant women feel as though they are “in the clear”). And female fetuses tend to have slightly faster pulmonary development than male fetuses.

And I consider myself one of the fortunate ones. I was part of the 36% who got pregnant during the first cycle of IVF. I was part of the 45% whose frozen embryos survived and delivered healthy boy/girl twins 364 days later (that is, after much deliberation, a transabdominal cerclage, progesterone injections through the end of 2nd trimester, preeclampsia and more bed rest). Our twins are now six years old and we had an unexpected, natural

pregnancy (child is now five). Countless friends have experienced far worse (11 cycles of IVF, placenta previa with massive hemorrhage at delivery, every pregnancy complication in the textbook in the same friend), and a few were unable to conceive at all. While I now, thankfully, feel far removed from that experience, below are a few lessons that I learned. I hope that in sharing my experiences it will make yours more bearable. There are many of us going through the same thing.

1. It is always a good time to have children.

We usually hear the opposite (it is never a good time to have children), but I couldn't disagree more with that common saying. One of my attendings told me that “it is always a good time to have children” right after I got married and was knee-deep in CT residency. And now I understand what he means. Creating life is such a privilege. Those who wait and have

difficulty (from infertility to pregnancy complications) regret the wait. I have never met someone who started early complain about it. The rest (child care, finances, etc.) will figure itself out.

2. IVF happens.

Or at least requiring assisted reproductive technology (ART) happens. Data has shown that female physicians, surgeons in particular, have a higher rate of requiring fertility treatment than national average.^{1,2} This higher rate is a result of multiple factors (delay in child bearing due to extended education/training; high stress demands of the profession; a suboptimal nutritional state). Don't be weary of seeking assistance, and seek it earlier (six months) rather than later. Finally, it is about the statistics so do your research. ART success is all about the clinic (or, more importantly, the fertility lab) you choose. www.sart.org is your new best friend.

3. Pregnancy complications happen.

We typically have delayed childbearing and we have high stress lives. It has been demonstrated that pregnant residents are more likely to have hypertensive disorders of pregnancy, intrauterine growth restriction, placental abruption, and miscarriages than a cohort of pregnant women of similar age. Longer operating hours and having more than six nights on call per month are associated with obstetrical complications.³

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Take care of yourself during your pregnancy. Find a maternal fetal medicine (MFM) specialist. Nothing matters more than your and baby's(ies') health during those (ideally) 40 weeks.

4. Remember that infertility affects your partner, too.

Whether or not your partner is contributing to the medical reasons for the infertility, s/he experiences the emotional roller coaster that accompanies infertility as well. And, trust me, no partner enjoys "timed intimacy."

5. Do not underestimate the emotional toll infertility takes on you.

Surgeons are not used to feeling helpless or out of control. We are terrible at it, in fact. Find a network of support; people who have gone through or are going through ART, or simply unconditional friends. There will be many periods of waiting with anxiety, and plenty of disappointments. Have loved ones on speed dial. Cry if you need the emotional release.

6. Be a patient, not a doctor, and avoid the blogs.

The Internet, in particular blogs, is not screened for the accuracy of the information provided. Be weary of what you read. Often the blogs will be filled with horror stories

8. Remember that it will be okay.

Easy for me to say-I had my "happy ending," right? Nothing about my ending was easy; but all bad things must come to an end. We are resilient. Whatever the ending is,

that increase anxiety. Find physicians (REI, MFM) whom you trust implicitly and let them guide your decisions.

7. Be patient.

ART does not work with our surgeons' (impatient) timelines. While you are planning on starting injections, egg retrieval, and implantation next month the REI is thinking about having you on OCPs for three months, then maybe starting a cycle, then freezing the embryos and implantation only in six months at the earliest. The process takes a lot longer than you think. Find ways to be okay with a slower timeline-the anxiety and stress otherwise will only impair success (so they say).

you will find a way to be okay.

And, guess what? I have the coolest photo of my twins as day three embryos. I will cherish that photo (and their Petri dish, which I also have) for life!

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Brigid Scanlan-Eiyneck Memorial Traveling Mentorship Award



Jennifer C. Romano, MD, MS

Associate Professor of Cardiac Surgery & Pediatrics
Associate Director, Pediatric Cardiothoracic ICU
Program Director, Congenital Cardiac Surgery Fellowship
University of Michigan C.S. Mott Children's Hospital



Stephanie Nguyen

4th Year Medical Student
University of Texas Health Science Center at Houston
Class of 2019

Unstoppable

This perfectly sums up pediatric cardiothoracic surgeon, Dr. Jennifer Romano. Not only is she an incredibly talented surgeon who makes operating on walnut-sized hearts look easy, but is also a skilled intensivist who leads a multidisciplinary team to provide the best patient care and outcomes. She has a vibrant energy that fills the room and brings out the very best in those around her. Dr. Romano is one-of-a-kind and truly is unstoppable.

As an Aussie and Texas transplant, my only experience with snow has

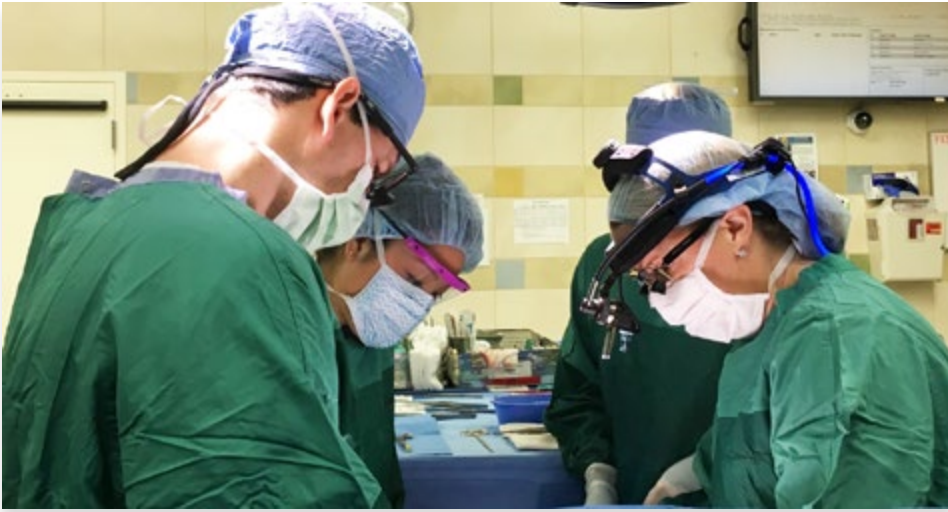
been watching the Winter Olympic Games on television. Needless to say, Ann Arbor in February was life-changing. Each morning began the same way: trudging through the snow to the Pediatric Cardiothoracic Unit to review chest x-rays, followed by echo or ICU conference with the pediatric cardiology fellows. Attending these conferences vastly improved my fund of knowledge in echo interpretation and pathophysiology of complex congenital heart disease.

On the other hand, Dr. Romano's OR schedule was

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Jennifer C. Romano, MD, MS



Assisting Dr. Romano on a Norwood procedure for a patient with hypoplastic left heart syndrome

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far from routine. She often had multiple cases a day, ranging from simple ASD closures to the most complex neonatal repairs, some of which had been deemed inoperable. During surgery, she always made sure I had an excellent view of the field and provided commentary on the anatomy, physiology, and procedural steps. I observed a wide variety of procedures, including the Norwood/Hybrid palliation, Bidirectional Glenn, Hemi-Fontan, Arterial Switch, AV Canal repair, Tetralogy of Fallot repair, PDA ligation, balloon atrial septostomy, open/percutaneous valve replacement, VAD placement, and heart transplantation. My most memorable case was a truncus arteriosus repair in which Dr. Romano performed an aortic valve and root replacement, unifocalization, RV-PA conduit, and VSD closure. I watched on in awe as she made one anastomosis after the other; each stitch millimeter perfect,

each hand constantly moving in purposeful synchrony. It became very clear why Dr. Romano is considered one of the best technical surgeons in the country.

Outside of the OR, Dr. Romano possesses a quiet confidence and humility. She leads by example, fueled by a contagious energy and enthusiasm that is loved by all. She is genuine, down to earth, and has a witty sense of humor that makes her so much fun to be around. When introducing myself as a student rotating with Dr. Romano, I would receive the same response from people who have known her for more than a decade: "You are working with the best...you've got big shoes to fill." Thus, it has been an absolute privilege to learn from her.

Dr. Romano also provided invaluable mentorship and went out of her way to ensure that I had the best clinical experience. She introduced me to her colleagues in the Congenital Heart Center, enabling me to spend time learning in the catheterization lab, echo lab, ICU, cardiology clinic, and on the cardiac anesthesia, heart failure, and pulmonary hypertension services. I also had the privilege of scrubbing cases with her partners, two of whom had trained Dr. Romano when she was a congenital fellow at the University of Michigan. Overall, my diverse experience opened my eyes to the multidisciplinary team effort required in the management of congenital heart disease and helped me to build many friendships and future career connections.

Continued...



Pictured with Dr. Romano, a wonderful inspiration and role model

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As an aspiring pediatric cardiothoracic surgeon, I realize that it is without a doubt one of the most challenging and demanding specialties in medicine; the hours are long, the highs are high, while the lows are heartbreakingly low. Nonetheless, through her relentless work ethic, passion, and selflessness, Dr. Romano transforms the lives of her patients and families on a daily basis. What keeps her going? Receiving holiday photos of healthy, chunky kids who were once fighting for life in the hospital – that's her 'why'. I left C.S. Mott Children's Hospital feeling inspired and extremely fortunate to have a new friend, mentor,

and role model in the unstoppable, Dr. Jennifer Romano.

I am sincerely grateful for this opportunity and would like to thank the Scanlan family, Women in Thoracic Surgery, and the wonderful faculty and staff at the Congenital Heart Center at C.S. Mott Children's Hospital for an unforgettable experience. A very special thank you to Dr. Edward Bove, Dr. Richard Ohye, Dr. Ming-Sing Si, Dr. Peter Sassalos, Dr. Greg Ensing, Dr. Mary K. Olive, Dr. Kim Watkins, Dr. Rob Sorabella, Dr. Jiyong Moon,



With the friendly and hilarious Mott OR staff

the OR team, Linsay Gardner, and of course, Dr. Jennifer Romano. I will greatly miss my Michigan family and the snow!

The WTS would like to thank its Institutional Members for their support:

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

WTS Scholarship Opportunities

The WTS Carpenter Scholarship

We just completed another exciting application process for the 2019 Carpenter Scholarship. This award named for Dr. AJ Carpenter, the 63rd president of the Southern Thoracic Surgical Association (STSA), a national leader in education and a tremendous mentor to a growing cohort of young surgeons nationwide. The award allows young women in medical school or surgical training interested in cardiothoracic surgery the opportunity to attend the STSA Annual Meeting and be mentored throughout.



The Carolyn E. Reed Traveling Fellowship

Applications are now being accepted for the Carolyn E. Reed Traveling Fellowship. The scholarship was established to honor Dr. Reed's innumerable contributions to our field, the lives of patients and the lives of all who knew her. The annual award allows a clinically established woman thoracic surgeon to travel to another institution for the purpose of learning a new skill or technology. [Click here](#) for additional information.

WTS-Intuitive Robotic Fellowship

The Women in Thoracic Surgery (WTS) and Intuitive Surgical Inc. have partnered to create a unique opportunity in advanced robotic training for a female thoracic surgeon by a female thoracic surgeon. The overarching goals are to establish a mentoring relationship for a new female robotic surgeon and assist her in successfully launching her robotic surgical practice. WTS encourages both recent graduates and established surgeons to consider this exceptional opportunity to enrich their surgical skill set. [Click here](#) for additional information about this scholarship. *Congratulations to all those who applied!*



INTUITIVE.



WTS Brigid Scanlan Traveling Mentorship Award

The WTS Brigid Scanlan Traveling Mentorship Award is made possible by Scanlan International, Inc. and provides support for medical students and general surgery residents to gain exposure to women cardiothoracic surgeon mentors by visiting a WTS member for an elective period. Awards include \$2,500 towards travel-related expenses including room and board for the designated travel elective. [Click here](#) for additional information about this scholarship.

Good luck to all applicants and congratulations to all our past Recipients!



2016 Recipient, Dr. Kyla Joubert
with Brigid Scanlan Eynck

WTS Thistlethwaite Scholarship

This award named for Dr. Patricia Thistlethwaite, 43rd President of the Western Thoracic Surgical Association (WTS) and former leader with Women in Thoracic Surgery (WTS). Dr. Thistlethwaite is a nationally-recognized cardiothoracic surgeon who conducts clinical research and has led major national trials to treat lung cancer. In addition, Dr. Thistlethwaite plays a significant role in training future cardiothoracic surgeons. This award was conceived to allow young women in medical school, surgical training and women postdoctoral candidates in a research or other gap year who have graduated medical school who are committed to cardiothoracic surgery the opportunity to attend the WTS Annual Meeting, and to be mentored throughout the meeting by a WTS/WTS member. [Click here](#) for additional information about this scholarship.



AATS Congrats!

Mara Antonoff - University of Texas MD Anderson Cancer Center

Leah Backhus - Stanford University

Sandhya Balaram - Mount Sinai St. Luke's

Elizabeth David - University of Southern California

Carolyn Dresler - FDA

Stephanie Fuller - University of Pennsylvania

Camille Hancock-Friesen - University of Texas Southwestern

Cynthia Herrington - University of Southern California

Teresa Kieser - Libin Cardiovascular Institute of Alberta

Linda Martin - University of Virginia

Stephanie Mick - Cleveland Clinic

Rita Milewski - University of Pennsylvania

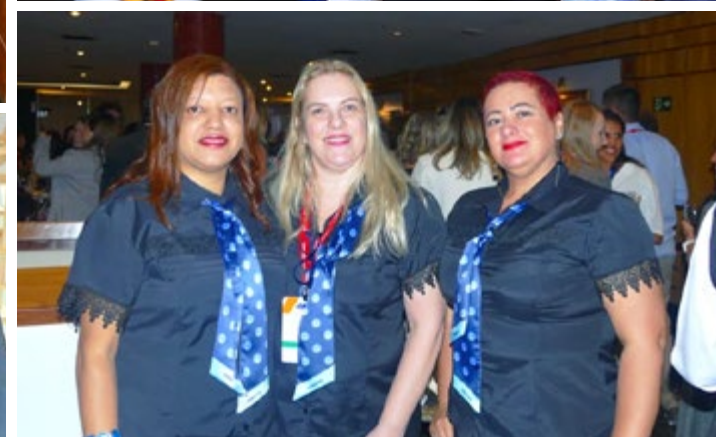
Maral Ouzounian - Toronto General Hospital

Paula Ugalde - Laval University

Andrea Wolf - Icahn School of Medicine at Mount Sinai



AATS & ESTS



AATS & ESTS



AATS & ESTS



Editor's Editorial

Surviving The Imposter Syndrome



By: Erin Gillaspie, MD, MPH

I am often asked how it is that I am a thoracic surgeon at such a young age, or how it is that I came to work at an amazing academic institution. My answer is always the same "Oh I have been incredibly lucky." I have heard this exact phrase come from the lips of mentors, advisors, colleagues and juniors.

But is this the reality? Are we just lucky?

Well, we are all very academically accomplished. We worked countless hours in medical school to acquire a dense and complex medical knowledge. We all scored admirably on national board examinations. We worked tirelessly during residencies and fellowships to become excellent surgeons, leading researchers and teachers; with many women also balancing family life. It was that dedication, hard work and intelligence that created opportunities and opened

doors...and yet we describe it as luck.

It is estimated that 70% of high achievers share this same attribute – they ascribe their accomplishments to serendipitous luck rather than intelligence and hard work.

Last year I attended an incredible early career professional development lecture on a topic called "The Imposter Syndrome." Fueled by what I had heard, I spent time reading articles and books to learn more about this phenomenon such that I could empower myself and share it with friends, colleagues and mentees.

The term Imposter Syndrome became part of lexicon thanks to clinical psychologists Pauline Clance and Suzanne Imes in their intriguing 1978 article "*The Imposter Phenomenon in High Achieving Women.*" This new term emerged after interviewing 150 high achieving women who were all recognized nationally or internationally for their profession excellence. Despite this success, the women seemed to lack internal recognition of their accomplishments, feared that their achievements had been overstated and that ultimately people would reveal them to be frauds.¹

Since 1978, the imposter syndrome has been the basis of many additional studies

with a recent, particular interest in the medical field.

Many women in medicine suffer from the imposter syndrome. In fact, a 2016 study showed that 49% of female medical students have felt like an imposter at some point in their education.²

While the imposter syndrome manifests in a variety of subtypes and severities, ultimately it is problematic and can have negative consequences both professionally and personally.

In medical education, those suffering are less likely to speak up, volunteer information or give answers. This can be detrimental to learning and to the perception of educators.²

In addition, imposter syndrome can lead to burnout due to excessive work hours, the need for perfectionism, and an inability to delegate or unplug from work. Many professionals with imposter syndrome set unrealistic goals and expectations which can be impossible to achieve thereby leading to a self-perpetuating cycle of self-doubt, criticism and negativity.

Studies have also shown that the feeling of inadequacy can lead to self-sabotage by not seeking out opportunities. This was well illustrated in a 2012 study

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performed at Hewlett-Packard when the organization set out to determine why there weren't more women in management positions. They discovered, interestingly, that women applied for promotion only when they believed they met 100% of the qualifications listed for the job. Men were happy to apply when they thought they could meet 60% of requirements.³ Scientists have since attributed this singularity to the imposter syndrome.

"Every time I was called on in class, I was sure that I was about to embarrass myself. Every time I took a test, I was sure that it had gone badly. And every time I didn't embarrass myself - or even excelled - I believed that I had fooled everyone yet again. One day soon, the jig would be up ... This phenomenon of capable people being plagued by self-doubt has a name - the impostor syndrome." - Lean In, March 2013.

Dr. Roozehra Khan, an assistant professor of clinical medicine at the University of Southern California, and frequent lecturer on the imposter syndrome shared that "imposter syndrome can be linked to self-esteem measurements and anxiety" and emphasized that this topic needs ongoing study to identify optimal methods to combat the syndrome.⁴

So how do we fix this?

Here are some tips from experts in the field Dr. Khan, Sheryl Sandberg and Dr. Valerie Young on how to overcome the imposter syndrome:

1. Surround yourself with good people – breaking the silence is key. The support of friends is invaluable. Jim Rohn has famously said that we are the average of the five people we spend the most time with. Choose those people carefully!⁵

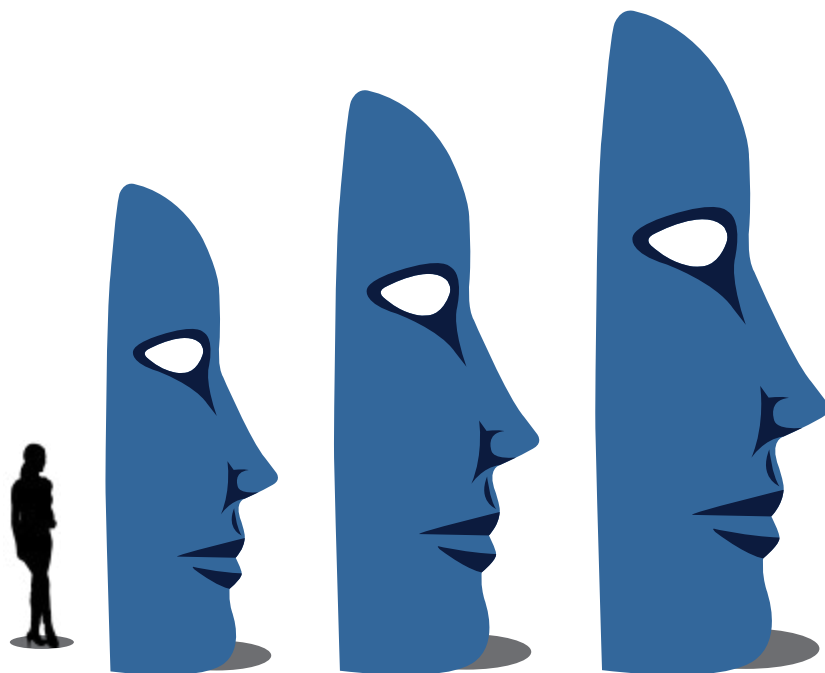
2. Collect your positive experiences – celebrate your wins, celebrate your accomplishments and give yourself credit for your hard work. Build a collection of small mementos – thank you cards, positive words and feedback.^{4,5}

3. Overcome negativity bias – it is, unfortunately, far easier to pay attention to negative. For example, when people receive both a compliment and insult for the work performed, the insult is what will be most readily recalled. Overcome this by maintaining awareness of your thoughts and purposefully focusing on the positive.⁵

4. Ask questions and for feedback – the more you hear about the value you are adding, the more you can internalize and believe it.⁵

5. Separate feelings from fact by reframing mistakes – mistakes are an important part of learning. Don't let the fear of making an error prevent you from applying for opportunities, or taking risk. Understand that making a mistake is not evidence of your lack of qualifications.⁶

6. Right the rules – many people operate falsely under the assumption that you should always



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know the right answer or never ask for help. Even experts don't know all the answers, so why should you? Remember asking for help shows both humility and strength.⁶

7. **Visualize success** – like an athlete, picture yourself performing a successful surgery, speaking clearly and giving a great presentation, and importantly believe in your skills.⁶

8. **Re-Write your Narrative** – change your script from “I am not as smart/ accomplished” to positive affirmations about yourself “I am contributing to science and medicine by ...”⁶

To any woman out there who is or has suffered from imposter syndrome, please know this - you are brilliant, you are extraordinary, you are accomplished, and you are worthy of all the opportunities that have presented themselves to you. Enjoy the day, enjoy your success and please go out and pass your

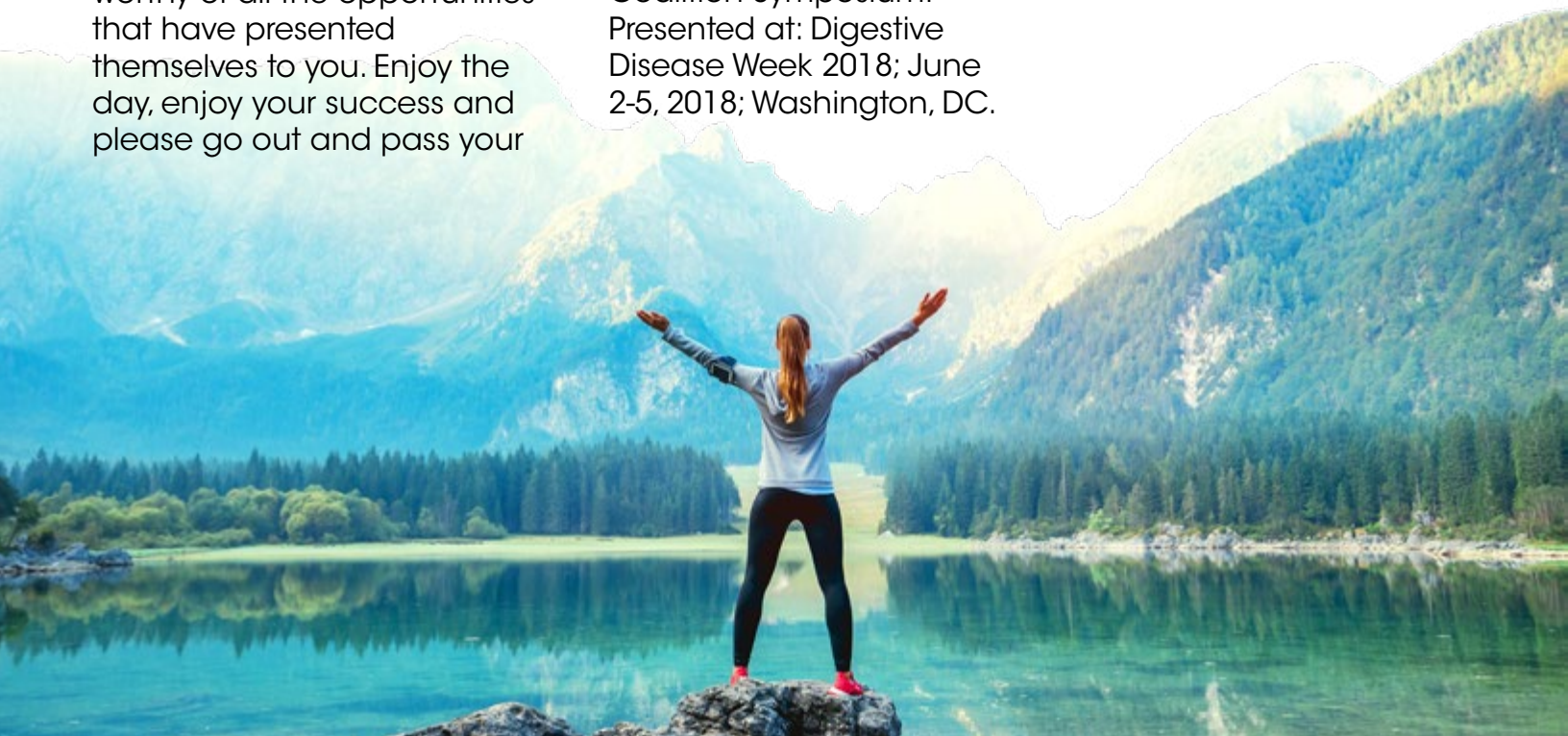
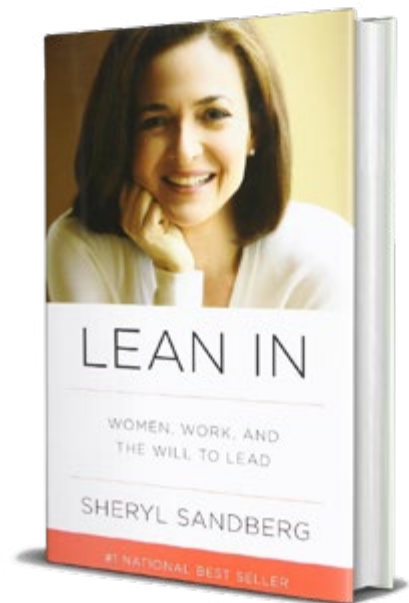
optimism and confidence on to others!

If you would like to read a bit more please check out Sheryl Sandberg's book *Lean In: Women, Work and the Will to Lead*.

Happy summer everyone!

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Why Join the American College of Surgeons?



By: Virginia Litle, MD, FACS

As a cardiothoracic surgeon, why should I be engaged in the American College of Surgeons? Do you ever ask yourself this question and then rattle off multiple reasons - More organizations? How many do I need?! More meetings? No time! More dues? No way! Last year's ACS Initiates class of 1,970 was the largest and that included 66 CT surgeons. So...there are now 66 more CT surgeons with FACS after their name. This is the first step to being engaged but for most CT surgeons, it is typically the last. At the 2018 Congress in Boston, there were 8,522 physician attendees, but only 266 (3%) were cardiothoracic surgeons. As the Women in Thoracic Surgery Representative on the ACS Advisory Council for Cardiothoracic Surgery, I'd like to give you six reasons to be engaged.

1. Don't live in a silo! We can learn from the other

surgical specialties. Thinking out of the box takes a little R & D. ERAS started in the colorectal world, and now leaders in the ERATS field include WTS member Linda Martin from UVA. I learned about extended prophylaxis to prevent postoperative VTE from my surgical oncology colleagues and helped introduce it to the Thoracic audience. I don't see many vascular surgeons at CT meetings, but they are at the ACS presenting at endovascular sessions. Just to share a few examples.

2. CT Presentations.

There are CT surgery presentations at the annual congress meeting. For example, in San Francisco in October, the following presentations will be available to attend:

- Opportunities for Women to Excel in CT Surgery
- To Stent or Not to Stent; Appropriateness of Endovascular Care
- Robotic Cardiothoracic Surgery
- Enhanced Recovery after Surgery (ERAS) Pathways for General Thoracic Surgery
- Rib Fixation: Who, When, How?

- Extracorporeal Life Support (ECLS): What's the Role in Trauma?
- Paraesophageal Hernias: When and How to Operate in 2019
- Avoiding Surgeon Burnout with Lifestyle Modifications

Yes, we have talks like these at the STS and AATS Annual Meetings and at smaller CT meetings; however, we lack the cross-pollination at the CT meetings. When you attend sessions with similar-sounding topics, you get diverse presenters. For example, there are minimally invasive surgeons and surgical intensivists as well as trauma surgeons contributing their views and allowing for potential collaboration to move our fields forward.

3. Committees including Political Action Committee.

ACS has multiple committees that our organizations may not have the bandwidth to support or may benefit

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from more corporate knowledge. An example is the Patient Education Committee, which currently is addressing hot topics including the opioid crisis and pain management but they also have literature for patient management of wounds and feeding tubes. The American College of Surgeons Professional Association (ACSPA)-SurgeonsPAC works in a nonpartisan way to contribute to congressional candidates and political campaign committees to affect change to benefit our patients and practices. Another example is The ACS Division of Advocacy and Health Policy which is promoting a Stop Overregulating my OR (SOMO) initiative for a widespread health data system with interoperability. The ACS advocates for

all surgical specialties at state capitals and before Congress, and the annual Leadership & Advocacy Summit in D.C. in March is an educational opportunity for all surgeons.

4. The **President-Elect of the ACS** is Valerie W. Rusch, MD, FACS. The theme for the 2019 Clinical Congress is: For Our Patients. Dr. Rusch embodies a patient-first approach to a clinical practice. She is a woman, thoracic surgeon, academic and clinical leader and role model for all of us.
5. The **Association of Women Surgeons (AWS)** annual conference overlaps with the Congress. AWS offers coaching programs in conjunction with the meeting (Deadline August 1st. <https://www.womensurgeons.org/>

[page/CoachingProject](#)), surgical leader fellowship grants as well as other opportunities for research funding.

6. Through ACS there are grant opportunities, postgraduate courses, guideline development, quality improvement initiatives and so much more.

There is also the *fun* factor. Attend the annual meeting and see old friends from surgery residency. After spending ~80-120 hours per week with fellow trainees you can develop close friendships that are difficult to maintain when you subspecialize. Register for the 2019 ACS meeting in San Francisco <https://www.facs.org/clincon2019> Consider joining AWS: <https://www.womensurgeons.org>



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