(theme music)

Seán Collins (00:05):

Who's that in the operating room?

Dr. Jyoti Shah [recorded audio clip]:

Surgery still remains very male-dominated, and it does still appear as an Old Boys' Club. And you are very much an outsider as a woman you are trying to break into their gang, almost

Seán Collins (00:20):

Jyoti Shah successfully broke into the gang. She's now a consulting urological surgeon in the UK. But despite more than half of medical students in the US being women, far fewer women than men end up in surgery. Why is that? Cynthia Shortelll is Chief of Surgery at Duke University.

Dr. Cynthia Shortell [recorded audio clip]:

The overt discrimination on the basis of gender that we saw when I was a trainee has now been replaced with, I think a more malignant form of microaggression, which is much more difficult to identify and root out

Seán Collins (00:58):

On today's program saying so long to the Old Boys' Club as we talk about women in surgery with three surgeons making a difference in and out of the OR. This is the Hear Me Now podcast that comes to you from the Providence Institute for Human Caring. I'm Sean Collins. Glad you're listening. Stay with us.

(music ends)

(01:29):

I'm really happy to welcome to the program today three surgeons from around the country who know firsthand the hurdles faced by women in surgery. Dr. Julie Sosa is chair the Department of Surgery at UCSF, the University of California San Francisco. She's also the editor in chief of the World Journal of Surgery, Dr. Sheina Theodore is a trauma and acute care surgeon at the Boston Medical Center. And Dr. Cristy Smith is a cardiothoracic surgeon and the surgical director for heart transplant and mechanical circulatory support at the Providence Sacred Heart Medical Center in Spokane. Doctors, it's great to have all three of you here today. Thank you for taking the time to talk about this issue with me. Welcome.

Guests (02:21):

Thank You for having us. Thanks. Thank you.

Seán Collins (02:24):

We just heard a moment ago a surgeon referr not only to an Old Boys' Club, but she went on to say it's like breaking into a gang. Obviously all institutions are different and we know progress is happening all over the place and we celebrate that, but inequality still exist and I'm wondering what the landscape looks like to you for a young woman wanting to go into surgery. Let's start in San Francisco. Dr. Sosa?

Dr. Julie Sosa (02:56):

Well, first of all, thank you for the privilege of participating today and I'm super excited actually to expand my sisterhood and to meet the other panelists. So this is a great opportunity to network

and strengthen bonds because, you know, I will say it is so important that each of us work together communally rather than by ourselves. I guess I can reflect a little bit about the past. I'm sort of a very upbeat person, so I'm gonna wanna focus on the present and the future. But I'm about 20 years into my career as a faculty member. I would say when I was a learner and a junior faculty member, the way I would describe life is kind of lonely as I looked around me. And I think that's because when I looked around myself, there weren't a lot of role models.

(04:02):

And I'm sort of an intersectional person. I think many of us are intersectional. And you can sustain microaggressions across any dimensions of your person. And as a woman, as an immigrant, as a Latina, I think all of them make you lonely. And then when you're sort of all of those things together, you feel particularly lonely. When I finished my residency program, which wasn't that long ago, it was 20 years ago, I was just the seventh woman to finish training. And, and I think that really speaks legions as to how lonely it was. I would say, you know, you observed, I'm in San Francisco and maybe I'll stop my comments here and say that when I was a medical student looking at residency programs, I remember interviewing at UCSF and you could say, well, why do you remember that? And I remember it because UCSF had a woman chair.

(05:08):

And at that time it was such a curiosity. And I remember flying home to Baltimore and thinking, what a magical and mystical place the San Francisco is, that there is a woman chair. And our chair was obviously Dr. Nancy Asher, a pioneer of American transplantation. And I said, when I returned home, I was like, one day I am gonna go to that place. And you know, I say this is my dream job. And I say this as a woman because our department is the only department that has had two consecutive women chairs. I think many other departments are celebrating their first woman chair and they should celebrate that. But I think it is only when we start to look at seconds and thirds do we start to truly believe that being a woman in American surgery, you are on equal footing. So maybe I'll stop there on a hopeful note.

Seán Collins (06:11):

That was a great point. But we're gonna return to the issue of culture in institutions and how that changes. Dr. Theodore in Boston, what's your take on the landscape?

Dr. Sheina Theodore (06:23):

Thank you. I'm so grateful to be sharing this platform with amazing women in surgery and people that I can look up to and can be role models for me. So I don't know how I got here, but I'm really happy that I was invited. So I'm newer to the surgery world. I just started as faculty in Boston this month, November 1st. So I can kind of speak to the culture now. And I would say that it's definitely, from what I've heard of the past on the upswing, but there's still so much work to be done. Similar to Dr. Sosa, I am a woman, but I am also black. And those two things being in surgery, it's difficult to find role models and people that look like you or people that want to mentor or sponsor you. Because there are at times where you want to be a part of the culture, but your own culture might be different.

(07:29):

'cause Like was mentioned, the beginning of this podcast, surgery at times in different specialties of surgery, I think do this more so than others can be very much so a boys club. So for someone that was raised with three brothers , I use those things to, to my advantage. But should it be that you have to take the culture that you're being given and conform yourself for that culture? Or should that culture open up its horizons and be a more accepting of people that are from different backgrounds. And for our conversation purposes here, women versus versus men. So in conclusion, I would say that the culture is better than what I've heard it was before, but we still have so much work to do in order to increase the inclusivity of it all.

Seán Collins (08:21):

More work. Thanks, Dr. Theodore, Dr. Smith in Spokane?

Dr. Cristy Smith (08:26):

So I'm close to Dr. Sosa, not quite there I am 19 years in. And I, I mean, I feel like I've seen an incredible sort of gamut and an ebb and flow. I can resonate a little bit more with the initial opening comments. I think, I mean, when I first interviewed for general surgery, I, I'm not kidding when I tell you that. One of the places I interviewed, I sat down and the woman, the the man interviewing me said, well, you know, they're making us take women in the program these days, to which I looked at and I said, I've heard that's why I'm here. And then he said, well, I miss the, I miss the old days when the only thing a woman was good for in the OR was to pat her on the rear and grab her breasts -- though not quite that politely.

(09:10):

She, it was, I mean, astoundingly it was that I had, I interviewed at a different place. They asked me to ch you said, I won't hire anyone that can't do more pushups than I can. So we did pushups and I beat him. So it was great. But, you know, these are the things that I discovered now I went from that to be incredibly blessed to work under and to do general surgery with a gentleman by the name of Dr. L.D. Britt, who is an amazing surgeon, an amazing man, and an amazing mentor. And he did not care whether you were a woman or a man. And he trained many women in his day. And then I did thoracic training under Dr. Jack Copeland, who also had trained at least three other women in thoracic surgery before I ever went through. Which again, in that day was unheard of.

(09:59):

So i, I feel like I was well supported, especially in the academic center. And now moving on to moving on to the private sector, which is where I am now. It is interesting to see how it has gone from the overt to definitely, I won't say it's microaggression so much as it's pure ignorance of how to interact with someone that is not part of your Old Boys' Club. I really think is how it's, so

I'm really excited to continue to work forward, to continue to try and move things and looking forward to the day when, it doesn't matter if you're a man or a woman where it's not, we celebrate this person because they became a chairman and they're the first woman, but rather we celebrate them because they are Dr. So-And-So who is exceptional at their craft. And so that's really where I hope we end up.

Dr. Sheina Theodore (10:49):

I think that last part that you mentioned is so incredibly important because I think we glorify when we say, oh, this is the first woman chief of this, or the first woman chair, or the first, and I'm like, we're in 2022. I would love if we could just say, this person made it as chair, and that alone is an accomplishment whether they are a woman or a man. But I think it speaks to the work we still have to do, the fact that we're still mentioning first and women and these positions in the same sentence.

Dr. Julie Sosa (11:22):

Yeah, I, I love those comments. I, I guess I would add two things. You know, my first observation is gender is not binary. And you know which is a new concept for a lot of our colleagues, but an important one. And so the concept of gender is very complicated, but I definitely do not think we have yet reached a stage in American surgery where we can drop the word woman from a lot of these, these discussions. And I think until we reach a landscape that is truly level and where there is true equity and inclusivity, we need to continue to discuss issues unique and challenges unique to, to women or other minoritized genders.

Seán Collins (12:13):

Mm-Hmm. , I have a patient's view of this, I guess. Seven years ago I had open heart bypass surgery, and while I was recovering, I did some math -- reflecting on the people who do this really life-altering work my surgeon was the only woman among more than a dozen cardiothoracic surgeons at a large teaching hospital. And she told me she often did two,

sometimes three procedures per day. And with the cost of open heart surgery being, say anywhere from $60 to $120,000 that's close to a million dollars a week that the hospital can bill for each one of those cardiothoracic surgeons, making them really significant revenue centers for the institution -- paying salaries for people who work in the ORpeople doing research in labs, people providing patient care throughout the hospital. So if a grumpy old surgeon longs for the day of groping his colleagues in the workplace, there might be an institutional reluctance to urge him to knock it off. I could see where the institutional inertia might be tempted by the balance sheet and say, 'let's let this old guard pass away and will change things in the next generation.' Question is, can we really afford to wait another generation?

Dr. Cristy Smith (14:01):

I mean, I think you kinda have two a twofold process in there. I I can see where there could be some inertia from the, just the pure financial side, et cetera, having a successful surgeon, someone who's, who's revered in their practice because they've been there for so long, or maybe they established the practice. But I also think that the people coming in the new intensivists, the new surgeons, you know, the the younger generation of hospitalists and and physicians that are now entering the fray have all been schooled in a different time and are, are truly intolerant of this stuff. And honestly shocked when they see overt sexism happen in, in any way, shape or form. So I do think that that balance is coming into play and I think that most of the generation of that sort have have faded if not gone on to other things. It's, I think it's, it's, once again, I think it's becoming a little more subtle at this point. I mean, I don't know what, what the other ladies think, but at least that's what it seems to be. It seems like it's, it's trending towards not the overt classic, you know, Archie Bunker style blah blah blah, you know, going after you, but, but more of the just inadvertently exclusionary.

Seán Collins (15:19):

But remember we heard at the top of the show from a surgeon at Duke who said microaggressions had replaced overt discrimination. Do you agree with that?

Dr. Julie Sosa (15:31):

Well, you know, a couple things. One is microaggressions are overt and when you are the victim of them, it hurts as much as a slap in the face. And for many of us, microaggressions are not measured weekly and monthly, but daily or even hourly. And you think of how much energy it takes to exist today in this pandemic where wellness is extinct, where everyone is burned out. And for those of us who are the victims of microaggressions, it's like a whole bunch of energy needs to be put into addressing those, healing from them, figuring out how to call them out to sustain change. So I would say, first of all microaggressions when you're the victim are as macro as anything comes, I would say secondly, and this is an observation I would make, is I have gone from junior to maybe less junior or more senior.

(16:39):

I'm not sure if I'm senior, but more senior. And that is to my eye, it gets worse as you become more senior. And I'm not quite sure why that is. I, I suspect it's multifactorial. I think one is things that I didn't see before I see now. And I think that's some of the naivete, some of the maturity comes from experience and realizing what actually is happening around you. Cuz you don't know what you don't know. But I think the second thing, and this is disturbing to me, is that as the stakes go up, right, when the gains are bigger gains, the losses are bigger losses, people become more entrenched and people feel who are empowered and privileged feel more vulnerable. And for instance, I'll give you an example. I've had the experience where a mentor, a really, a person who I thought was a great mentor and a great sponsor, as I became more senior and other mentees became more senior, this person became not a good mentor, not a good sponsor, and actually a competitor. And I think this is what happens as you go through your career. And I think the question for all of us is how do we push those in front of us and pull those behind us to overcome the challenges that all of us I'm pretty sure face

Seán Collins (18:14):

I'm seeing nodding in Boston and in Spokane.

Dr. Sheina Theodore (18:17):

My comment to add to this conversation would be that I think that we're in a point of overlap and in transition. I don't think that we have to necessarily completely replaced the old generation because some surgeons are malleable. In fact, many are. I mean, we have seen trends in medicine itself going from open surgeries to invasive with laparoscopic and robotic and all the things that happen in terms of research. And all of that comes out. And, and some of that translates to this conversation, which the overarching umbrella is diversity, equity, and inclusion. Whether you're talking about gender, sexuality, race, disability, immigration status, this is the overarching umbrella of our conversation. So some people allow themselves to see what may not have been the right way in the past and change. So those folks are the older generation and the newer generation are being taught that this is not something that we will tolerate. So I agree with Dr. Smith and Dr. Sosa that the newer generation is very intolerable of these, of these macro and microaggressions. And it's starting to be embedded in the surgical curriculum from even medical school where you're talking about microaggressions, how to seek them out, how to speak up, what avenues you have to talk about that. And you're essentially equipping the younger generation with the tools that they need in order for us to hopefully eradicate this and, and get the playing field more leveled.

Seán Collins (19:52):

Can we be specific about that? How does that work in different institutions, Dr. Smith?

Dr. Cristy Smith (19:57):

Well, it's, it's interesting a for no reason other than just chance. I had a conversation with my husband who is amazingly supportive through all of this about, you know, empowering women to, to be able to move into surgical careers and things like that for a number of reasons. We were having this conversation. And I think it really speaks to what Dr. Theodore was talking about, which is not just for women, but for anyone, anyone wanting to go into the surgical field in this current environment where we are all tired, we are all exhausted, all of our empathy has been sec dry in the last couple of years with Covid and everything else. How do you empower

anyone who wants to become a surgeon to do that job to the best of their ability? Because maybe it's it's someone who wants to be a part-time surgeon and wants to be at home with the kids, or maybe it's someone who, you know, wants to job share or maybe it's someone who they are primarily into their career and we have to find ways to support their significant other to help them to be successful in their career.

(21:03):

I mean, there are so many things I, so many avenues I think we need to explore to figure out surgery in general is an amazingly dynamic field. How do we help anyone who wants to become a surgeon to be the best surgeon that they can be while still maintaining their humanity?

Seán Collins (21:21):

We're talking about whether surgery remains an Old Boys' Club today. My guests are Dr. Julie Sosa, chief of surgery at UCSF in San Francisco. Dr. Sheina Theodore, a trauma surgeon at the Boston Medical Center, and Dr. Cristy Smith, who does heart transplants at the Providence Sacred Heart Medical Center in Spokane. One of the factors that gets mentioned frequently in this debate is that the training for surgery is long and can conflict with planning a family. The argument being that one of the reasons women were not traditionally favored in surgery was that it was thought that they were going to be absent for long stretches of time. Doesn't it then just fall to the institution to come up with parental leave policies that let people have a family and have a career?

Dr. Julie Sosa (22:18):

Well, I, I think these are important issues for mothers and fathers equally. And so it, it really speaks to creating, you know, a culture and a community where we provide support for fertility, for child bearing child rearing, adoption, all of these things. And I would say, you know, the training for surgery is long, but we live in a hyper specialized medical community, right? Training is long now for every specialty as we pursue hyper specialization. And so I think, you know, all

of us need to work together to find ways to support paternity maternity leave, right? For childcare in surgery. The challenge is the childcare has to start earlier, stay later and include on call, right? When there are emergencies, it's things like lactation, right? And providing facilities, facilities that are adequately equipped and proximal to to operating rooms, right? And I think it is around, it is around having policies where people are accountable if they don't do do these things. And I would say it is still very much a minority of institutions that do this. And I would say this is not for departments to solve. This is too big an issue. This is really at an institution or a profession level.

Dr. Sheina Theodore (24:03):

I definitely would agree with that. I know that there is the certain residencies not all because you have to just apply to be a member, but there is a union for surgical residents and some residency programs, their residents, you know, have come together, filled out whatever is necessary and joined those unions. And one of the things that the unions discuss on a ACGME level, which is the governing of not just surgery residencies, but all medical training at different institutions and basically say, you're doing a good job, you're not doing a good job and have the power to put residencies on probation or not. One of the things that these unions fight for is the, the very things we're talking about Lee for both mothers and fathers having lactation rooms, having just support to bring, you know, someone through that time and still not feel like their training will be in jeopardy. So that's one of the things, and again, I completely agree with Dr. Soa that it's institutional based because not all residency programs their residents are part of this union. But that's one of the things that this union fights for for the residents.

Dr. Cristy Smith (25:20):

One of the other pieces of that I think that you need to put in there that I felt at least cuz I've got two kiddos is the how to maintain someone at least somewhat cerebrally active in their specialty while they're on leave. Cuz my biggest fear was I'm gonna come off a maternity leave. I'm early in my career, I don't have as many reps under my belt where everything is just easily wrote memorization. I'm gonna come back. Having not been in practice for three months or however long you wanna take your leave, you know, how do you stay relevant and how do you look at

your fellow partner who did get in 300 more surgeries than you did in the last year because you weren't there? And how do you remain competent and competitive in that world? And I think that's the other half of this is it's not just providing the leave, but it's providing the leave and yet still allowing you to be a vital and impactful person within your practice, within your specialty. And for you to not feel like you've lost something in that interim. Cause it, it becomes a big quandary and in a, a conundrum when you're a a like, in my case, a mom looking down and wanting to be that nurturing mother and loving the, the moments I'm spending with my child, but missing the challenge of my surgical career and missing the early parts of my career where I was really excited to be be doing surgery and learning something new every time. And you, you get really torn

Seán Collins (26:47):

What institutions are doing it right?

Dr. Julie Sosa (26:51):

Yeah. I think it, it's impossible to, you know, provide a, a thorough inventory of you know, those are doing it right. I suspect no one's doing it right. There are probably some institutions that are doing it better than others, but I suspect nobody is doing it right. And this continues to be a challenge. And I guess it's just to say these are really hard problems, right? Like, if it was easy, we would've solved this. And I think in the end, solutions to inequity, lack of inclusivity you know, is really coming at the problems from multiple directions with different kinds of interventions. And I suspect in some micro climate, some departments, some institutions, some are more important than others. And that's why I feel like opportunities like this where we can discuss and share best practices are really important. So that, you know, if Dr. Theodore did the experiment in Boston and said, this failed, but this worked, I can avoid doing the experiment and take what worked and run with it. And so that's why I'm thankful when we have opportunity to exchange ideas.

Dr. Sheina Theodore (28:19):

I would definitely agree. I think one of the areas where we're able to have those conversations are many of us are a part of national organizations. There, there are so many national surgical organizations, subspecialties education, you can't be a part of all of them, but a lot of us are a part of those things. And because conversations like this one are being more readily had because people are open to listening, we're able to share ideas at these national platforms. And even at these national meetings too, having, you know, a room for lactation, having a room for childcare, having just, just different things that may be specific to a woman or a man in surgery as it relates to having to take care of children. Just things like that where I would think 30, 50 years ago were not even on the table as discussion residents are going to these national conferences and presenting their work on pre and post surveys of how to include, like I said, this is falls under the umbrella of dei, how to include this in the curriculum when, what works and what doesn't work. And that's been huge for us in order to, like Dr. Soso says not repeat something that failed. Cause then that would just be a waste of time. ,

Dr. Cristy Smith (29:41):

I mean, I think it would be amazing if there was a way to take all of these, because you're right, there are hundreds of, you know, women in medicine, you know, different subgroups and clubs and you know, all these things. It would be wonderful, there was a single repository where you could put all of that data where you could have access to all that. Where someone who was really interested in that, I mean, I had a friend send me a couple of papers I didn't even know existed on, you know, women think that they have equity in the workplace, but they really don't, and here's why. And you know, they did like some actual research to show some of the the inequities that had happened, you know, that are currently happening. And I had no idea that research was even being done. So where do, unless you really start Googling and then kind of do your own repository of that information, I think the sharing amongst our groups of just, Hey, what ideas did we come up with? Is, is a challenge in and of itself. I mean, we're in a, an incredibly communication rich world, but yet so many of those communications happen in parallel rather than, you know, being able to overlap.

Dr. Julie Sosa (30:47):

Yeah. I think if, if I can say, you know, I and the other two speakers have touched on this as have you where you asked the question, you know, are we just, should we just wait for people for generational change to occur? And I think what accelerates the process is allyship and you know, everyone on this podcast, we are allies for each other, right? But some of the most powerful allies and and therefore engines for change are not women. They are men in powers in powerful positions or privileged positions like Dr. Brit, for example, who was called out as an ally who can deploy their power and their privilege to affect change. And I, and I think it, it serves all of us well to align what we are doing with others, whether it's say our department aligning with our school of medicine, our health system, our institution, or all of us on this podcast aligning with you know, the Association for Women's Surgeons, meaning there is strength in numbers and the numbers should be women, they should be men, people of all genders working together to common goals. So I I would stress allyship,

Seán Collins (32:14):

It's almost like you're describing a vision of a new medicine. Yeah. Maybe I'm wondering about outreach to undergraduates in college is, yeah. Is there any sort of messaging that's being targeted to young women in college who probably need to know that surgery is a viable career path for them?

Dr. Cristy Smith (32:33):

Dr. Theodore is the, the newest to, to this. How were, how were you encouraged to go into surgery?

Dr. Sheina Theodore (32:38):

, that is a great question. Because I came into medicine originally thinking I was gonna be a pediatrician. And because I had a phenomenal pediatrician when I was growing up, so that was my only vision of a doctor. She was from India and she was just amazing. Like, I just absolutely adored her and I thought she was perfect. She was for our community. But then when I went to

medical school, I sadly was like, oh, I don't think I wanna do this. But then fell in love with surgery. And I think to Dr. Sosa's point, allies are super important because I did not have many women mentors when I started in surgery. But I had really great male mentors that saw something in me and said, listen, you're gonna be great at this. Like, you know this, do this and this and that.

(33:32):

And just kind of pushed me in the right direction of what I needed to do in order to succeed. And it was only until later in my training when I started, you know, having women mentors and women sponsors. But I think that in terms of engaging early on, there's always mentorship and, and outreach and like I mentioned, a lot of our national societies, wherever the city is that we hold our conference, we try to do an outreach event for even high school students. A lot of our researchers that are part of our, our teams either basic science or outcomes research, they're undergrad or graduate students. But I think that with anything with dei, we have to be careful of the leaky pipeline. So I don't think there's so much of a, there is not people that want to go into surgery from high school, undergrad, graduate.

(34:27):

I think that there is interest and then it gets down to the funnel of the point from medic medical school into residency and somehow the pipes start leaking and we don't retain or we don't continue to keep the interest of those that originally thought. And it's for many different reasons. I remember I was very sad that I didn't wanna go to pediatrics, but I was very sad that I wanted to go into surgery because I was like, well, that's it, right? I won't have time for travel, which is what I love to do. I won't have time for my friends and family who are like my people, my support system. And it wasn't until a male surgeon sat me down was like, listen, you can have time for whatever you wanna have time for. If you want to continue to travel, then you'll do that.

(35:09):

You'll fit it into your schedule if you want to, you know, make sure you make it to certain events for your friends and family, you'll fit that in. And I don't think he knew how huge that conversation was for me. It might have been something small, just a couple of comments for him, but it stuck with me. And I think that where we're losing people are in this pipeline and for whatever reason from between medical school and residency, something deters them. Either a encounter with a surgeon that wasn't pleasant or a lifestyle that they don't think that they would fit into. Or even I got the, you're too nice to be a surgeon. Like, all, all those kinds of things where we need to change the, going back to what we talked about earlier, the culture of it all so that it is more inclusive and someone that likes to travel and spend time with their family and is bubbly and laughing and joking can still be a trauma surgeon. , like that those things are not mutually exclusive.

Dr. Cristy Smith (36:03):

I think it's also interesting if you look, so a lot of trauma surgeon and you know, correct me if I'm wrong, but a lot of trauma surgery are now starting to go to almost more of a, a shift kind of based mentality. Like you're, you're doing it for 12 hours, you're off for 12 hour, you know, you have that kind of a schedule like an intensivist or a hospitalist, which is very different from, you know, I mean like right now with the transplant things that I am doing, I'm more or less on call 24 7, 365 depending on what's going on. And it's, it's the lifestyle of surgery outside of trauma and ones that are easily kind of pushed into a shared shift mentality that I think is, is challenging too. And I think that's the other part of it, is rethinking how we create these surgical careers to dovetail more with lifestyles that, that everyone is seeking to have a balance.

Seán Collins (36:57):

Yeah, my father was an OB/GYN who did his training back in the 1930s and was a surgeon during World War II and then started a private practice and rode the crest of the baby boom for the next 30 years. If someone asked him what he did for a living, his answer was always, "I'm a physician and surgeon." It made an impression on me as a kid that he made a distinction. I'm wondering if that's just a very old-timey hearkening back to the way people were trained, going all the way back to the middle ages when surgery was a distinct profession. Or is there a culture

to surgery — a mystique — that makes you all different in some way from your other colleagues in medicine?

Dr. Cristy Smith (37:49):

I think I make that distinction every time someone calls me a cardiologist instead of a cardiac surgeon. It, it's, it's interesting cuz my, you know, I work really closely with one of the cardiologists and it's just, it's a different, it's a little bit of a different culture, but it's also depending on what you do, there are, there's a longevity to some of the, the more medically based specialties, you know, pediatrics or family medicine where, you know, they, they really follow these patients for years and years and years. And unless you're in surgical oncology or transplant, you're not gonna have that as much. And it's a much more I don't wanna say energetic, but just more frenetic kind of a pace when you're doing it. And so I think that's at least one of the distinctions, but I feel like there really is a distinction to what draws you to the field. But I'd love to hear what the ladies say.

Dr. Julie Sosa (38:39):

I don't know. Most people think I'm a nurse or a student, so you're doing, they think you're a cardiologist, but, and I, when they say, are you a nurse? And I usually say, thank you , thanks very much. I appreciate that. You know, so I, you know, people stereotype all the time. I, I guess, you know, I think here's a story I really hate and it happens every time a new group of medical students rotate onto surgery. They do their clerkship with us, and at the end we go, how, how is your experience? And they say, oh, it was excellent. I'm so shocked. And I'm like, what? Like, why are you shocked? Right? And it is, and it's not their fault. I totally get that right. But it is because they have grown up with stereotypes, right? Based on implicit bias that somehow surgeons formerly barbers, right?

(39:37):

Surgeons are different than other physicians. Usually not in a good way. They're not as nice, you know, and they're not as kind as, and they're not as patient. So I guess I'm someone who tries to lump rather than split and to say, let's overcome these implicit biases. Any physician can be mean, any physician can be kind, right? And we should be spending less energy stereotyping and more energy trying to get everyone, you know, great. Right? and I guess, you know, the other thing is how do we improve the circumstances for women? And I, I think you have to come at this many ways. I'd say we gotta pay 'em the same. You know, and the sad fact of the matter is women make what now? 90, 90 to 92 cents on the dollar compared to men in the health professions in 2022, it's obscene. So we gotta pay them as much. We've gotta promote them, we've gotta train them so they're ready for that leadership opportunity. We gotta spend a lot of time retaining and even more time, you know, recruiting and how to do that. It's super complicated, right? You need job descriptions, you need transparency, you need to put together the right search committees. I honestly feel like that's where our energy should be focused enough about the past focus instead on the present and what we can do to make the future even better.

Seán Collins (41:15):

As we begin to wrap up. I, one last question for you all. How did you come to know that surgery was the right path for you?

Dr. Sheina Theodore (41:25):

So for me, it was when I was in medical school during my clinical rotations I was not the type of person that went into medical school with a super subspecialty in mind. I thought I was gonna do pediatrics, but I was open to allowing the experience of medical school to help me to choose what would be the best for Sheina as a person, how I could provide most for my community. Like where would my special set of skills, personality, uniqueness do the most for the community that I wanted to reach? And I felt that in surgery I not only had the complex physiology, the anatomy, but I also had the ability to affect change with my hands. And also the ability to comfort someone in their most vulnerable state, because I think there's a lot of vulnerable states in medicine, but I may be biased in saying this, going under and having a

procedure and having surgery done is probably top three, if not number one on the list of vulnerability. And I thought that who I was as a person, how I had been trained, my experiences, my uniqueness, I was the person to take care of people in that state. So once I had that experience and that exposure, I did what any surgeon does trust by verify. So I did a whole bunch of extra rotations, to make sure and it made sense and I 100% am happy with my decision.

Dr. Julie Sosa (43:09):

Yeah, I was I was like Dr. Theodore, I thought I was gonna be an internist. And then I did surgery, which I kind of put off cuz I thought I was gonna be an internist. And the reason I went into surgery so I'll just preface this by saying I love roller coasters. I know some people hate roller coasters. I love roller coasters. But but the way I felt in the operating room was the way I feel on a rollercoaster. It's this extreme. I'm an endocrine surgeon, so I think a lot about hormones. Like, it's like this extreme adrenaline, no adrenaline, a rush and a high that I have never felt doing anything else. And that's still the way I feel in the operating room. So that's how I knew I wanted to be a surgeon. That's

Dr. Cristy Smith (43:59):

Great. I know for me, I actually also thought I was gonna do pediatrics for a while. And I I recognized that it, it was a, it was a very distinct moment that I remember vividly because I was walking down the hallway, getting ready on my pediatric rotation, actually getting ready to go see one of my patients that was on the floor and do like an afternoon check on that patient. And then they wield past me with a young girl on a gurney who I had previously taken care of. And they were wheeling her into surgery to do her surgery. And I literally followed the gurney, got to the doors of the, or they shut. And I realized I can't, I can't go in there. I'm not doing the surgery. And it was just such an amazing moment to sit there and say, that's where I wanna be.

(44:46):

I don't wanna go to the, I wanna go in there, I wanna be the one who's helping to fix her. I wanna make it better. And I, I recognize for me it was that moment of recognizing that I want to be able to definitively fix something and, and for surgery you get a lot more of that. You know, my husband calls me Iggy, instant gratification girl. You get a lot more of that instant gratification by fixing something you know, right there in the or. And so that was my, that was my realization moment.

Seán Collins (45:15):

That's Dr. Cristy Smith, the cardiothoracic surgeon and surgical director for heart transplant and mechanical circulatory support at the Providence Sacred Heart Medical Center in Spokane. Also with us... Dr. Sheina Theodore Trauma and acute care surgeon at the Boston Medical Center. Dr. Julie Sosa, chair of the Department of Surgery at the University of California, San Francisco, UCSF. And she's the editor in chief of the World Journal of Surgery. I'd like to share with the three of you something a poet friend of mine, Alexandra Beers, in Brooklyn, sent me after my heart surgery.

(45:59):

It's called "Recovery"... for Seán Collins.

(46:04):

"They open your heart the way dentists open your mouth, as if they can just peek inside, and then they start with the loud drills and suction and all manner of vocabulary is tossed about and picking and pulling until they have cleaned you up, and afterward you are supposed to just spit and go on living the way you did, your teeth or your chest or your whole self sore for a bit, and you avoid hard candies and proceed with caution. Then you almost forget and you just bite and swallow and breathe easily again. Only if you are alive, really alive to this you are never the same. You are deeply in love with the people who fixed you and you want to stay in their care forever. Yet you must rise, rise each day to the blessing of blue true nothing of all knowingness

that they bestowed on you as they sewed you up with the twine of science and grace and sent you out to join the rest of us. Be brave, and share."

(music under)

(47:34):

Doctors, I want to thank you for all the healing that you do. Thank you for fixing people with the twine of science and grace. I really have enjoyed the conversation today and so grateful for your time.

Guests (47:47):

Thank you so much. Thank you. It was really nice to meet all of you. Oh, fantastic. Thank you .

Seán Collins (47:54):

The Hear Me Now podcast is a production of the Providence Institute for Human Caring. The program is produced by Scott Acord and Melody Fawcett. We have research help from medical librarians Carrie Grinstead, Basia Delawska-Elliott, Sarah Viscuso, and Heather Martin. Our theme music was written by Roger Neill. The executive producer is Michael Drummond. Join us in two weeks for our end-of-year episode and an exploration of music that promotes wellbeing. What tunes do we turn to when we need to take care of ourselves? I'm Sean Collins. Thanks for listening. Be well.

(music ends)