



Women In Surgery

VOL 1, ISSUE 2

CAREERS ON THE CUTTING EDGE

Survey Shows Women Happy in Surgical Career

A typical Tuesday in the Troppmann household begins at 5 AM when Kathrin Troppmann, MD, and her husband, Christoph Troppmann, MD, wake up and get their children ready to go to day care. One parent drops off the kids while the other goes ahead to the University of California (UC), Davis Medical Center where they both work as surgeons.

The husband and wife MDs—a transplant surgeon and a gastrointestinal surgeon, respectively—see each other at the hospital’s morning morbidity and mortality meeting before parting for the day, each heading to their respective ORs. They often pop into each other’s ORs to get a sense of how the other’s cases and day are going,

and to discuss when the kids need to be picked up. They occasionally communicate important information through the circulating nurse, such as if one of the children is feeling ill.

When asked how she compares with other female surgeons, Dr.

Troppmann paused and said, “I never really thought about it that way, but I guess I’m quite typical of a woman surgeon.”

According to a recent study co-authored by Dr. Troppmann and published in the *Archives of Surgery*, the typical female surgeon is happy with her career and would

see CAREER, page 5



INSIDE

- 2 Meeting Calendar
- 3 Residency Corner: Surgeons discuss the role of mentorship in a surgical career.
- 7 Best Practices: Women surgeons talk pregnancy and motherhood.
- 11 Tips: Surgeons share their preference for music in the OR.

GENERAL SURGERY NEWS



Surgeons Eager To Social Network

Ramona Bates, MD, is a cosmetic surgeon who runs her own solo practice in Little Rock, Arkansas. Dr. Bates has privileges at 3 local hospitals, but nevertheless, the combination of being a specialist with a solo practice can leave her feeling somewhat disconnected from her colleagues.

Because of this, in part, Dr. Bates also is a prolific blogger. Over the past 3 years, Dr. Bates has posted nearly 1,000 entries to her blog “Suture for a Living” and garnered dozens of followers who regularly comment on her posts.

She knows many of the other physicians within her social network only by their online handles—names like “Buckeye Sur-

geon” or “Denver Doc”—but nevertheless these online conversations provide a sense of community that often can be lost for a solo practitioner.

“There is just that nice camaraderie that I miss from the days of medical school, residency, and fellowship where you had these other colleagues, and they weren’t always your specialty, but they were people who understood the frustrations that you were dealing with,” said Dr. Bates.

Since starting her blog in May 2007, Dr. Bates has met many of these colleagues at national meetings like Blog World Expo and has extended her dialogue into other social

see SOCIAL NETWORKING, page 9

Meeting Calendar 2010

SOCIETY OF CRITICAL CARE MEDICINE (SCCM)

January 9-13, 2010
Miami Beach, FL
<http://www.sccm.org>

ACADEMIC SURGICAL CONGRESS

February 3-5, 2010
San Antonio, TX
<http://www.academicsurgicalcongress.org>

WOMEN IN SURGERY CAREER CONFERENCE FOR RESIDENTS

February 25-26, 2010
The University of Maryland, Baltimore, MD
www.womeninsurgery.com

NATIONAL WOMEN IN SURGERY CAREER SYMPOSIUM

February 27, 2010
The University of South Florida, Tampa, FL
<http://www.cme.hsc.usf.edu/wis>

HEALTHCARE INFORMATION AND MANAGEMENT SYSTEMS SOCIETY (HIMSS)

March 1-4, 2010
Atlanta, GA
<http://www.himss.org>

CARDIOTHORACIC SURGERY SYMPOSIUM

March 4-7, 2010
Newport Beach, CA
http://www.amainc.com/cref_cardiothoracic.html

AMERICAN HERNIA SOCIETY (AHS)

March 17-20
Orlando, FL
<http://www.americanherniasociety.org>

SOCIETY OF AMERICAN GASTROINTESTINAL AND ENDOSCOPIC SURGEONS (SAGES)

April 14-17, 2010
Landover, MD
<http://www.sages.org>

DIGESTIVE DISEASE WEEK (DDW)

May 1-5, 2010
New Orleans, LA
<http://www.ddw.org>

WOMEN IN SURGERY CAREER CONFERENCE FOR RESIDENTS

May 8-9, 2010
New York University, New York, NY
www.womeninsurgery.com

AMERICAN SOCIETY OF COLON AND RECTAL SURGEONS (ASCRS) ANNUAL MEETING

May 15-19, 2010
Minneapolis, MN
<http://www.fascrs.org>

WOMEN IN SURGERY CAREER CONFERENCE FOR RESIDENTS

May 21-22, 2010
The University of Minnesota, Minneapolis, MN
www.womeninsurgery.com

AMERICAN SOCIETY FOR METABOLIC AND BARIATRIC SURGERY (ASMBS)

June 20-25, 2010
Las Vegas, NV
<http://www.asmb.org>

WOMEN IN SURGERY CAREER CONFERENCE FOR RESIDENTS

TBD, 2010
Stanford University, Stanford, CA
www.womeninsurgery.com

DISCLAIMER—*Women in Surgery* (brought to you by *General Surgery News* with editorial and financial support from Covidien) is designed to be a summary of information. Although it is detailed, it is not an exhaustive review. No liability will be assumed for the use of this publication. Readers are urged to consult any relevant primary literature.

Copyright © 2009 Covidien. Printed in the USA. All rights reserved, including the right of reproduction, in whole or in part, in any form.

Supported by

December 2009



COVIDIEN

GENERAL SURGERY NEWS

Find Your Guiding Light in Residency

Lori Brown, MD, was pleased to be paired with a female mentor with whom she could identify when she started training at the general surgery program at the University of South Florida (USF). "I think that oftentimes the value of the advice is increased when you feel like you can relate to the mentor in some ways," said Dr. Brown, a first-year resident and intern at USF in Tampa.

Her mentor, Sharona B. Ross, MD, assistant professor of surgery, director of surgical endoscopy, and MIS Fellowship director, Tampa General Hospital, USF, offers Dr. Brown guidance on a variety of matters concerning her education and personal life. "She is available to answer questions, offer guidance in terms of what I can expect from different rotations, and what I can expect from the program year to year as I progress," said Dr. Brown. "Also, because she is a woman surgeon, she can offer insight as far as balancing family and career."

Dr. Ross serves as Dr. Brown's formal mentor, an arrangement that began when Dr. Brown first joined the program. In most institutions, a mentor is assigned to first-year residents to give them support; over time, residents may find other, informal mentors who better fit their needs.

"We do assign mentors when they come in, in case they inherit a problem before they can build up a mentor relationship," said Julie Ann Freischlag, MD, chair, Department of Surgery, surgeon-in-chief, Johns Hopkins Hospital, Baltimore.

"We try to match them up by maybe where they're from, or what they state their interest is, or where they went to medical school. But obviously, none of those things really make a mentor," said Dr. Freischlag. "Once they're established here we try to have them choose someone they admire."

Indeed, because everyone has particular strengths and areas of interest, Dr. Freischlag encourages residents to have several mentors. New faculty also are assigned formal mentors and are encouraged to find informal mentors both within and outside of the institution.

"Over time we've learned that you need different mentors for different things," she said. "Some people are really good to mentor you on your research, and others to mentor you on clinical matters."

The fact that Dr. Brown has a female mentor places her in the minority of mentees. "We don't have many woman mentors," said Dr. Ross, a problem that she views as systemic

and a possible explanation for the small number of women who choose surgical careers despite the fact that half of today's medical students are women.

To address this problem, Dr. Ross founded the USF Women in Surgery initiative. She hosted the preliminary meeting at her home, and 75 of the 100 guests were students. "Among those women there was a great request for something even bigger, more national; that's when we developed the first annual National Women in Surgery Career Symposium, which will be held February 27, 2010 in Tampa." Contemporary topics to be explored include leadership positions in surgery, mentorship, quality of life, and the advancement of women in surgery.

All of this is not to say that men make

see *MENTOR*, page 4



Medical students Lindsay Rumberger, Krista Haines, and Kathryn Crum.



Sharona Ross, MD, founded the USF Women in Surgery initiative. The first meeting on September 25, 2009 was attended by 75 medical students and set the stage for her National Women in Surgery Career Symposium which will be held February 27, 2010 in Tampa.

MENTOR

continued from page 3

poor mentors. “I think men can be very good mentors for women. I had male mentors who helped me a great deal,” said Dr. Ross. “But women have issues that male mentors just cannot relate to.”

A benefit of being mentored by someone who is similar to you is that it encourages a positive response to the question “am I capable of this?” This may be a needed validation for many women.

“Women don’t necessarily mentor better, but they look like you, and that actually makes people think they can do it,” said Dr. Freischlag. “I think one of the biggest issues we have with women taking leadership positions is that they just don’t see many—there are only 3 [female surgery department] chairs in the country.”

For this very reason, Dr. Freischlag gives presentations to create awareness around women in surgery. “People often can’t see a lot of women surgeons in their own institutions; it’s very important for us to be out there making that happen for those who are coming behind us.” In light of the looming surgeon shortage, this may be particularly important for the health care delivery system.

Although women in the field of surgery—mentors and mentees alike—remain fairly scarce, the numbers have increased since Dr. Freischlag, who is 55 years old, began her medical career in 1986. Likewise, the face of mentoring has changed considerably.

“You talked about your mentor, who was mainly the guy you liked best,” said Dr. Freischlag. “It was usually because they were a great surgeon or a great person, or you worked in the research lab. But no one had coaches, and no one thought of mentoring as an art form.”

Back then, a mentor was, to some degree, someone who told you what to do. “Frankly, they would mainly tell you to

be like them,” said Dr. Freischlag. “They never really asked you what you wanted to do or what your goals were.”

An ideal mentor should be knowledgeable, available, and approachable. “[Mentors are] like a life coach, educational advisor, or career advisor who will guide the mentee along,” said Dr. Ross. “The mentor should be a source of information and someone who can advise good habits and create opportunities for networking and clinical publishing.”

But a good mentoring relationship requires a commitment from the student as well.¹ “The mentee has to be available, and to realize that the mentor’s role is not necessarily to agree with you,” said Dr. Freischlag. Also, the mentee has to be willing to view the mentor as a confidante. “If you’re not telling [the mentor] about the issues or problems you’re having, that won’t allow the mentor to do a very good job.”

Furthermore, Dr. Freischlag urges that you must be able to solve some of your own problems. “A mentor is not going to be your defensive line all the time,” she said. “You have to write your papers and grants and do the cases and the work. Having a mentor doesn’t allow you to do less work, it just lets you be focused—it is really on your shoulders to try to make it work better.”

For more information about USF Women in Surgery or the upcoming symposium, please contact Dr. Ross at sross@health.usf.edu or 813-844-4006. To search the Association of Women Surgeons mentor database, please visit http://www.womensurgeons.org/home/Get_A_Mentor.asp.

REFERENCE

1. Mentorship. Association of Women Surgeons. <http://www.womensurgeons.org/CDR/Mentorship.asp>. Accessed November 23, 2009.

TABLE. HOW TO BE A GOOD MENTEE

- Be eager to learn
- Be flexible with mentor’s schedule
- Be prompt and come prepared to meetings
- Ask for advice
- Listen and consider options
- Show appreciation

Adapted from reference 1.

“[Mentors are] like a life coach, educational advisor, or career advisor who will guide the mentee along. The mentor should be a source of information and someone who can advise good habits and create opportunities for networking and clinical publishing.”

—Sharona B. Ross, MD



**Women
In Surgery**

**ARE YOU A MENTOR OR A MENTEE?
PLEASE VISIT WOMEN IN SURGERY ON FACEBOOK TO SHARE
YOUR MENTORSHIP EXPERIENCE.
WWW.FACEBOOK.COM/WOMENINSURGERY**

CAREER

continued from page 1

choose surgery again; is married to another professional; has 2 children who were born after her residency; relies heavily on professional sitters; wants a more flexible work schedule; and would love a child-care facility at the workplace.¹

“One of the goals of this project was to present a very realistic portrait of the positives as well as the negatives of the profession,” said Dr. Troppmann.

“The important implication is to let female medical students know that the hours are long. There are challenges, but they can be overcome with the appropriate knowledge, planning, prioritization, and support.”

Dr. Troppmann’s study, which was co-authored by her husband and other colleagues from the Surgery Department at the UC Davis Medical Center, provides an illuminating portrait of male and female surgeons—how they practice and how they live outside of the hospital.

The survey obtained responses from 895 surgeons (178 women, 698 men; 25.5% response rate). The results showed that although men and women share a high level of satisfaction with their professions, women differ significantly from their male colleagues on other matters.¹

Female surgeons are less likely to become parents (63.8% vs 91.3%; $P < 0.001$); if they do decide to start a family, they wait longer than their male colleagues. A large number of female surgeons with children (62.5%) had their first child after they started practice, whereas many male surgeons (60.2%) became fathers before they finished residency.¹

Marital patterns differ as well. Women are more likely to marry another professional (43.5% vs 23.1%; $P < 0.001$), other physicians (18.1% vs 13.9%; $P = 0.21$) or, especially, surgeons (18.8% vs 2.7%; $P < 0.001$). Fewer than 10% of female surgeons have stay-at-home spouses, a stark contrast to the 56.3% of male surgeons whose wives are homemakers.

Instead, female surgeons heavily rely on professional, in-home babysitters. More than 40% of female surgeons pay for professional, in-home child care, whereas only 10.5% of male surgeons do the same.¹

Will the findings deter women from surgery? “Not at all,” said Dr. Troppmann. “We’re busy. ... But, if you have a will, it can work. That’s it.”

Dr. Troppmann’s study sent questionnaires to US surgeons who were board-certified in 1988, 1992, 1996, 2000, and 2004. The survey included a variety of questions related to practice type, number of years in surgery, marital status, number of children, child-care arrangements, and work schedules. The responses were compared based on gender.¹

“Surgery has traditionally been one of the most male-dominated specialties in medicine, so the conversations about workplace changes that could encourage women to choose and to stay in surgical careers are just getting started,” said Dr. Troppmann.

“Our goal was to provide health care leaders and policymakers with good information for encouraging those conversations.”

“This study pretty much echoes what we all thought but gives some validity to what we all perceive,” said Celeste Hollands, MD, director of pediatric surgery at the University of South Alabama in Mobile.

Dr. Hollands and her husband postponed having children because they worried about the extra cost of child care, and balancing their careers with children. In the end, they decided to have dogs rather than children.

Dr. Hollands said she is amazed at some of the creative ways she has seen women balance their work and personal lives. She said one of her first bosses used to bring her baby to the office and breastfeed between cases. The secretary would look after the baby during cases.

“I hope [this study] will change the thinking of hospital and university administrations so that they find some way

to partner with their faculty, allowing them to focus more on family and have child care available. That’s what I hope it changes,” said Dr. Hollands, adding that men also want more time with their families.

Nicole Fox, MD, MPH, administrative chief resident at

see CAREER, page 6



“I hope [this study] will change the thinking of hospital and university administrations so that they find some way to partner with their faculty, allowing them to focus more on family and have child care available.”

— Celeste Hollands, MD

TABLE. PORTRAIT OF TODAY’S FEMALE SURGEON

Works full time	93.8%
Married	75.6%
Spouse is a homemaker	9.4%
Spouse is also a surgeon	18.8%
Has a child	63.8%
Waited until after fellowship/residency for first child	62.4%
Relies on in-home babysitter	40.4%
Believes work should provide a child-care facility	86.5%

Adapted from reference 1.

CAREER

continued from page 5

the general surgery residency program in Christiana Care, Newark, DE, noted that the 2010 graduating class is comprised of all women. “Three [chief residents] are starting fellowships—2 in trauma, one in breast—one is going into private practice, and 1 is undecided.”

Dr. Fox balances her general surgery training and family demands. “One thing I have learned since I had my daughter 15 months ago, is to make efficient use of my time at work. This usually means no lunch or break during the day. That way, the 2 or 3 hours I have at night with my daughter I can focus solely on her (and my husband).”

“I think for anyone considering going into surgery, you need to accept and understand that your 5 years of residency are a time of sacrifice for you and your family,” added Dr. Fox. “After that, you can make some decisions about how you want your life to be.”

The majority of men and women surveyed said that child-care facilities should be available at work (69.7 vs 86.5%).¹

Both male and female surgeons reported working long hours; men worked an average of 65 hours, compared with 60 hours per week for women. There were no significant

differences found between different surgical specializations. The only exceptions were breast surgery, where women outnumbered men (20.2% vs 1.3%) and vascular surgery, where men were overrepresented (10.3% vs 2.9%; $P=0.002$).¹

Women were more interested than men in part-time or shift work. Women also were more likely than men to support full-time, shift-work opportunities (39.8% vs 29.1%) or part-time work opportunities with call cross-coverage (66.6% vs 45.5%).¹

According to the US Department of Labor,² only 8% of surgeons worked part-time in 2007.

“Hospitals and offices will have to consider the needs and expectations of women,” said Dr. Troppmann. “Otherwise, it will be difficult for institutions to recruit top surgeons. And, if the workplace can’t be flexible, the surgical field will lose a lot of talented women.”

“Surgery has opened up to new systems and schedules, with more options for women and for families today,” said

Lyssa Neida Ochoa, MD, a first-year vascular fellow at Baylor College of Medicine in Houston.

“I chose surgery as a medical student because I was passionate about surgery ... I chose vascular surgery as a resident because it gives me more leeway in a future career in case I want a family,” she said.

Dr. Ochoa, who is not yet married and has no children, plans to have a family eventually. She will manage her career around her family life, she said.

“I definitely think it’s manageable. We have 4 people in fellowship: 2 males and 2 females. I don’t feel there is a stress that I can’t be both a vascular surgeon and a wife with kids if I choose,” she said.

“The important implication is to let female medical students know that the hours are long. There are challenges, but they can be overcome with appropriate knowledge, planning, prioritization, and support.”

—Kathrin Troppmann, MD

TABLE. TIPS FOR MAKING IT WORK

Have a social support system

Find a family-oriented surgical practice

Arrange for child-care service at the workplace

Leave room for family time in your schedule

REFERENCES

1. Troppmann KM, Palis BC, Goodnight JE, et al. Women surgeons in the new millennium. *Arch Surg*. 2009;144(7):635-642.
2. Bureau of Labor Statistics, US Department of Labor. <http://www.bls.gov/oco/ocos074.htm>. Accessed November 5, 2009.



**Women
In Surgery**

**ARE YOU MARRIED TO ANOTHER SURGEON?
PLEASE VISIT WOMEN IN SURGERY ON FACEBOOK TO SHARE
YOUR EXPERIENCE IN A DUAL-SURGEON MARRIAGE.
WWW.FACEBOOK.COM/WOMENINSURGERY**

Surgeons Talk Pregnancy and Motherhood

Urologist Lori Lerner, MD, got pregnant easily when she was 34 years old and just entering her second year of practice.

Her pregnancy, however, did not progress smoothly. She developed contractions at 18 weeks. She kept working but the contractions worsened as the weeks wore on. At 36 weeks, her physicians prescribed bed rest and her labor was eventually induced.

At age 38, Manjula Jeyapalan-Noone worked throughout her pregnancy without a hitch. She performed 2 operations on Nov. 10, about 2 weeks before her due date. She delivered that evening.

“Some women surgeons have a lot of pregnancy complications. Other women have no problems, even later in life. Why, we really don’t know,” said Dinee Collings Simpson, MD, a general surgery resident at Brigham and Women’s Hospital in Boston, who is currently pregnant with her first child.



Women surgeons experience high rates of complications during pregnancy, far higher than most women in the United States.

As recently as a decade ago, the surgical community rarely discussed pregnancy—officially, anyway. There were no dedicated panels at surgical meetings, no surveys, no support groups. Pregnancy was dealt with on a woman-by-woman, hospital-by-hospital basis.

Now, the profession is starting to speak more candidly about pregnancy and women surgeons. At least 2 studies are currently under way, and at its 2009 Clinical Congress, the American College of Surgeons offered a first-ever panel session devoted to pregnancy. Today, the Internet provides information and support and that will increase next year when Dr. Collings Simpson launches a Web site focused on motherhood and women surgeons.

One clear fact that’s emerged from the discussion is that women surgeons experience high rates of complications during pregnancy, far higher than most women in the United States.

Dr. Lerner has spent the past 3 years looking at pregnancy outcomes among surgical specialists. After her own difficult pregnancy, she launched a study to explore pregnancy complications among urologists and, in 2007, surveyed the 365 board-certified female urologists about their experiences.¹

The results amazed her. More than one-fourth reported complications. One in 10 used assisted reproductive technologies (ART) because they could not conceive—a rate 10 times higher than the national norm, according to the Centers for Disease Control and Prevention. One in 5 women was placed on bed rest (21.2%) during her pregnancy, and 1 in 3 (31.8%) was induced early.

“The take-home message of this study is that, if you’re a female urologist, you’re more likely to have complications than other women. The odds are high, very high,” said Dr. Lerner, an assistant professor of urology with the VA Boston Healthcare System and Boston University.

The study had some significant limitations. The urologists were not compared with other women, including nonworking mothers and other physicians. The survey was a glimpse into one group of specialists with less than 250 respondents and, likely, a selection bias (women who experienced complications or were concerned about complications were more likely to complete the survey, researchers surmised). And the investigators could not isolate the factors that put urologists at high risk for complications.

They did identify a number of possible contributing factors—older maternal age, long work hours and physical exertion during their pregnancy, and high rates of ART.

Last year, Dr. Lerner broadened the study to all women in surgical specialties. In April 2009, she e-mailed the 1,398 board-certified female surgical subspecialists listed with the American College of Surgeons, asking them 79 questions about pregnancy and childbirth.

Since then, approximately 1,000 women have replied—fewer than hoped for but enough for a preliminary analysis.

The early results indicate that women surgeons experience more pregnancy complications and fertility problems than the urologists, and significantly more than the average American woman. Of the 662 respondents who have at least one biological child, 26% had difficulty conceiving.² Forty-two percent experienced at least one complication with their first pregnancy—most commonly, preterm labor with preterm delivery (19%). Other frequent complications included hypertension and preeclampsia (18.6%) and preterm labor with term delivery (11.5%).

The study did not track miscarriages or unsuccessful attempts to get pregnant.

Women surgeons who heard about the study are quick to point out that the results are not entirely bleak. Importantly, investigators found that the majority of female surgeons do

PREGNANCY

continued from page 7

have children. Nearly 70% of women surveyed had at least 1 child. The mean number of children per mother was 2. Moreover, Dr. Lerner's study showed that the vast majority of mothers—81%—said they were satisfied with their pregnancy.

However, the same women surgeons say they are concerned about the rates of pregnancy complications.

The grueling hours of surgery, long periods of standing, chronic poor hydration, and irregular eating habits might drive complications. Poor sleep patterns—a known risk for pregnancy complications—likely contribute as well.

And then there's the fact that most women surgeons postpone having a baby until they are in their 30s—another widely documented risk for complications. Dr. Lerner's study showed that women surgeons have their first child at a mean age of 33.1 years, almost 8 full years later than the US average.³

Experts point out that women in all types of demanding careers postpone childbirth until their 30s or 40s which is driving down birth rates among these women.

“At mid-life, between one-third and half of all high-achieving women in America do not have children,” writes economist Sylvia Hewlett.⁴ In a series of books, Dr. Hewlett argued that women in demanding careers often put off having children and turn to fertility treatments in their late 30s and 40s, often to no avail.

TABLE. PREGNANCY TRENDS AMONG WOMEN UROLOGISTS

ART births	OR, 9.77; 95% CI, 5.91-16.16
Pregnancy complications	25.3%
Bed Rest	21.2%
Induced early	31.8%
Cesarean delivery	24.35%

ART, assisted reproductive technology; CI, confidence interval; OR, odds ratio
Adapted from reference 1.

At the 2009 Clinical Congress, the American College of Surgeons offered a first-ever panel session devoted to pregnancy.

No study directly compares pregnancy outcomes for women surgeons with those for women in other industries. Several studies suggest flight attendants have high rates of menstrual irregularities, infertility, and fetal loss—although, as one study notes, there are no good comparison groups of other women.⁵ A survey of women lawyers—the most similar professional group to surgeons that has been studied—showed that 18.15% experienced spontaneous fetal abortion, ectopic pregnancy, or fetal death.⁶ Work hours and self-reported stress, again, were linked to fetal loss.

Surgeons and researchers hope that future studies reveal more about pregnancy in surgeons.

Dr. Lerner is asking all women surgeons to complete her survey. (Anyone interested should e-mail her at lori.lerner@va.gov.) She hopes to garner enough responses to compare the surgical specialties and, eventually, put together recommendations.

For now, she encourages women to not push themselves during pregnancy and asks program directors to offer flexibility and encouragement to pregnant residents.

“We need to get to the point where pregnancy is not an issue, not a source of stress. We need to be more accommodating to women,” she said.

REFERENCES

1. Lerner LB, Stolzmann KL, Gulla VD. Birth trends and pregnancy complications among women urologists. *J Am Coll Surg*. 2009;208(2):293-297.
2. Based on an unpublished presentation to the 2009 Clinical Congress of the American College of Surgeons
3. Mathews TJ, Hamilton BE. Delayed childbearing: More women are having their first child later in life. NCHS data brief, no 21. Hyattsville, MD: National Center for Health Statistics. 2009.
4. Hewlett, Sylvia Ann. *Creating a Life: Professional Women and the Quest for Children*. New York, Hyperion; 2002.
5. Lauria L, Ballard TJ, Caldora M, Mazzanti C, Verdecchia A. Reproductive disorders and pregnancy outcomes among female flight attendants. *Aviat Space Environ Med*. 2006;77(5):533-539.
6. Schenker MB, Eaton M, Green R, Samuels S. Self-reported stress and reproductive health of female lawyers. *J Occup Environ Med*. 1997;39(6):556-568.



**Women
In Surgery**

**ARE YOU A PARENT OR CURRENTLY EXPECTING?
PLEASE VISIT WOMEN IN SURGERY ON FACEBOOK TO DISCUSS
PREGNANCY AND MOTHERHOOD.
WWW.FACEBOOK.COM/WOMENINSURGERY**

SOCIAL NETWORKING

continued from page 1

networking mediums like Twitter and Facebook.

One key aspect of Dr. Bates' social networking landscape is that each tool tends to target a specific audience. Although her blog includes posts on unique cases of interest only to other cosmetic surgeons, it also includes basic descriptions of surgical procedures that she can direct patients to—"general good information about plastic/cosmetic surgery that isn't overly hyped." Her Facebook page, on the other hand, is highly guarded, and accessible only to family members and those colleagues with whom she feels comfortable sharing personal information.

Dinee Collings Simpson, MD, a surgical resident at Brigham and Women's Hospital in Boston, is in the process of developing a social networking site targeting female surgeons seeking information and advice about combining family and a surgical career.

"When it came to finding someone who could share with me about this specific point in my career—being a resident and wanting to start a family—it was very difficult and I was very disappointed to find that of all the social networking sites I found about women and family, none of them met the unique needs of female surgeons," Dr. Collings Simpson said.

Her site's narrow focus will function in several ways, she said. It will include specific resources, such as links to the American Board of Surgery's policy on leave, as well as editorials and journal articles related to pregnancy and child development. Even more specifically, the site also will provide a way for female surgeons to find information on dealing with unique issues such as heading single-parent families, raising children from a spouse's previous marriage, or adoption or reproductive assistance, Dr. Collings Simpson said.

The central feature of the site will be a social networking forum where surgeons can comment on the most important topics around family, such as balancing a demanding career and a family or achieving a family-friendly work environment.

Perhaps most importantly, the site also will provide privacy. "Anonymity and a perceived lack of judgment are key in getting people to a Web site to talk about sensitive issues," said Dr. Collings Simpson. "The family issue is still a very sensitive subject in the field of surgery, [and] there are a lot of stereotypes and obstacles that we'll need to overcome."

The site is still in development, and Dr. Collings Simpson is in the process of working with collaborators to launch the

site within the next year.

Thus far, however, her colleagues have unanimously embraced the idea, she said.

"They all felt there was a need to have a place to gather information to learn from others, and to be inspired by people who have [balanced career and family] successfully already," she said.

"And because of this geographic disconnect, a Web site is the best idea. With a Web site you can connect with people at any time, across the nation, and log in when you have the free time rather than try to fly across the country to attend a conference."

But these delineations are not always clear, and boundaries about what is appropriate have yet to be established as one social networking technology after another is being rolled out.

Danielle Walsh, MD, a pediatric general surgeon in Jacksonville, FL, eventually had to stop her Facebook activity because of professional concerns.

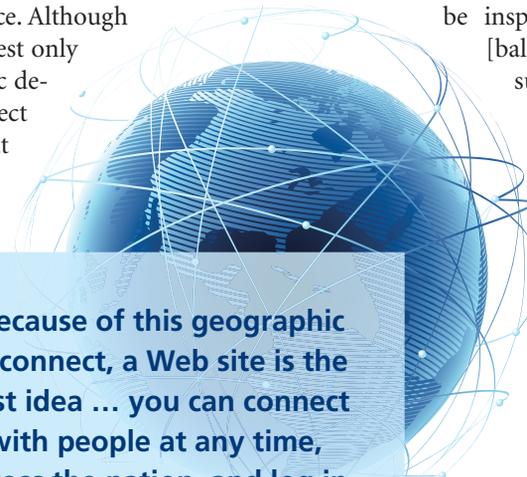
"I noticed that I started to get friend requests from people who I didn't always recognize and perhaps unwisely I accepted some of these people for friends," said Dr. Walsh, who often thought that these requests were most likely from old classmates or friends who had simply taken married names. "When I went into their sites I realized that they were patients or more commonly parents of patients who I had cared for."

After the parents of one particular patient began soliciting money for an operation Dr. Walsh was to perform, she felt professional boundaries had been crossed.

"I was concerned about my being able to make appropriate decisions knowing some of the things that I knew about their family," said Dr. Walsh. "I thought [that] this might skew how I take care of this person, and even subconsciously I might make decisions that are a little different knowing this. This could be good or bad, but at that point, I felt that this wasn't the appropriate arena for me to have an interaction with patients or their families."

The idea of posting something on a patient's Facebook "wall" also struck Dr. Walsh as a potential HIPAA violation.

Indeed, egregious HIPAA violations already have taken place on mainstream social networking sites. In 2008, a nurse at a Chicago hospital created a Facebook page about an indigent patient who routinely showed up in local emergency



"Because of this geographic disconnect, a Web site is the best idea ... you can connect with people at any time, across the nation, and log in when you have the free time rather than try to fly across the country to attend a conference."

—Dinee Collings Simpson, MD

SOCIAL NETWORKING

continued from page 9

rooms with acute alcohol intoxication. The page—titled “Did You Know This Alcoholic Indian?”—eventually had approximately 600 “friends,” including health care, EMT, and police professionals, before being closed when Native American activists became outraged.¹

To protect against these violations, some hospitals, such as New England Baptist Hospital in Boston, have banned Facebook and social media use outright.²

But even Dr. Walsh, who has largely stopped using Facebook, says there is some utility for social networking among doctors (Table). She sometimes uses Twitter at national meetings, where real-time updates on important sessions can be helpful, and believes that medical institutions are missing an opportunity if they aren’t representing themselves in the social media sphere. “These social network sites have a tremendous role and could be used very well for getting patients information about where to get good care and even about [medical] institutions or about your professional practice,” Dr. Walsh said. “If your institution doesn’t have a Facebook page, it’s making a mistake,” she added, particularly for residency programs, where potential recruits are not only fluent, but even reliant, on social networking tools to gather information.

Although Dr. Bates uses several social networking platforms, she too worries about potential HIPAA violations. A physician at one of the hospitals in Little Rock was recently investigated by the FBI for a HIPAA violation. The physician was convicted in October.³

“I’m not about to mess with HIPAA,” she said. But, she added, “if all of us would keep to some general principles of privacy that we were taught years ago in medical school that wouldn’t be an issue.”

TABLE. SURGERY-RELATED RESOURCES

www.womeninsurgery.com
www.womensurgeons.org
www.rlbatesmd.blogspot.com

Considering these issues, social networking’s greatest utility may lie in avoiding patients altogether, and instead focusing on providing a platform for surgeons to exchange information specific to a career in surgery.

REFERENCES

1. Natives Against Racism. Chicago’s Staff Infection. <http://nativesagainstracism.weebly.com/index.html>. Accessed November 9, 2009.
2. McConville, C. Hospital cuts off use of Facebook. *Boston Herald*. Oct. 14, 2009: <http://www.bostonherald.com/business/healthcare/view.bg?articleid=1204514>. Accessed November 9, 2009.
3. News Release, US Attorney’s Office, Eastern District of Arkansas. Doctor and Two Former Hospital Employees Plead Guilty to HIPAA Violation. July 20, 2009: http://www.justice.gov/usao/are/news_releases/PDFs_2009News_Releases/July/3plea_HIPAA_07202009.pdf. Accessed November 9, 2009.



Women In Surgery



The new Women in Surgery Facebook page is offering women surgeons another way to stay connected. Become a fan of the page to receive regular updates on upcoming events, and the latest research and resources. Fans can also use the discussion board to engage in meaningful conversations and raise important issues. Can’t make it to a Covidien Women in Surgery Career Conference? Check out videos and photos from past events.

JOIN THE WOMEN IN SURGERY COMMUNITY ON FACEBOOK!
WWW.FACEBOOK.COM/WOMENINSURGERY

The Sounds of Surgery: Music in the OR

When Jennifer Rosen, MD, prepares for surgery, she goes through her standard operating room routine: scrubbing in, donning a surgical mask, mentally preparing for the procedure, and setting the radio dial to 94.5 FM, a local Boston hip-hop station.

The use of music in the OR has become commonplace in hospitals throughout the United States, with surgical teams transplanting, removing, stenting, and bypassing to the sounds of everything from ABBA to Zappa. “I think it helps with the general vibe in the OR, keeping everyone relaxed and focused,” said Dr. Rosen, assistant professor of surgery, Boston University School of Medicine.

The positive effects of music on surgeons and OR staff alike have been documented. Ullman and colleagues conducted a study of 171 OR doctors and nurses, and found that 65.8% of respondents believe music makes them calmer during procedures. Furthermore, 63% thought it improved communication between the team during procedures.¹

“Music often prompts enjoyable conversation between staff members, fostering camaraderie,” said David N. Brotman, MD, general surgeon with the Langhorne Surgical Group, in Pennsylvania. “I also ask patients [when awake] what genre or artist they would like to hear; it may help them relax or foster conversation, distracting them from the procedure.”

The relaxing qualities of music certainly have a place in the high-pressure environment of the OR. Maintaining comfort, tranquility, and focus is of the utmost importance for surgical staff. “I do believe in the adage that music calms the savage beast and that this applies to surgeons as well,” said Marc Neff, MD, a general surgeon with Surgical Specialists of NJ in Cherry Hill. “I personally find my temper shorter when the radio is playing music that I don’t like or doesn’t work.”

The type of music selected also plays a role in the overall demeanor of the OR. Tempo, volume, mood, and lyrics can all affect the staff’s ability and enthusiasm to perform. Different styles may sometimes be preferred for different procedures or points during surgery. Dr. Rosen remembers how during her residency attending physicians would play classical music and the effect it had on her. “It

would put me to sleep, so now I’ll listen to basically anything but that during surgery,” she said.

“My choice depends on my mood, but I’m sure that it is affected by the nature of the case,” said Susan Kaiser, MD, clinical assistant professor of surgery, Mount Sinai School of Medicine, New York City. “Cancer, for example, doesn’t go well with Gilbert and Sullivan operettas.”

Similar to the climax of your favorite films, or matching the proper Cabernet and steak together, the pairing of songs appropriate to the situation can be a real boost to the performance of all involved. “‘Highway to the Danger Zone’ from the ‘Top Gun’ movie soundtrack coming on from an iPod during the moment of firing of a [surgical stapler] is a great matchup,” said Dr. Neff. The song’s singer, Kenny Loggins,

would likely be interested to hear this alternate use for his opus.

Sometimes it can be important for the staff to match music with a certain part of the procedure.

“Back in

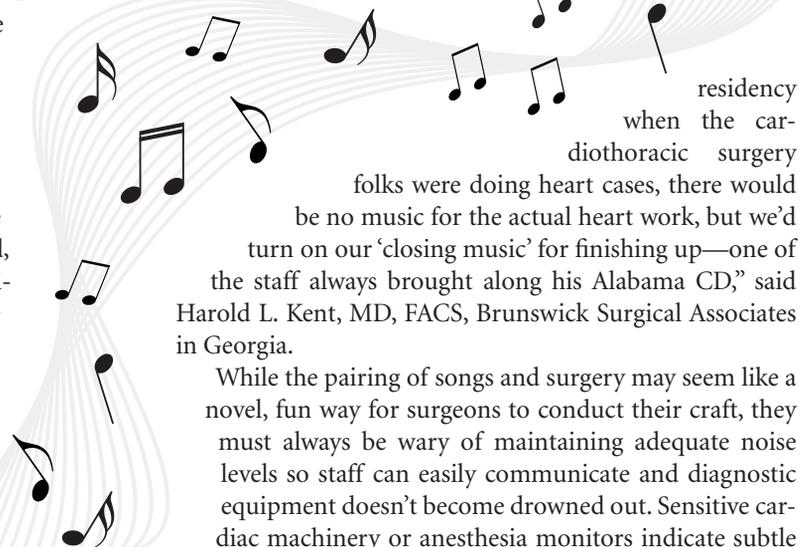
residency when the cardiothoracic surgery folks were doing heart cases, there would be no music for the actual heart work, but we’d turn on our ‘closing music’ for finishing up—one of the staff always brought along his Alabama CD,” said Harold L. Kent, MD, FACS, Brunswick Surgical Associates in Georgia.

While the pairing of songs and surgery may seem like a novel, fun way for surgeons to conduct their craft, they must always be wary of maintaining adequate noise levels so staff can easily communicate and diagnostic equipment doesn’t become drowned out. Sensitive cardiac machinery or anesthesia monitors indicate subtle but important changes in patient activity with slight changes in the pitch of an audible beep. The surgical staff must maintain focus and avoid being distracted by music.

see *MUSIC*, page 12

“I think it helps with the general vibe in the OR, keeping everyone relaxed and focused.”

—Jennifer Rosen, MD



Women In Surgery

MUSIC

continued from page 11

"I tend to always have one ear to the saturation monitor anyway; some music tends to distract other team members too much, either because they hate it or even sometimes if they like it too much," said Eva Wall, MD, general surgeon with the Everett Clinic in Washington. "I find myself having to bring them back to the OR when they get too carried away."

The study by Ullman and colleagues found that 51% of respondents preferred music to be kept at a low volume, and 47% requested a medium level.¹ "I try to play the music at a reasonable volume so that it does not take away from regular conversations or teaching," said Susan Lerner, MD, assistant professor of surgery at Mount Sinai School of Medicine.

Dr. Kent believes audible monitors, such as those for oxygen levels, should have never been invented. "Whenever I hear the tone change, I look at the anesthesiologist," he said.

Although it may seem a bit disconcerting to think about surgeons rocking out while removing an appendix, surgeons are still human beings sometimes

"I do believe in the adage that music calms the savage beast and that this applies to surgeons as well. I personally find my temper shorter when the radio is playing music that I don't like or doesn't work."

—Marc Neff, MD

TABLE. MUSIC PATTERNS OF SURGEONS IN THE OR

65.8% find music calming during procedures

63% said music improves team communication

51% listen at low volume

47% listen at medium volume

Adapted from reference 1.



requiring a little additional motivation to get through long, cumbersome procedures.

"Surgery is in some ways like driving. While every moment is critical regarding attention, reaction times, and focus, much of it in experienced hands is routine," said Dr. Brotman.

"Background music makes the hours spent in the OR more enjoyable, and a happy surgeon and staff is a better one."

REFERENCES

1. Ullman Y, Fodor L, Schwarzberg L, et al. The sounds of music in the operating room. *Injury*. 2008;39(5):592-597.



**Women
In Surgery**

DO YOU LISTEN TO MUSIC IN THE OR?

PLEASE VISIT WOMEN IN SURGERY ON FACEBOOK TO SHARE YOUR MUSIC PREFERENCES IN THE OR.

WWW.FACEBOOK.COM/WOMENINSURGERY