

Women In Thoracic Surgery



ORACLE

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

President's Corner



By: Jennifer S. Lawton, MD

We are now well into 2015 and spring is here. With this in mind, I am thrilled and excited in anticipation of the Women in Thoracic Surgery 30th Anniversary in 2016! Since the inception of WTS, it has grown into a vibrant and expanding organization (see the article on social media by Mara Antonoff, MD).

What originally was the Women in Cardiothoracic Surgery in 1986 when Dr. Leslie Kohman gathered a group of women to meet during national meetings is now the Women in Thoracic Surgery

(WTS). WTS presently has 181 members (active 81, associate 6, candidate 63, international 5, and institutional 26). WTS is a young organization in relation to our larger national organizations. For example, the American College of Surgeons was founded 1913; the American Association for Thoracic Surgery was founded 1917 and will soon celebrate its Centennial; the Southern Thoracic Surgical Association was founded in 1954, the Society of Thoracic Surgery was founded in 1964; and the Western Thoracic Surgical Association was founded in 1974. Despite this, WTS members have accomplished a tremendous amount during this short time. WTS members have been Governor of the ACS (Carolyn Reed); President of the STS (Carolyn Reed, posthumously); the STSA (Carolyn Reed, President elect presently AJ Carpenter); chair of the ABTS (Valerie Rusch); Councilor of the AATS (Valerie Rusch and Lynda

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Mickleborough); Program Chair (Thoracic) for the AATS 2015 meeting (Yolonda Colson); Director of STS (Shanda Blackmon); Councilor of the STSA (Shanda Blackmon, Jennifer Lawton); Director of the ABTS (Yolonda Colson), and I have been fortunate to

have been the Chair of the AATS membership committee. Many of our members have served as committee members for our national organizations in leadership roles in their respective institutions, and on editorial boards. Approximately 260 women have been board certified by the ABTS, beginning with Dr. Nina S. Braunwald in

1961 (Figure 1, data courtesy of Jessica Donington, MD). Figure 2 depicts the number of female members (estimated total 32 ever) in the AATS (currently 728 members).

I would encourage you to read the History of the WTS by Dr. Nora Burgess on the WTS website www.wtsnet.org. **The mission of the WTS** has been to *further the achievements of women practicing thoracic surgery by providing mutual support and facilitating professional advancement.* WTS member interests in mentoring and sponsoring other women began in 2004 when the first WTS scholarships were awarded to women to attend the STS meeting. In this past year, the WTS awarded 12 scholarships along with the generosity of the STS. The WTS now also awards two Scanlan / WTS Traveling Mentorship Awards yearly for women who wish to spend time with a WTS mentor.

I would encourage activism and participation in our national organizations to increase visibility of our members, inclusiveness in recruitment to our field, and inspiration to others to consider our amazing specialty. The WTS will continue efforts to attract talented and skilled women to CT surgery, and I look forward with great anticipation to many more exciting accomplishments in the future.

Figure 1
Number of ABTS Certified Women by Year

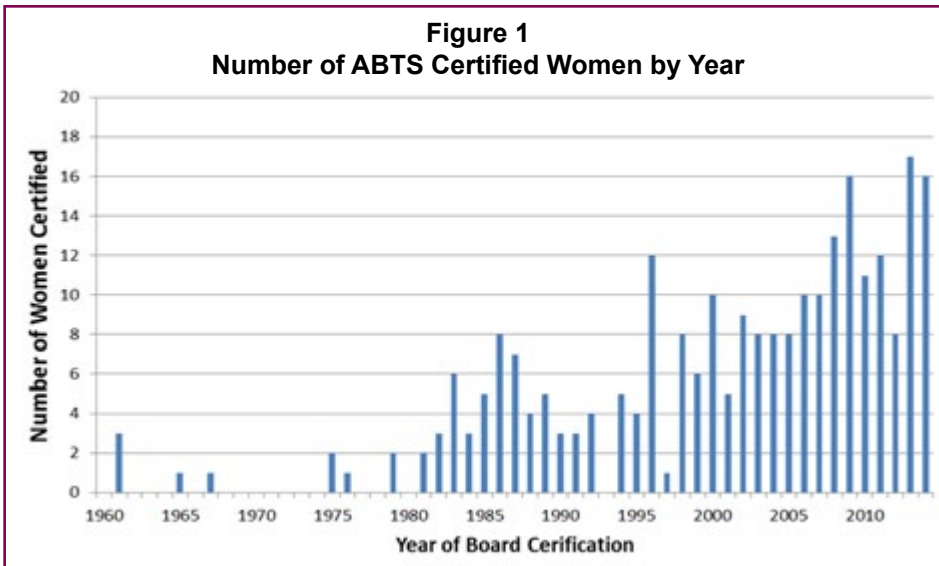
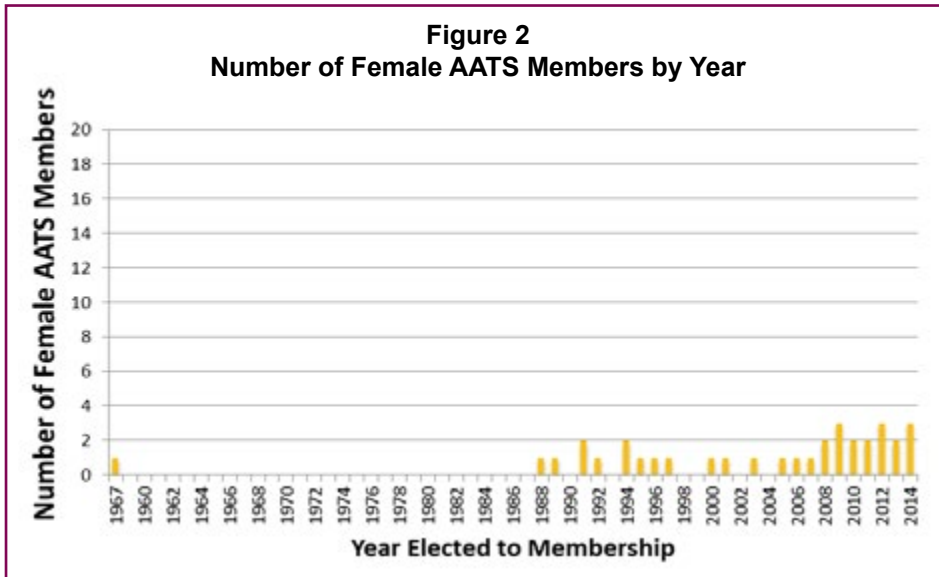


Figure 2
Number of Female AATS Members by Year



WTS Leadership 2015

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From So Many Tragic Events, So Much Good Has Come

By: Linda W. Martin, MD, MPH

Dr. Martin is an Assistant Professor of Surgery in the Division of Thoracic Surgery at the University of Maryland Medical School

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I have had the great honor of receiving the first annual Carolyn E. Reed, MD, Traveling Fellowship. I distinctly remember hearing of her sudden unexpected passing, now almost 2 years ago. The concept of the traveling fellowship in her memory was a great idea - a chance to learn a new skill for a female general thoracic surgeon who is established in her practice. What an opportunity. Several of my friends had separately approached me about applying – it seemed like it was designed specifically for me, as I had been intrigued by robotic surgery. I had done several VATS lobes but it was always a struggle and didn't really "click" for me. Robert Cerfolio's outspoken views against VATS resonated with me; so when he became an advocate of robotic surgery, I took notice. If he had become such a "convert," then perhaps he was the guy to learn from. I was well aware that I could not become proficient with robotics in a 1 or 2 day course, that it would take dedicated study and practice and continued contact with a

mentor to successfully master it. This fellowship was the perfect setup to do so; I enthusiastically submitted my application with his support.

On a Sunday morning in January, during the STS meeting that I was scheduled to attend, I got a phone call from AJ Carpenter congratulating me on being selected as the first recipient of the Carolyn Reed Traveling Fellowship. Believe it or not, I had been secretly hoping I would NOT get the award - so many other things were going on in my life. The previous 4 months had been extremely tough for me – my best friend in the whole world, my sister Karen, had just

been diagnosed with colorectal cancer. And on that Sunday morning I was sitting outside of her bedroom in San Diego where she was resting on a

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Dr. Martin and her sister, Karen, shortly after Karen started treatment for colon cancer.

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hospital bed, under hospice care, meeting with her most cherished friends and family, to say goodbye; we had found out just 8 days before that her liver was full of tumors and she was dying. I asked AJ not to misinterpret my sullen voice – I was truly honored and thankful, but feeling incredibly sad that circumstances had led me to be sitting at my sister's death bed instead of giving a talk and receiving this award at the STS. Later that day, just minutes after I got up from hugging my sister, she had a 26 minute grand mal seizure. She never fully regained consciousness; she slipped into a coma and died 3 days later.

Sadness and grief permeated nearly every waking moment for the next few months. I trudged along, but my zest for life was missing. I knew the fellowship had to be scheduled during 2014, so I worked on travel dates and logistics with Dr. Cerfolio's assistant to plan the visit to Alabama. I postponed it a few times. Slowly but surely I worked my way through the paperwork. I had to get an Alabama state license and hospital privileges if I wanted to participate in more than a handful of cases. Knowing Cerf's reputation for productivity I knew this was a necessary step. The license required getting electronically fingerprinted – it took me nearly a month to find a place that could do it! At so many points I thought that something would fall through, either the licensing,

the scheduling on his behalf, or mine. Halting my practice for 3 weeks and getting coverage was another obstacle, as our division was functioning with too few people already. By the time I was ready to depart for Alabama, I was so stressed out about having my practice and my home life in order that I really hadn't prepared at all for robotic training. And, admittedly, I was... skeptical about starting a robotic practice.

And then, the adventure began. All the efforts were proven worthwhile. I shadowed Dr. Cerfolio and his wonderful team for the next 3 weeks – participating in all cases (and there were a LOT – typically 4-10 cases per day), going to clinic, rounding. I was there to learn robotics, and there was so much to incorporate - everything from OR positioning, how to set up the robot, dock the arms, cautery settings, humidified CO2 insufflation, which staplers to use, anesthesia set up, and use (or nonuse) of monitoring lines – it was all so well-orchestrated and everything was done with a purpose, with efficiency, and with teamwork. I was immediately blown away with the robotic technology in terms of visualization, instrumentation, and the prospect of doing a better



Karen Martin and Dr. Martin's two sons.

lobectomy in half the time I could do via thoracotomy. Cerf insisted I get on the simulator immediately, which meant coming to the hospital into the evening hours when the OR was empty to get used to the equipment. It was fun and challenging and I frequently lost track of time. Many evenings were spent doing this, as for once, I didn't have any other responsibilities except to learn - my favorite thing to do. Within just a few days, I was participating in port placement, getting on the second (teaching) console and actually doing part of each robotic case.

I participated in 7 lobectomies, 2 esophagectomies, and over 20 nonrobotic cases; I observed another 5 robotic lobectomies. There were lessons to be learned in even the most

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minor of cases – for example, I did more rigid bronchoscopy than I had in my training and 9 years of practice combined. I went to all the clinics; I rounded everyday; not because I had to or was expected to, but I wanted to see a 2 day recovery from lobectomy (was this for real? YES!) and also how patients were doing at their follow up visits. Seeing the whole picture absolutely convinced me to bring robotic thoracic surgery to my practice. An unanticipated benefit of this fellowship came from the skills I gained working with one of the best in our field: learning better time management, leadership skills, observing an incredible work ethic, and gaining a better sense of how to enjoy work and take pride in what you do. To Cerf's credit, he genuinely wanted to learn from me too. We had so much fun exchanging tips and advice about how we each approach clinical and surgical problems. Most importantly, my love for thoracic surgery came back – I was infected with enthusiasm once again after a long bout with melancholy and apathy. My job had once again become my passion.

Upon return to Maryland, I immediately embarked on a "culture change" in the OR – operating faster and more confidently than I ever have before; seeing more clinic patients in one day than ever before; changing my thoracotomy positioning, ET tube placement, using rib blocks, finishing research



Dr. Martin and Dr. Cerfolio on the last day of her Reed Fellowship

projects, working smarter instead of just harder, and assuredly interfacing with hospital and academic leadership to set up a robotic program. Within 4 weeks I identified a team, OR block day, equipment pick list and target date for a mock and then a real robotic case. I worked on the robotic simulator for 1-2 hours per week. My first robotic case was a left lower lobectomy. We successfully achieved a completely portal robotic

resection. Blood loss was 70 cc and the patient went home in less than 48 hours and started adjuvant chemotherapy at 4 weeks after surgery.

I still can't believe my good fortune in receiving the Carolyn Reed Traveling Fellowship grant. This has been a transformative event in my career. From so many tragic events, so much good has come.

Resident's Feature

Women in the I-6 Training Programs: Increasing Our Presence in Cardiothoracic Surgery

By: Sabrina A. Oldfield, MD

Dr. Oldfield is currently in her 2nd year of the I-6 training program at the University of California, Davis

Thoracic Surgery has consistently remained in the top 3 specialties dominated by male residents, along with Orthopedic Surgery and Neurosurgery (1-3). The field has made substantial strides with more than 200 female board certified cardiothoracic surgeons as of 2014. However, that constituted only 4% of the board certifications during the 30 year period since the first female certifications were awarded by the American Board of Thoracic Surgery in 1980. In 2007, a new training paradigm was introduced with an integrated residency program at Stanford University (5,6). The growth of these integrated six-year programs (I-6), which includes a few seven-year programs, has been exponential, blossoming from one program in 2008 to 24 programs in 2014 (7).

Still in their infancy, I-6 programs encompass only 0.1% of all residency training programs, and are the smallest subset of all surgery and surgical subspecialties⁸. Therefore, there is limited information about their female constituents. In 2012-2013,

female residents made up 22% of the I-6 resident population (8). Since last year, at least three new programs have been added to the roster. A survey of all 24 programs (87.5% response rate) indicated a current 19.5% female composition. The applicant pool has consisted of between 17-20% female applicants per year over the last four application cycles⁹. Female applicants for fellowship positions also ranged from 15.5-22% over the same application periods¹⁰, with an average of 20% female residents for all of thoracic surgery during this time period (2,3). This indicates that there is no selection bias based on gender. Dr. Gasparri from the Medical College of Wisconsin stated, "We are gender, race, religion and nationality neutral. All residents in our program are selected based on merit and all are held to the same high expectations." This sentiment was also expressed by Dr. Hicks of the University of Rochester, "I have never looked at the male/female thing as an issue because anyone dedicated to patient care and intent about the art of cardiac and thoracic



surgery is welcome at our program."

The importance of female faculty role models and mentoring was discussed at the 2012 annual meeting of the Society of Thoracic Surgeons (STS)(4). Currently, 67% of the training programs have one or more female cardiothoracic faculty on staff. How female residents feel about training with all male educators has not been explored. From the faculty perspective, Dr. Yuh noted of the 1 female resident in the 2 resident first year program at Yale, "We have not observed any discrimination [toward her] on the part of our all-male faculty, who have embraced the opportunity to train this new category of cardiothoracic surgical trainee." At the same STS meeting, the misconception of higher attrition rate among women was discussed (4). Based on survey responses, there are six people who have decided not to continue or pursue training in I-6 programs after having

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matched, only two of which were female.

Interestingly, of the 21 programs that responded to the survey, 10 had a female resident in their inaugural year (47.6%). This included Stanford, which is the only integrated program to have graduated residents, with one of their four graduates being female. The overall performances of the female residents were praised by several program directors with statements that included the following: “The female residents in our program have been amongst the best residents

we have had. They are attentive, capable, and eager to learn.”; “...thus far, we are thrilled with [our female resident’s] performance. Her enthusiasm and aptitude for learning have impressed us and are consistent with the qualities that many integrated programs are observing with their integrated residents.”

Women have an increasing presence in cardiothoracic surgery. In the current I-6 training model, the majority of female residents has exposure to a female faculty role model, and make up a significant portion of those pioneering the change in cardiothoracic surgery

training. We’ve evolved from no female board certified surgeons 36 years ago, to 4% of the certifications 4 years ago, and now 20% of the trainees. Given that the percentage of female trainees reflects the ratio of those that apply, the best way to increase the number of women in the field is to spark an early interest and encourage their application. Dr. Chikwe, the program director from Mount Sinai, reflected, “... There is a lot more potential for engaging with medical students and undergraduates to encourage them to consider cardiothoracic surgery at an earlier stage.”

References:

1. Women in U.S Academic Medicine: Statistics and Benchmarking Report, 2008-2009 < <https://www.aamc.org/download/53502/data/wimstatisticsreport2009.pdf> > p7, 14. Accessed 12/17/2014.
2. Women in U.S. Academic Medicine and Science: Statistics and Benchmarking Report, 2011-2012. <<https://www.aamc.org/download/415556/data/2011-2012wimsstatsreport.pdf>> p15. Accessed 12/17/2014.
3. Women in U.S. Academic Medicine and Science: Statistics and Benchmarking Report, 2013-2014. <https://www.aamc.org/download/411784/data/2014_table2.pdf> Accessed 12/17/2014.
4. Donington JS(1), Litle VR, Sesti J, Colson YL. The WTS report on the current status of women in cardiothoracic surgery. *Ann Thorac Surg.* 2012 Aug;94(2):452-8; discussion 458-9. Epub 2012 Jun 13.
5. Lebastchi et al. First nationwide survey of US integrated 6-year cardiothoracic surgical residency program directors. *J Thorac Cardiovasc Surg.* 2014 Aug;148(2):408-15.e1. Epub 2014 Apr 12
6. Preliminary Review of the Integrated Residency Program in Cardiothoracic Surgery. Executive Summary conducted by the Joint Council on Cardiothoracic Surgery and the Thoracic Surgery Directors Association. July 2012 <<http://www.tsda.org/wpcontent/uploads/2013/02/I-6-Year-Program-Survey-Report-final-7-2012.pdf>> Accessed 12/17/2014.
7. Integrated Thoracic Surgery Residency Programs. Thoracic Surgery Directors Association (TSDA) website. < <http://www.tsda.org/the-tsda/ct-residency-programs/integratedresidency-programs/>>. Accessed 11/12/2014.
8. ACGME Data Resource Book 2012-2013. <http://www.acgme.org/acgmeweb/Portals/0/PFAssets/Publications-Books/2012-2013_ACGME_DATABOOK_DOCUMENT_Final.pdf>. Accessed 11/12/2014
9. Electronic Residency Application Service (ERAS) data, through the aamc. I-6 Applicant Statistics <<https://www.aamc.org/download/359152/data/thoracicsurgery-integrated.pdf>>. Accessed 11/28/2014
10. Electronic Residency Application Service (ERAS) data, through the aamc. Thoracic Fellowship applicant Statistics <<https://www.aamc.org/download/360242/data/thoracicsurgery.pdf>>. Accessed 11/28/2014

STS 51st Annual Meeting Highlights

The WTS Annual Meeting and Reception

The STS 51st Annual Meeting was held in San Diego, CA Jan. 24-28, 2015. The Women in Thoracic Surgery continued to make our growing presence felt at the meeting. The Annual WTS Membership Meeting and Reception was held on Jan. 26 and was a full house! All of our scholarship recipients were acknowledged and honored.

The highlight of the evening was the WTS guest speaker, Dr. Diane Simeone. Dr. Simeone is the Lazar J. Greenfield Endowed Professor of Surgery and Physiology of the University of Michigan Medical Center. *“Women and Leadership in Academic Surgery: Challenges and the Path Forward”* was the title of Dr. Simeone’s talk which inspired a great discussion and hopefully some future leaders among our group!



Dr. Simeone at the WTS Reception



The WTS Annual Membership Meeting and Reception was packed!



WTS Early Riser Session: Practice Management

Drs. Robert Higgins, Susan Moffatt-Bruce, Joseph C. Cleveland, Richard Whyte and Valerie Williams facilitated a panel discussion on current issues facing physicians regarding the business of medicine. The session was well received and a nice adjunct to the previous night's discussion of the importance of female leadership in all aspects of cardiothoracic surgery.





WTS Social Media Presence Continues to Grow

By Mara B Antonoff, MD

Our social media presence has continued to soar over the last year, with efforts continued toward networking with other academic organizations, cardiothoracic societies, women's academic and leadership groups, and individual surgeons and trainees throughout the world. We've shared with our followers a breadth of opportunities, events, and important relevant issues in our discipline, and our following has skyrocketed.

We currently have 1002 Facebook friends, up from 554

at this time last year, with a remarkable rise over the last quarter (Fig 1). Our diverse fans originate from 45 countries and speak 34 languages. Our heaviest demographic group includes American women, aged 25-34, but these individuals still only constitute a minority of our following. We expanded our use of Facebook to include a closed group for trainees, providing a safe and comfortable forum for collaboration and mentorship. Access to this private group has been a selling point for new candidate members, with 27

individuals actively using this private group.

Over the last year, we have also worked to expand our Twitter following, working to build momentum with conversations, interactions, and networking efforts toward individual practitioners, patients, research and patient advocacy groups, academic and healthcare institutions, and societies. Our followers have grown from approximately 250 one year ago, to 556 as of February, 2015 (Fig 2). We

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have been added to 5 curated lists (Cardiac Surgery, heart-health, Surgery, Surgeons, and Women Tweeting). Our Twitter following differs somewhat from our Facebook following. Our tweets are read by fans that are 58% male. The majority of these individuals are from the US, and 23% are from abroad. They are an academic group of individuals, with interests in health, science, and technology, and they follow other academic and educational societies and institutions.

We continue to maintain a closed WTS Members LinkedIn Group, for a more formal approach to professional

networking within our membership. Essentially functioning as a database of our membership, we can each be easily identified as an expert when other members seek paper reviewers, moderators or speakers at national meetings, or collaborators for research projects and mentorship ideas. We presently have 57 WTS members engaged with the LinkedIn site, and we are eager to get more involved.

Finally, we have continued to update our website, keeping in stride with our social media efforts. Over the last 6 months, we have transferred the technical aspects of web-editing to the Social Media Director/Website Editor from

STS support staff. We recently added a medical student corner, with our first article written by Caitlin Brown on “Lessons Learned” serving as an incredibly popular hit through our Facebook and Twitter accounts, generating much laudatory praise and discussion. In all, it has been another big year for social media growth and development, and we look forward to continuing to grow this aspect of WTS’s global presence. Areas for continued development will include better utilization of the LinkedIn site, expansion of the medical student column on the website, and greater connectivity through Twitter.

Figure 1

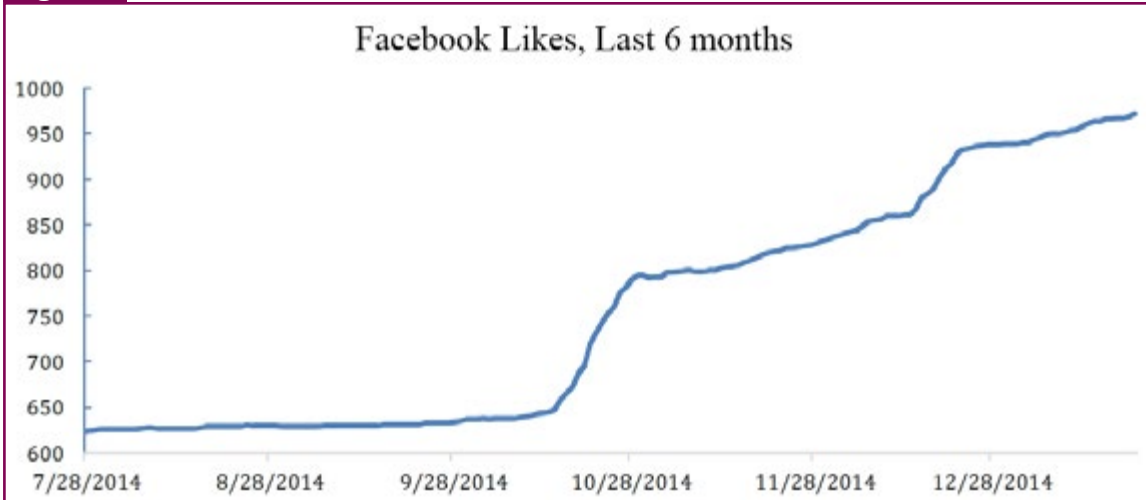
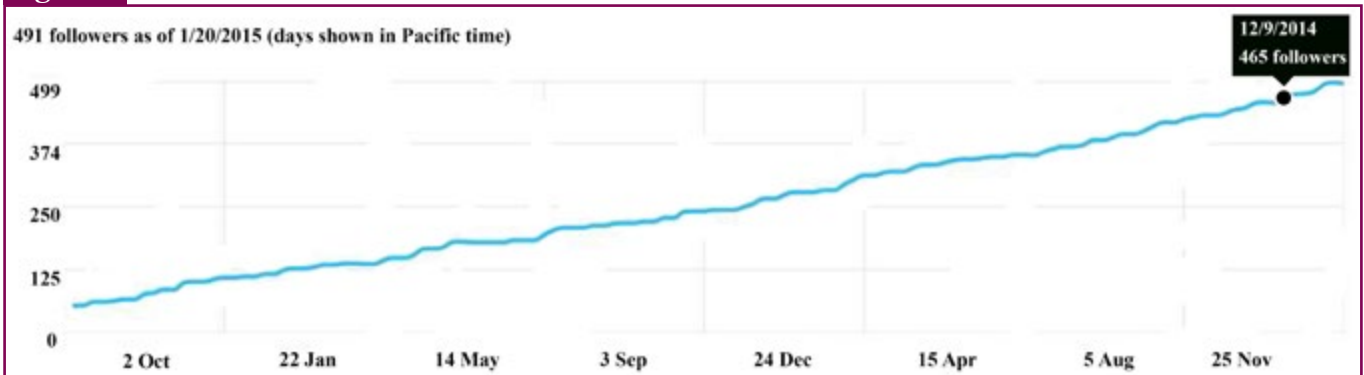


Figure 2



Getting to Know You

– Dr. Melanie Edwards, MD

By Elizabeth A David, MD

Dr. Edwards is an Assistant Professor of Surgery at Saint Louis University Hospital in St. Louis, MO with special interests in minimally invasive thoracic surgery and foregut surgery.

Why did you choose to go into medicine?

I made the decision at age 12. I liked science, I always wanted to help people and I really embraced the challenge medicine presents to always do our best. I love people and I am glad I am practicing medicine. It is one of the greatest privileges to be entrusted with people's family members. For me, its really all about the patients.

Why did you decide to pursue additional training in minimally invasive thoracic surgery?

I looked at a lot of options in the early part of my career of ways to learn and stay current with



changing technology. At the time I wasn't doing advanced minimally invasive cases since I didn't have the right case mix or clinical support to integrate new technology as easily as I would have liked. After 3 years in practice, I knew I needed to evolve as it became apparent to me that every thoracic surgeon should know how to do a VATS lobe. I thought additional training would accelerate the learning curve and also teach me how to integrate that and any additional technology in future practice settings where I would need to build programs.

Was it difficult to re-enter training after several years in practice? Would you encourage or discourage trainees from that path?

Honestly, it was an easy transition. I knew what was important in and out of the OR so I could focus on what I needed to get out of the training. I was



very selective about my training program so that I made sure to maximize that year. It is not the right move for everyone, but I could be completely immersed in the techniques that I wanted to learn.

What is your favorite case to do?

VATS lobe. Even though I love the esophagus, I love a great VATS lobe. Every so often, just when you think you are cruising along it will remind you to respect the anatomy. I enjoy approaching the logical anatomy of the lungs yet always thinking about the possible variations in the anatomy, looking for a common vein etc.

What is the most satisfying aspect of your job?

Being able to see patients when they come back to the office for a postoperative visit. They are grateful for my efforts. It is a great feeling to know that

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they believe I am committed to doing the right thing for them. Also, getting a really sick patient home is a relief and great feeling as well.

If you were given a million dollars, how would you spend it?

Well, I'd pay off my student loans and make frequent trips to Nordstrom. Seriously though, I would actually use the money to set up scholarship funds for under represented minority students for summer research. This would give them access to mentors that they wouldn't be able to meet otherwise.

What are you most proud of outside of work?

I am making efforts to spend more time with my 6-year-old nephew and who just made me an awesome handmade birthday

card. I am really proud of my relationships with my family. I'm also starting salsa lessons again! Having some balance in my life is helping me realize that everything isn't about earning a promotion and operating all the time.

Are there any mentors who have made a difference in your career?

Keith Naunheim and Rob McKenna have been very supportive. Ed Hoover is the nicest guy. I can call him out of the blue for advice; he's always available and accessible. Each of these individuals has been inspirational and made a significant impact at various stages of my career.

How have race and gender impacted your career? Has one played a bigger role than another?

It really never occurred to

me as being an issue early on. I had grown up in the Caribbean where race was not as prominent an issue as it is in the US. I just decided to become a surgeon and set about doing it as best as I could figure out at the time, somewhat naively. I have mostly run into some unspoken, sort of undercurrents over the course of my education and training and one is never sure which is the bigger problem, race or gender. Looking back, I think that the biggest problem was that I did not have mentors who looked like I did when I was in medical school and for that reason, I want to support groups that foster interest at the medical student level for students who might not otherwise be interested in surgery. I think that because there are more women than minorities and more tangible progress is being made on that front. Access to mentors for students is improving in both areas as well so I think progress is being made.

One ironic thing is that I was not aware of the Society for Black Academic Surgeons during my medical school and training because no one in my institutions was involved. I eventually did find out about the organization and it has become a tremendous opportunity for me to meet other minority surgeons at different institutions. It's a great networking opportunity. Because it is a small organization, one can sit down



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with leaders in the field of surgery face to face. It serves a great purpose and is a very good resource for minority students and faculty!

What has the WTS meant to you as an organization?

It has been a great opportunity to meet role models, successful female role models. WTS is a tremendous group of very accomplished women. I think

we are on the cusp of being able to successfully overcome a lot of barriers – barriers that used to seem insurmountable no longer are.

Is there anything else you would like to say to the Oracle audience?

The WTS has grown and will continue to grow as more women enter the field. It has an important mandate to support the advancement of women in cardiothoracic surgery. We

will still need the WTS even after women are 20% of ABTS certified surgeons or even 50%. As women, we need to be aware of those around us and those who are navigating the same path we did. We can't forget where we have been as individuals and help people with struggles and offer advice.

Thank you, Dr. Edwards, for allowing all of us to get to know you!

Women in Thoracic Surgery Book

*History of
the WTS
organization
and women
pioneers
in thoracic
surgery*



Cost: \$150.00

Please send check payable to Dr. Shanda H. Blackmon
200 First St SW
Rochester, MN 55905

WTS at the STS 51st Annual Meeting



WTS at the STS 51st Annual Meeting



WTS Scholarship Program

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

The TSFRE/WTS Carolyn E. Reed Traveling Fellowship

is now in its second year. Drs. Jessica Donnington and Melanie Edwards have been selected as honorees and they will both be spending 4 weeks with Dr. Robert Cerfolio at UAB honing their robotic skills. Congratulations ladies!

The Scanlan/WTS Traveling Mentorship Award

is continuing this year as well. This award provides an opportunity for a trainee who does not have exposure to a CT surgery mentor at her own institution to travel to spend a week with a WTS Mentor. Laura Muscianese from UC Irvine and Dr. Amanda Stramm from Indiana University were both selected to spend time with Dr. Kathleen Fenton gaining more exposure to international congenital cardiac surgery. We hope you have an enriching experience ladies. Congratulations!

The WTS Scholarship Program

is now in its 11th year! We were thrilled to have additional support from the STS this year which allowed



us to offer 12 scholarships to interested female medical students and trainees. The scholarship included meeting registration fees, hotel accommodations, \$500 in travel expenses, and provided the recipients with a dedicated mentor to help them navigate and network at the STS 51st Annual Meeting in San Diego, CA. Thank you to all the applicants and members for your active participation in an activity that helps not only the recipients but our field by helping to recruit the best and brightest!

Enjoy the winning essays! This year's essay topic was: **“How will public reporting of surgical outcomes impact cardiothoracic resident education?”**

Megan Loo, Medical Student, USC

Public reporting of outcomes represents commitment to transparency, a fundamental tenet with broad implications for resident education. Public reporting will increase the pool of data available for quality improvement and research. Externally disclosing outcomes also provides transparent and realistic expectations for informed shared decision making with patients. Finally, in my opinion, the most important reason for cardiothoracic training programs to support public reporting is engendering a sense of accountability among the teaching staff, fellows, and residents. Every patient encounter, decision, and intervention contributes to outcomes that reflect the

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overall care provided by the organization, and will inspire continual improvement.

Brandi Scully, General Surgery Resident, Baylor College of Medicine

Public reporting of surgical outcomes is here to stay. It is essential for informed consent—we can no longer speak to patients about risk in generalities. But surgeons, teachers and trainees alike, must reject the idea that this will be detrimental to resident education. It has always been the goal of surgical training to provide the best care, and reporting our outcomes does not change this. Cardiothoracic surgeons will continue to hold trainees to the highest standards, with graded independence based upon mastery of skills. Our patients will remain our first priority. Emphasizing this will only make us better.

Christina Lineback, Medical Student, University of Michigan

The STS has been a leader and innovator for decades in public reporting of surgical outcomes, a tool essential for improving

patient outcomes. Nevertheless, the tools used to quantify surgical outcomes must be held to high standards to account for variability in patient population and hospital demographics, including monitoring for ‘risk aversion’. Application of proper risk-adjustment in these reports should alleviate fears of cardiothoracic resident education impacting outcomes. The VA demonstrates a great training opportunity for residents and has long reported outcomes for cardiac surgery procedures. Furthermore, public reporting has an important ethical implication for patient and physician improvement.

Heather Palomino, Medical Student, University of California San Diego

Public reporting of surgical outcomes is ethical, increases transparency, and improves quality of care. Although, reporting may have unintended consequences such as surgeons electing to operate on lower risk patients or increased reluctance to allow residents to partake in rare high-risk cardiothoracic surgeries in which the surgeon has marginal performance outcomes. Yet according to the 2010 CCORP data, there was a decrease in mortality for CABG in California, not attributed to changes in caseload volume, suggesting public reporting has not negatively incentivized surgeons to perform surgery on lower risk

patients and, if extrapolated, will likely not negatively impact resident training.

Emi Manuia, Medical Student, Geisel School of Medicine at Dartmouth

Public reporting of surgical outcomes bolsters cardiothoracic resident education through immersion in quality assurance for patients and demonstration of excellence to attending surgeons. As preoperative, intraoperative, and postoperative actions contribute to patient safety and display resident competence, these actions provide a means to assess readiness to assume higher acuity responsibilities that are within resident abilities and that accurately reflect the surgical groups’ strengths. Hopefully this will motivate residents to hone technique and adaptability to form a strong basis with which to attack complicated cases and, ultimately, to assist those in greatest need of cardiothoracic services in our future independent careers.

Sara Kim, General Surgery Resident, UNC Chapel Hill

With public reporting of outcomes, we are forced to have realistic discussions with ourselves and also with the people that we treat regarding the care that we provide. As surgeon trainees, having difficult discussions regarding the risks of the interventions that we provide is a crucial part of our education and growth.



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Further, when we compare outcomes amongst ourselves, we are able to collaborate and we commit ourselves to becoming better surgeons. Transparency is an opportunity to share our individual successes and failures, which strengthens our field as a whole.

Mansi Shah, General Surgery Resident, UNC Chapel Hill

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

non-operatively. Hopefully with continued improvement towards risk-stratification, public reporting of surgical outcomes will improve surgical results without any negative impact.

Janani Arun, General Surgery Thoracic Surgery Resident, Mayo Clinic

The benefits of public reporting are well-described, including professional accountability, visibility, and cost-effective health care. Composite scoring metrics suggest a role for performance evaluation and hold implications regarding future employment and reimbursement. Further, the transparency of an individual center's case volumes and outcomes are pivotal for fellowship selection to ensure adequate training. For residents, calculating risk adjusted outcomes to counsel patients would guide surgical decision making, instill a personal sense of responsibility, improve training by striving towards a national standard,

and predict morbidity and mortality outcomes that are patient specific.

Julia Tolentino, Medical Student, Temple University

The modern physician guides her decisions by evidence based medicine. She weighs risks and benefits and considers terms like "statistical significance," "power," and "endpoints." The modern healthcare marketplace is far more complex, albeit similar. Public reporting of surgical outcomes will serve as the literature upon which the patient chooses to undergo a certain procedure by a particular surgeon within a given specialty, which may in turn affect costs and reimbursements of hospitals. This transparency will dictate the types of procedures a cardiothoracic resident sees, limiting her exposure to certain surgeries and patients while enhancing her proficiency in handling others more common.

Gal Levy, General Surgery Resident, Rutgers NJMS

A common expectation of public reporting of surgical outcomes is to promote an economy in healthcare performance that will encourage consumers to choose access to high quality providers. Public disclosure can promote quality improvement by encouraging providers to focus on quality problems. The smart surgeon-teacher will recognize this as an opportunity to exact specific techniques out of the trainee in order to incorporate understanding outcomes and

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correlate that with surgical training. The emphasis should be balanced between the training processes of trial and error with final outcome results. Providing an additional layer of monitoring will ultimately improve cardiothoracic resident education.

**Sophie Hofferberth,
General Surgery Resident,
Brigham and Women's
Hospital**

Public reporting of healthcare outcomes asserts the right of patient autonomy, a fundamental ethical responsibility of our profession. Surgical report cards herald an unprecedented era of accountability and performance scrutiny in cardiothoracic

surgery. The phenomenon of risk aversion is an adverse consequence of public reporting that has important repercussions for trainees. Fear that poor outcomes will detrimentally impact reputations and referrals may result in residents having less exposure to high risk patients, restricted independent operating privileges, and fewer opportunities to master complex procedures. Public reporting demands diversification of cardiothoracic resident education; simulation and specialized skills training may be useful educational adjuncts.

**Erin Schumer, General
surgery Resident,
University of Louisville**

Public reporting of surgical outcomes is necessary in order

to improve national surgical care and practice standards. By setting standards for practicing cardiothoracic surgeons and institutions, thoracic surgical education may be positively influenced by setting higher standards for residents and fellows to follow. Furthermore, transparency of information may decrease disparities among cardiothoracic training programs. Overall, surgical outcomes reporting will demand excellence from our leaders and teachers, which will secondarily demand excellence from trainees, and thus ensure a promising future for the field of cardiothoracic surgery.

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

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Elizabeth's Editorial

By: Elizabeth A David, MD

"I figure if a girl wants to be a legend, she should just go ahead and be one."



I'm one of those people who always wanted to be a doctor. My parents encouraged me and I never once heard, "you can't do that because you are a girl." In fact, I am pretty sure I can say that I cruised through life, even matriculating at Wellesley College, not realizing that this was not the case for all women. I was fortunate to train in programs where there were other female trainees and mentors so I am used to seeing women in roles to which I aspire.

Just recently, in my clinic, I met a patient who had a look of surprise when I walked into the room. I have seen this look before so I'm used to talking to patients about it. The patient and his wife readily admitted that they were surprised because "surgeons are men." I'm used to hearing that I look too young to be their doctor, but no

one's face had ever had a look of surprise that I was a woman. After an awkward moment, we all moved on to the pressing matter at hand. Later that same day, another patient told me how glad he was that I was a woman because he felt "female doctors really listened and were very detail oriented." After these interactions, I will admit that my emotions were running a little wild. Like a good surgeon, I decided to compartmentalize these thoughts and focus on providing high quality surgical care for my patients.

When I got home that evening, I took a few moments to reflect on my interactions with these two patient interactions. I remembered Dr. Simeone's talk at the WTS reception about the absolutely dismal statistics related to female leadership in academic surgery. Then a replay of the

#likegirl ad popped up on TV. Maybe it's because I am one, but it seems that women are demanding and in some cases receiving more and more recognition in society. Today women are represented in all forms of media from female political candidates making their presence known and now a new social media campaign, #LeanInTogether, aimed at educating men how to support and encourage women.

So where does that leave us? I think the WTS is more important now than ever. As female cardiothoracic surgeons, we can support and nurture each other and recognize the accomplishments of the women who have come before us and those who will follow. Our role is to lead by example and mentor new members as well as each other. By providing the highest quality patient care, and advancing the science of the diseases for which we care with innovative research, our patients, our field, and the world will see that we are leaders in our profession. I think Calamity Jane summed it up the best when she said, "I figure if a girl wants to be a legend, she should just go ahead and be one."

And the Oscar goes to...
 Check out these fabulous movies
 featuring WTS Members!

Click the title to see the movie

Disney's Black History Month
 Leah Backhus, MD, MPH

A Day in the Life of a Thoracic Surgeon
 Shanda Blackmon, MD, MPH



Please join us for the
WTS Spring Networking Reception
Sunday, April 26
7:00-8:00pm

in conjunction with the
 AATS 95th Annual Meeting in Seattle, WA
 Washington State Convention Center, Room 304

We hope to see you there!



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

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Become a Member


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Membership
Guidelines &
Application

Become a Member of Women in Thoracic Surgery

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

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

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

WTS has six membership categories for individuals and institutions.

Active Membership

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

Candidate Membership

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

Associate Membership

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

Institutional Membership

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

Honorary Membership

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

Emeritus Membership

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

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

Women in Thoracic Surgery

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