SUMMER 2011

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

As the academic year draws to a close and we attend graduation dinners and watch this years fellows leave to start their own practices, it is important for us to think back on what it was like when we were at that stage in our lives, and more importantly, what we have learned since finally starting our practices and our "new lives".

I just started reading a book by Meghan Daum, entitled "Life Would Be Perfect If I Lived in That House". I think it is a title we can all relate to – life would be perfect if (insert material request of your choice). Dreaming of a better life is human nature. It is how we get through residency and fellowship, and it is how civilization advances and how we make a better life for ourselves and others. However, in our current world of "retail therapy" where we "buy success" in the form of fancy cars and beautiful houses, we need to stay focused on what we are really buying and what we are really seeking. These same lessons apply to our careers and practices as well. "Life would be perfect if I worked at that institution," or "lived in California," or "if I got this grant," or "if I was promoted to assistant/associate/full professor." But would life really be perfect? Would life somehow magically change and be smooth sailing without any problems? What would be different? Is the real difference actually you and your definition of perfect?

One buys a house not a home, just like you can't buy a perfect life or a perfect career. A home, a happy life, and the "perfect" career don't just happen and we can't just order them off a menu. Rather, they take personal commitment, active hard work, and long hours, much more than money (although money is certainly helpful and a base amount is required). The house doesn't make the life. For better or worse, we do.

What Ms. Daum eventually discovers through her journey of multiple moves, apartments, duplexes and homes in search of the perfect life, is that the desire to keep moving toward the perfect life was at some point actually running away from the life she had – the life that could be perfect and fulfilling with commitment, work, patience and time. What she realized is that it wasn't the house she wanted but rather that feeling of belonging, and not feeling like an imposter in her own life. I think women cardiothoracic surgeons often feel like they don't belong. But we really do belong – we just may not recognize what we need to do to turn the existing "house" into a home. Can you create the perfect life in your current house or at your current institution? What really is the difference between what we imagine as our perfect life, and our life as it is right now? Do we really want a new house or new job, or is it just a few items that can be changed or added that can make it perfect, and with a lot less work, drama and cost to you in terms of time, money and lost productivity? If the perfect life really does require a change of scenery or a new house or job, choose it because it is necessary to make the dream come true and it gets you more involved in your own future and not because it magically symbolizes the perfect life as seen in a magazine. By building your dreams around yourself rather than a house, a promotion or a location, you can identify what you really need to be successful and what your dreams really need in order to grow.

Therefore, as we start the new academic year, I want to wish you all success in building your perfect life as a cardiothoracic surgeon. Dream – but dream to build a new reality, not an old fantasy. Happy summer!

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Surgeons of Excellence

The "Surgeons of Excellence" column is dedicated to honoring outstanding surgeons who inspire us, and who make us want to be better professionally and personally.

Surgeons of Excellence: Diana Lee Farmer, MD
By Virginia R. Litle, MD

Dr. Farmer during her induction as a fellow of the Royal College of Surgeons of England.

In January 2011, WTS had a 50/200 celebration at our annual meeting at the Society of Thoracic Surgeons meeting in San Diego. Our guest speaker that night was Dr. Diana Lee Farmer, MD, Chief of Pediatric Surgery, Vice Chair of Surgery at the University of California, San Francisco, and Surgeon-in-Chief, UCSF Benioff Children's Hospital. Dr. Farmer summarized her professional biography and colorfully shared her journey from budding marine biologist to academic leader and visionary fetal surgeon.

Why is Diana an inspiration? After an upbringing in the Midwest and then Idaho amongst a clan of brothers, Diana moved to Massachusetts, where she attended Wellesley College. Aspiring to a career in marine biology, she obtained a BA degree in marine and molecular biology from Wellesley College in the 1970's and went on to study at the Bermuda Biological Stations in Bermuda, the Stanford University Hopkins Marine Lab in California, and the Woods Hole Oceanographic Institute in Massachusetts. However, her life course changed dramatically one fateful night while traveling cross-country to interview as a Rhodes Scholar finalist, when she was involved motor vehicle accident. During her recovery from the severe injuries she sustained, Diana decided to pursue a medical career. After completing post-baccalaureate classes, she obtained her MD at the University of Washington in Seattle and completed her general surgery residency at UCSF. During her general surgical residency, she was exposed to the pioneering work of fetal surgeon, Michael Harrison, MD. Diana subsequently did a pediatric surgery fellowship at the Children's Hospital of Michigan in Detroit. After working in private practice for three years, she returned to the academic arena in full force at UCSF.

Since joining the faculty at UCSF, Diana has been a busy clinician and researcher. She too is a pioneer in the field of fetal surgery. Among her many notable accomplishments, Diana is the first woman fetal surgeon, the second U.S. woman to be inducted into the Royal College of Surgeons, and is the senior author of the 2011 NEJM article reporting a multicenter, randomized controlled trial of intra-uterine surgery versus postnatal care of spina bifida. Achieving a new pinnacle of success, Dr. Farmer was just appointed to be the Chair of Surgery at the University of California, Davis.

She is an inspiration because she exemplifies, albeit parenthetically, the four goals of WTS: to enhance the quality of our patients' medical care; to mentor women thoracic surgeons; to enhance education of patients with heart and lung disease particularly among women; and to educate women thoracic surgeons through formal programs. Dr. Diana Farmer epitomizes the vision of our organization. Through her research as a lead investigator, she has enhanced the quality of patient care; she has excelled as a clinical, scientific, and global mentor; she has enhanced the education of patients' and their families through her community, national, and international service; and she is an educator of young surgeons through formal programs. She is not only a teacher, a clinician, and a scholar but also a role model for any academic surgeon. As a focused, ambitious surgeon and a grounded person, Dr. Farmer is a professional and personal inspiration.

Highlights from the AATS 91st Annual Meeting

Presidential Address on Surgical Mentoring

During the AATS 91st Annual Meeting, AATS president Irving L. Kron, MD delivered a heartfelt presidential address entitled "Surgical Mentoring". In this address, he outlined the common obstacles to teaching, including the belief that observation is the best way to learn, teaching on patients is committing malpractice, surgeons must do the entire case, and that there is no time to help a resident do part of a case.

Dr. Kron also emphasized that in an effort to improve surgical education, residencies need to be more streamlined, residents need to be taught in a more standardized fashion, and simulation needs to play a larger role in surgical training. Furthermore, Dr. Kron stated that while surgery needs to be performed efficiently and certain essential steps of the operation should be done by the attending surgeon, an important element of teaching surgery is that it be "hands-on", that the resident and attending review for the case together, and that the level of responsibility must increase with the seniority of the resident.

Finally, Dr. Kron emphasized that being a mentor in surgery is more than just teaching the technical aspects of surgery, it's about life. Surgical mentors who have been entrusted with the great responsibility of training the next generation of surgeons should be invested in their trainees, should get to know them as persons, and should be interested in their lives. Dr. Kron concluded, "they are our surgical children. We must love and cherish them all."

Dr. Meena Nathan

Dr. Meena Nathan presented her paper entitled "Intra-operative Adverse Events can be Compensated in Infants After Cardiac Surgery: A Prospective Study" during the plenary scientific session. In this study, infants less than six months of age and RACHS categories of 2-6 undergoing cardiac surgery were prospectively studied to define the relationship between technical performance, intra-operative adverse events, and major post-operative adverse events. She concluded that patient outcomes were not effected by intraoperative events, suggesting successful compensation

Highlights from the AATS 91st Annual Meeting

New Sex and Gender Session

A session entitled “Sex and Gender: The Impact on Disease and Patient Outcomes in Cardiothoracic Surgery”, chaired by WTS president Dr. Yolanda Colson, was held during the AATS 91st Annual Meeting. The one and a half hour session was the first such session of its kind to be held at an AATS meeting. Data investigating gender-based differences in the presentation, outcomes, and risk factors of several common cardiothoracic diseases and procedures were presented. The clinical areas included coronary artery disease, lung cancer, valve choice in women of child-bearing age, heart failure, heart transplantation, ventricular assist devices, esophageal disease, lung transplantation, aneurysms, and dissection.

Dr. John Puskas of Emory University discussed gender differences in coronary artery disease, emphasizing that CAD is even more prevalent than breast cancer, affecting one out of every five women. Dr. Puskas explained that CAD presents differently in men versus women. In addition, he discussed that women with acute coronary syndrome are twice as likely to have normal coronary anatomy, women are more likely to have complications following CABG, and differences in outcomes tended to equalize with OPCABG.

Dr. Yolonda Colson of the Brigham and Women’s Hospital discussed lung cancer in female smokers as well as the barriers to smoking cessations specific to women. She discussed that women are less likely to successfully stop smoking due to weight gain, increased incidence of depression, and increased incidence of symptoms of withdrawal, among other reasons. In addition, she found that successful smoking cessation in women is disproportionately dependent on social support, environmental/occupational exposure to smoke, and the smoking status of a spouse compared to men.

Dr. Lawrence Cohn of the Brigham and Women’s Hospital discussed valve choice in women of child-bearing age. He concluded that bioprosthetic valves was the option of choice if repair is not possible.

Dr. Sara Shumway of the University of Minnesota discussed the impact of size and gender on heart failure, heart transplantation, and VADs. She found that obesity is associated with left ventricular diastolic dysfunction and that obese children undergoing heart transplantation have a higher operative mortality. In addition, in terms of cardiac transplantation, she found that gender matched donors to recipients (i.e. male:male or female:female) were associated with a 13% lower risk of graft rejection and that multiparous women undergoing heart transplantation have an increased risk of graft rejection and mortality. In terms of complications associated with VADs , she found that in patients undergoing LVADS as a bridge to transplantation, hemorrhagic CVAs were more common in women and infection was more common in men. Finally, she concluded that early referral for VAD placement resulted in better outcomes in both men and women, but especially in multiparous women.

Highlights from the AATS 91st Annual Meeting

Dr. Thomas W. Rice of the Cleveland Clinic discussed the effect of gender on esophageal disease. He found that women with GERD were less likely to have an abnormal 24 hour pH study. In addition, he discussed that squamous cell carcinoma of the esophagus is four times more common in women and that there seems to be some protective effect against the development of esophageal cancer in women which is lost with age.

Dr. G. Alexander Patterson of Washington University School of Medicine discussed gender differences in lung transplantation. He noted that there is a decreased survival in male transplant patients with female donors. In addition, he discussed that there is a marked gender difference in quality of life following lung transplantion, with women reporting decreased quality of life largely related to body image and changes in mood. Finally, he found that although no gender difference exists in terms of the incidence of the diagnosis of bronchial obliterans, women have a faster rate of progression compared to men once diagnosed.

Dr. Irving Kron of the University of Virginia discussed aneurysms and dissection in women. He stated that women have a lower incidence of thoracic aortic aneurysms (4:1), but tend to have worse outcomes and increased incidence of a need for emergent repair compared to men. In addition, estrogen appears to be protective against the development of TAA. Dr. Kron stressed the need for more focused research on the role of gender in aortic disease.

Surgical Management of Stage IIIA NSCLC

Dr. Valerie Rusch presented at the General Thoracic Surgery Symposium, Sunday, May 8, 2011 at the AATS 91st Annual Meeting. Her talk was entitled “current surgical therapy for Stage IIIA (N2) NSCLC.”
Dr. Rusch primarily reviewed the EORTC randomized study (08941) of surgery versus radiotherapy after induction chemotherapy in patients with IIIA-N2 NSCLC. Patients were predominantly surgically staged with mediastinoscopy and then underwent 3 cycles of cisplatin-based doublet therapy. If subjects responded to 3 cycles of chemotherapy, they were randomized to radiation or to surgery. Surgical patients could receive postoperative radiation if incompletely resected. Median overall survival was similar (16 – 17 months) as were 5-year survival rates (14 -15.7%). Patients undergoing surgery had lower rates of local relapse but higher distant recurrence rates. These results were similar to those from North American Intergroup study INT-1039 (trimodality induction chemoradiation then surgery vs. bimodality chemoradiation alone). Dr. Rusch emphasized that surgery provided better local control but that patients must be selected carefully to optimize morbidity and mortality rates. Dr. Rusch concluded that the EORTC study provided more questions than answers and that management will be impacted by lung-sparing resections and by changing techniques in radiation fractionation and tumor targeting. She shared her hopes for well-designed clinical trials to validate putative molecular markers of prognosis and drug response.

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EDITORIAL:

Mentoring: A Lost Art?

Role of the Mentor

"Mentoring is a brain to pick, an ear to listen, and a push in the right direction."

– John Crosby

One of the most endearing stories in the history of cardiothoracic surgery is the timeless relationship between Dr. Owen H. Wangensteen and his resident Dr. C. Walton Lillehei, a relationship that was likely echoed among countless other trainees of Dr. Wangensteen's. Dr. Wangensteen was Dr. Lillehei's greatest supporter early in his training and remained so up until the time of his death. He believed in him, he encouraged him, he saw his potential and spoke vision into his future. He cared for him personally. He was there for him during a serious illness, waging war on the enemy of disease that threatened to claim his student, and he battled tirelessly to combat it. He was invested in him! Dr. Wangensteen was his mentor in every sense of the word.

One of the best things in surgery is the persistence of this unique relationship between the master and the apprentice, which few specialties can match. Mentoring is one of the most effective ways to pass on skills, knowledge, and wisdom to the next generation of surgeons. It is from a mentor that one learns the nuances of getting a feel for how much tension a 4-0 prolene can withstand, the ability to "see" through the tactile sensations of your fingertips when working in a hole, how to be constantly mindful of the sounds of the monitors while your eyes are focused on the surgical field, or how to angle the needle in the needle driver just so to make that crucial bite perfectly! However, the role of a mentor extends far beyond just passing on knowledge and surgical skills.

A mentor provides guidance, support, and insight. Mentors are a model of excellence, integrity, and character. They inspire their students to be better than they are, challenge them to push the limits of possibility, empower them to believe in their own ability, and ignite a fire for incessant pursuit of knowledge and mastery that cannot be quenched.

There are few things that I know to be true, but I know this to be absolutely true: mentorship is a kinship that cannot be faked; it is selfless love and support unfeigned.

Obstructions to Mentoring

"A child miseducated is a child lost."

– JFK

"All that is valuable in human society depends upon the opportunity for development accorded the individual"

– Albert Einstein

The most obvious obstruction to mentoring is the lack of desire to be a mentor. This lack of desire may exist for a variety of reasons, including a genuine disinterest in mentoring, time constraints due to enormous clinical or research responsibilities, or a belief that one is not qualified to act as a mentor. Everyday will likely present some opportunity to mentor, one just needs to want to capitalize on that opportunity. In the busyness of working to get to where you want to be, it can be easy to fail to appreciate where you are. Alternatively, once you have gotten to where you want to be, it can be easy to forget that you too where once a novice. At every level of training or practice, there are challenges. Some of these challenges may be universal, and some may be as varied as individuals. Through these experiences and lessons learned, you may be uniquely qualified to help someone else.

Another obstacle to mentoring is lack of commitment. One may be interested in mentoring, but not committed to it. A mentoring relationship is based on mutual trust and respect. These are the elemental building blocks without which a functional, working relationship cannot exist. Words without actions are impotent. Even worse than empty words, are broken promises. This does not foster trust, and eventually the relationship deteriorates due to disappointed hopes, and sense of being devalued, let down, and isolated. It is not enough to be a mentor in name only.

EDITORIAL:

Mentoring: A Lost Art?

Diversity is also an important subject to consider when mentoring. Surgery, thankfully, is becoming increasingly diverse. Mentors should not be bound or limited to working with people who look like you, who have the same background as you, who are related to you, or who are somehow connected through a shared circle of people. These things are in many ways inconsequential. The thing that matters is having a mentor who is present, who sees you, and who believes the best in you.

Finally, the working environment in which one is mentored may also act as a deterrent to successful mentoring. Not to be confused with some idea that I am advocating for a touchy, feely, tree-hugging kumbayah atmosphere – I'm not, however an extreme hostile, toxic working environment can be detrimental to creating a successful mentoring relationship. Creating a milieu that is conducive to learning, open communication, and personal growth are essential for fostering a mentoring relationship. If something is to grow, it must have the right atmosphere. Otherwise, roads that lead to nowhere are hard to build.

Mutual Benefits of Mentoring

"The greatest good you can do for another is not just to share your riches, but to reveal to him his own."

– Benjamin Disraeli

"What we have done for ourselves alone dies with us. What we have done for others and the world remains and is immortal."

– Albert Pine

"... plant a tree for posterity in the orchard of your profession. It will give you enduring satisfaction though you may never live to see it mature; its growth can project your image and wishes far into time and space."

– Owen H. Wangensteen

Mentoring is mutually beneficial for both parties involved. The benefits to the apprentice are clear. However, this dynamic, symbiotic relationship provides the mentor opportunities to learn from the apprentice as well. Through probing questions and exploration of new ideas, the mentor may discover her own strengths and weaknesses and learn new things. As the relationship progresses and the apprentice gains in knowledge and experience, the two may increasingly sharpen each other, challenge each other, and learn from each other. In the greater scheme of things, the mentor also benefits from the personal satisfaction of knowing that through mentoring one person, she has contributed to the specialty. Through mentoring one person, she has positively impacted the lives of patients she may never meet and enriched society as a whole in ways she may never fully appreciate.

As cardiothoracic surgery continues to grow and adapt to the challenges that come with implementing new and emerging technologies, forging multidisciplinary collaborations, and practicing within the confines of increasingly managed care, so too will the art of mentoring grow and adapt to this changing environment, forging a path that upholds the strong tradition of surgical mentorship that began so many years ago. So what would the great Dr. Wangensteen think about the state of mentoring in cardiothoracic surgery today? I do not presume to know the answer to this question. However, I do know that Dr. Wangensteen set the bar high, and his expectation would be for future generations to surpass him.

Davida A. Robinson, MD

This editorial is dedicated to my mentor, Dr. Kenneth G. Warner

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WTS Mentors

WEST

Nora Burgess, MD
San Francisco, CA
Nora.burgess@kp.org

- *Thoracic*

Cynthia S. Herrington, MD
Los Angeles, CA
cherrington@chla.usc.edu

- *Congenital*
- *Transplant*
- *Academic*

WEST MOUNTAIN

Gail Strindberg, MD
Salt Lake City, UT
gstrindberg13@msn.org

- *Cardiac*
- *Thoracic*
- *HMO*

EAST

Margarita Camacho, MD
Newark, NJ
mcamacho@sbhcs.com

- *Cardiac*

Yolanda L. Colson, MD, PhD
Boston, MA
ycolson@partners.org

- *Thoracic*
- *Research/Academics*

Jessica S. Donington, MD
New York, NY
Jessica.donington@nyumc.org

- *Thoracic*

Leslie Kohman, MD
Syracuse, NY
kohmanl@upstate.edu

- *Thoracic*
- *Academic*

Virginia R. Litle, MD
Rochester, NY
Virginia_litle@urmc.rochester.edu

- *Thoracic*

Joanne Starr, MD
Maplewood, NJ
starrdoc28@gmail.com

- *Congenital*

MIDWEST

Emily A. Farkas, MD
St. Louis, MO
efarkas@slu.edu

- *Cardiac*

Paula M. Flummerfelt-Guinnip, MD
Marion, IL
pguinnip@earthlink.net

- *Thoracic*

Renee Hartz. MD
Oak Park, IL
rshartzmd@aol.com

- Cardiac
- Thoracic
- Research/Academics

Rose Kelly, MD
Minneapolis, MN
kelly071@umn.edu

- *Cardiac*
- *Thoracic*
- *Research/Academics*

Jacquelyn Quin, MD, MPH
Springfield, IL
jquin@siumed.edu

- *Academics*

Donna J. Waite, MD
Mayfield Heigh, OH
waited@ccf.org

- *Cardiac*
- *Thoracic*

Tracey Weigel, MD
Madison, WI
weigel@surgery.wisc.edu

- *Thoracic*

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WTS Mentors

SOUTH

A.J. Carpenter, MD, PhD
San Antonio, TX
carpenterA2@uthscsa.edu

- *Cardiac*
- *Thoracic*
- *Transplant*
- *Research*
- *Academics*

Carolyn M. Dresler, MD, MPA
Little Rock, AR
carolyn.dresler@arkansas.gov

- *Thoracic*

Kristine Guleserian, MD
Dallas, TX
Kristine.Guleserian@UTSouthwestern.edu

- Congenital
- Academic

Qurania Preventza, MD
Houston, TX
opsmile01@aol.com

- *Cardiac*

SOUTH ATLANTIC

Mercedes K.C. Dullum, MD
Weston, FL
dullumm@ccf.org

- *Cardiac*
- *Transplant*
- *Academic*

Jennifer L. Ellis, MD
Washington, DC
Jennifer.Ellis@Medstar.net

- *Cardiac*
- *Thoracic*

Erica M. Giblin, MD
Charleston, SC
gibline@hotmail.com

- *Thoracic*

Betty Kim, MD
Charlotte, NC
kimbs@caromonthealth.org

- *Cardiac*
- *Thoracic*
- *Private Practice*

Blair Marshall, MD
Washington, DC
mbm5@gunet.georgetown.edu

- *Thoracic*

Carolyn A. Reed, MD
Charleston, SC
reedce@musc.edu

- *Thoracic*
- *Academic*

Becky Wolfer, MD
Huntington, WV
rwolfer@aol.com

- *Thoracic Academic*

INTERNATIONAL

Kalliopi Athanassiadi, MD
Athens, Greece
kallatha@otenet.gr

- *Thoracic Surgery*

Rebecca Dignan, MD
Liverpool, UK
Rebecca.dignan@sswahs.nsw.gov.au

- *Cardiac*

Lynn M. Fedoruk, MD
Victoria, Canada
lfeforuk@telus.net

- *Cardiac*

Kathleen Fenton, MD
Managua, Nicaragua
kathleennf@msn.com

- *Congenital*
- *Reseach/Academics*
- *Private Practice*

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

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

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GETTING TO KNOW YOU:

The ORACLE INTERVIEWS Dr. Kathleen Fenton

Dr. Kathleen Fenton enjoying some free time.

Dr. Kathleen Fenton completed her undergraduate work at Johns Hopkins University and medical school at the University of Maryland in Baltimore, MD where she graduated cum laude. She completed her general surgical training at the University of Louisville, her cardiothoracic surgery fellowship at Emory University, and congenital cardiac surgery fellowship at UCSF and the Children's Hospital of Pittsburgh. In addition, she completed a research fellowship in cardiovascular surgery at the Children's Hospital of Boston, and she was the recipient of the 1991 American Heart Association Affiliate fellowship grant.

Dr. Fenton is an active member of the WTS. She is the immediate past editor of the Oracle newsletter, and she currently serves as a member of the Board of Directors of WTS, as well as the secretary of the organization. Presently, Dr. Fenton works at the International Children's Heart Foundation in Nicaragua, where she has been instrumental in establishing and growing the congenital cardiac surgery program, acting as surgeon, clinical instructor, educator, and fundraising activist, working with both local and international benefactors. Dr. Fenton's research interests include fetal cardiac surgery, fetal physiology, single ventricle physiology, and cerebral oximetry in congenital heart surgery.

Oracle:
Tell me a little about yourself?

Dr. Fenton:
I was born in Washington, DC and raised in suburban Maryland, the first of three children. My two younger brothers are a communications technologist and a Catholic priest, respectively. I went to Catholic school for 12 years before going to Hopkins for college. I left Maryland to do my residency in General Surgery, with plans initially to be a Pediatric Surgeon. I lived in I think 8 different states in the US before I started working with the ICHF and moved to Managua. For that reason, moving to another country was not that difficult- except for learning a different language and a different culture, of course!! But still- I was used to being far away from "home" so it was not as difficult as one might think.

Oracle:
What is something that not a lot of people know about you but you wish more people could know?

Dr. Fenton:
This is a hard question to answer. I think I am fairly transparent, so that people who want to get to know me have no trouble with that. As a bit of an aside, though, I think that one huge potential advantage of the internet and specifically of social networking sites is that the almost century-long trend towards anonymity and compartmentalization of life is being reversed. What do I mean by that? Well, years ago everyone lived in a small town, where the banker, the shop owner, the pastor and the doctor all were neighbors. In the past few generations, for most of us this disappeared, resulting in the current situation where our work colleagues don't know our friends, our friends don't know our family, and so on. But social networking is reversing that, and I think for most of us that's a good thing. For example, I can post a link to an interesting article, and within hours sometimes there are comments from a kid who grew up with me in the "old neighborhood," a friend from college, a family member and a current work colleague. I find this just delightful!

Oracle:
What do you most enjoy doing when you're not working?

Dr. Fenton:
There are several things, actually. In the first place, I have been a scuba diver for about 15 years and I love diving! I wish I had more time (and money!) to go diving, and I kind of hope that one of my assignments with the ICHF will land me in a place where it is easy to go dive just for a day. Mostly I dive with my brothers and/or my niece, but occasionally I find other opportunities.

GETTING TO KNOW YOU:
The ORACLE INTERVIEWS Dr. Kathleen Fenton

Another thing I enjoy is studying philosophy, theology and ethics, and part of me regrets not having a better foundation particularly in philosophy as a student. If I were to give advice to college students, I would tell them to take a couple of philosophy classes! It applies to everything! In addition to diving, I often use vacation time to travel somewhere inside or outside the US to take an interesting class. I can then apply what I learn to both my personal and my professional life. For example, I currently serve on the Ethics Committee for the Society of Thoracic Surgeons, which I enjoy very much, and I am a member of the board of directors of the Nicaraguan Bioethics Association.

Finally, more on the home front, I love singing choral music, baking (mostly chocolate desserts, but also other things), and spending time with my dog. Choral music is the single thing I miss most in Nicaragua.

Oracle:
What has been the most challenging and the most rewarding experience you've had while working in Nicaragua?

Dr. Fenton:
Most challenging: Learning the culture has been a lot harder than learning the language, especially with respect to time management. Initially the whole thing was very frustrating for me and occasionally I still have to remind myself to take a deep breath and relax because I'm "not in Kansas anymore," as they say. What helped me a lot was some research information I was given on how time is really conceptually different in different cultures: "sequential time management" vs. "synchronically-organized cultures" to be specific. Understanding this really helped me to not get as frustrated or be as critical because I realize that the whole idea of punctuality is not the same! Also, it helps to take a book!

Most rewarding: There is a sense of urgency and desperation here that we just don't see in the US, because for us medical care is so readily available. This really was brought home to me the first year I was here. As a favor to a private practice cardiologist, I went with him one day to a different hospital to evaluate a child. Now, people are late to a lot of things here, but not usually to medical appointments because they are (rightly) afraid that the doctor will refuse to see them. So the cardiologist and I were surprised that the baby was not there at the scheduled time. We waited for about 30-45 minutes, chatting about the program, and finally I told him that I guessed the mother had a problem and was not going to make it, so he should call me when she reappeared and we could reschedule. About an hour later, I received a phone call from a hysterical young woman, who explained to me that the taxi had broken down or something similar, and told me over and over how sorry she was that she was late, saying, "Please take care of my baby!!" We rescheduled the appointment, and ultimately operated on the baby and he did well. The episode has always stuck in my mind as a vivid memory of the reason I am here.

Oracle:
What food do you most crave when you return home to the States?

Dr. Fenton:
There are a lot things I miss, and I usually fill up my suitcase(s) with nonperishable items on every trip home! That leaves me craving the fresh fruits and vegetables that I can't take through customs. Black raspberries are my favorite, but this year I was home in strawberry season for the first time in 5 years so I really enjoyed those! I also love white corn (the corn here is not the same), peaches and summer tomatoes.

Oracle:
Which team is your pick to win the NBA championship?

Dr. Fenton:
No idea! I'm a football fan (only), and my team (the Washington Redskins) has not done well for a number of years now, pretty much since Dan Snyder took over. I don't really pay much attention to other professional sports.

Oracle:
What have been your personal rewards of mentorship, and what is the most inspiring thing you can share with our readers to encourage others to become mentors?

Dr. Fenton:
I think mentorship gives me a fresh look at everything. We humans have a tremendous capacity to get used to things. Sometimes, that's good, but often it's bad. Things that were once exciting to us (putting in a chest tube as a med student, or doing your first valve replacement as a fellow) can become first humdrum and later even an unwelcome chore. Mentoring helps me go back and see again how tremendous my work really is!

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The Importance of WTS Membership

By Jessica S. Donington, MD

The WTS is currently undertaking an increased effort to expand its membership. Currently, only half of the women certified in Thoracic Surgery are WTS members. The WTS has made the recruitment and retention of young women to our profession one of our top priorities. A large active membership is essential to facilitate this goal in two ways. First, membership dues directly support our scholarship program. This program brings young women with an interest in cardiothoracic surgery to The Society of Thoracic Surgeons annual meeting each year. WTS members spend quality time with the scholars to mentor them at this national meeting. We are convinced that exposure of these young scholars to dynamic and successful female surgeons within academic cardiothoracic surgery will attract the best and the brightest applicants to our field. The WTS scholarship program is the oldest mentoring initiative within Thoracic Surgery and is incredibly popular. Last year there were 60 applications for six scholarships. Our appeal to women clearly falls on an area of need. WTS funds are limited and we hope to expand the program to offer at least 10 scholarships a year. We cannot do this without membership support!

The second important benefit of a large active membership is exposure. The WTS recently completed a survey of female cardiothoracic surgeons, and the overwhelming take home message from that survey was that the great majority (>90%) of female cardiothoracic surgeons are happy with their career choice. Unfortunately, in 2011, women still represent less than 2% of cardiothoracic surgeons in our country, and half of those entered the field within the last ten years. The scarcity of female role models and inability of young women to identify and see themselves within our profession cannot be overlooked. We want young women to know they are valued within our field and help them recognize that they have the same opportunities as their male counterparts to have a successful and rewarding career. Providing an avenue for young women to meet and interact with a large number of women at varied points in their surgical careers has a tremendous impact.

In addition to our scholarship program, WTS is also active in effecting change in our specialty and provides mentoring and networking opportunities for women at any level in their career.

If you are a WTS member and have not yet paid your 2011 membership dues, please do so right away. To request a copy of your invoice, contact WTS at wts@wtsnet.org. If you are not a member, please consider joining WTS now and become part of our positive force for change. Please complete the attached membership form and help support WTS efforts to recruit and retain women to our field.

New AATS Members

Newly Elected AATS Members!

Dr. Colson and the WTS would like to congratulate Dr. Virginia Litle and Dr. Andrea Carpenter for gaining membership to the AATS. Congrats!

Acknowledgements

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

WTS 2011 January Meeting
Covidien
American Board of Thoracic Surgery

WTS 2011 Scholarship Program
Ethicon Endo Surgery
Medtronic, Inc.
St. Jude Medical, Inc.

WTS Newsletter
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University of Colorado

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What's On Your Mind?

WTS is pleased to announce a new segment in the Oracle called "What's on Your Mind?" In this segment, we will address specific questions and topics of interest submitted by you, the WTS membership!

Please e-mail your questions and topics of interest to:

wts@wtsnet.org

subject heading "WOYM".

Find Us On Facebook!

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

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

Or search for:
Women in Thoracic Surgery

Visit us today. Once you've experienced it, invite a friend!

Save the Date

Planning is currently underway for a WTS meeting and reception, to be held in conjunction with the STS 2012 Annual Meeting in Fort Lauderdale, FL. Details will be posted to www.wtsnet.org as they become available. Plan to attend!

WTS is pleased to announce that the Association of Women Surgeons (AWS) will celebrate its 30th Anniversary in October 2011 in San Francisco in conjunction with the ACS Clinical Congress.
Activities will include:

- **Sunday, October 23:** AWS Annual Conference
- **Monday, October 24:** AWS 30th Anniversary Awards Reception and Dinner
- **Tuesday, October 25:** AWS Complimentary Networking Breakfast

You are invited to attend all AWS events. For more information about the program contact AWS at (630) 655-0392 or visit the AWS website at www.womensurgeons.org.

We hope to see you there!

Farewell Judy!

WTS would like to thank Judy Saxerud of Scanlan International, Inc. for her five years of dedicated service in her efforts of making the production of the Oracle newsletter possible. Best wishes on your retirement!

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WTS State of the Profession Survey

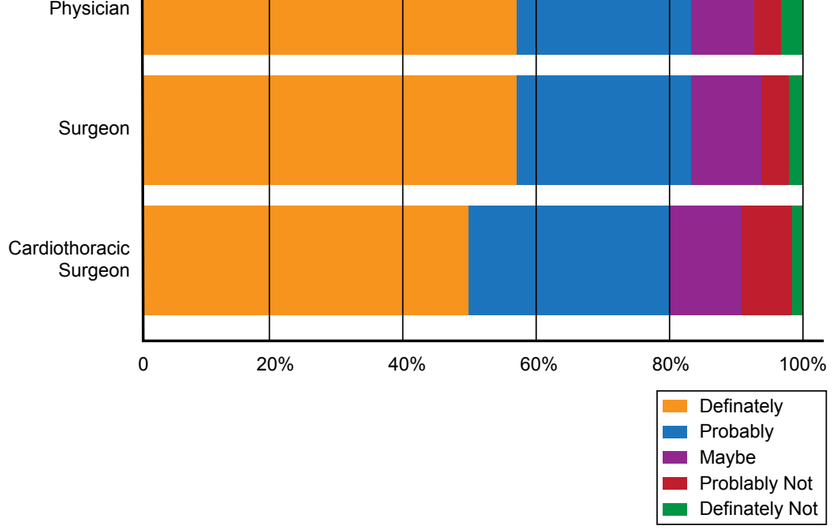
By Jessica S. Donington, MD

As part of the celebration of the 50th anniversary of the first woman certified by the American Board of Thoracic Surgery, WTS surveyed all women thoracic surgeons in the U.S. to measure career progression and satisfaction. The last widespread survey of this kind was performed in 2000 and published in a supplement of the Annals of Thoracic Surgery dedicated to Women in Thoracic Surgery.[1]

Attempts were made to anonymously survey all ABTS-certified women in December 2010, through surveymonkey.com. Questions were in five categories: demographics, training, current practice activities, activities of non-practicing CT surgeons, and career satisfaction.

Survey response rate was 64% (121/190). Reliable contact information was not available for 14 of the surviving 204 female diplomats. The most striking finding was that greater than 50% of women had finished training within the last ten years. The majority are Caucasian, in urban practices, and in groups of 2-10 surgeons. Half report having an academic appointment. In addition, 64% report being always or almost always satisfied with their career. The most commonly cited sources of job dissatisfaction were demand on time and work-place politics. When asked if they would pursue the same career choices if given the opportunity to do-it-again, the majority said they would pursue cardiothoracic surgery again (Figure).

If you had the opportunity to re-do your career decisions would you pursue the following again?



1. *Roberts SR, Kells AF, Cosgrove DM . Collective contributions of women to cardiothoracic surgery: a perspective review. Ann Thorac Surg. 2001 Feb;71(2 Suppl):S19-21.*

WTS Networking Reception

A WTS Networking Reception was held on Sunday, May 8th in Philadelphia during the AATS 91st Annual Meeting. This was a great opportunity to network and reconnect with fellow WTS members and prospective members.







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Betty Tong, MD

Membership Update

If you have not paid your 2011 membership dues, please do so today! It is through your support that we are able to continue our outreach efforts to women throughout the world who have chosen this specialty, along with influencing young women interested in cardiothoracic surgery through our scholarship program.

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

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

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

Women in Thoracic Surgery

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WTS Membership Application

Name: _____

Institution: _____

Address: _____

City: _____ **State:** _____

Zip/Postal Code: _____ **Country:** _____

E-mail: _____ **Phone:** _____

PLEASE PROVIDE THE FOLLOWING INFORMATION

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

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

DUES PAYMENT INFORMATION

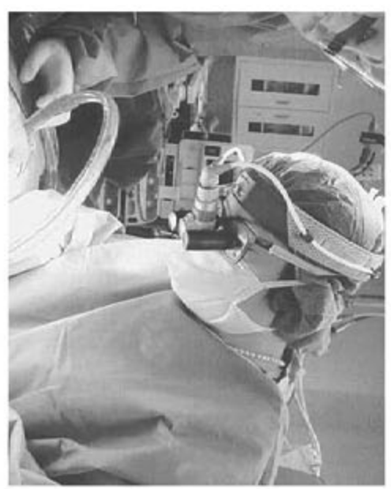
U.S. Active - $150 **International - $75** **Residents/Students - No charge**
Associate - $150 ***Institution Benefactor - $500** ***Corporate Benefactor - $1500**

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

Make check payable to: Women in Thoracic Surgery (*Tax ID#: 30-0003353*)
To pay by credit card: ___Visa ___MasterCard ___American Express
Card number: _____ **Exp date:** _____
Card billing address: _____
Name *as it appears on card*: _____
Signature: _____

Please note the credit card charge will show The Society of Thoracic Surgeons. If you have questions, contact WTS Headquarters at 312.202.5835 or wts@wtsnet.org.

Membership Guidelines



Women in Thoracic Surgery

Become a Member