cultural changes in our field, along with continuing to increase our numbers, will bring help to many of the problems highlighted by the anecdotes in “Beyond #ILookLikeASurgeon.”³ With greater numbers, we will most certainly be able to find proper locker rooms when going on procurements. As we change perceptions of what a cardiothoracic surgeon looks like, inappropriate and sexist comments will hopefully be fewer and further between. However, some problems faced by female cardiothoracic surgeons will persist, regardless of how many of us there are, and these issues were well highlighted by Stephens and Fiedler.³ Challenges of childbearing are biologically unique to women and occur disproportionately more often among female cardiothoracic surgeons.⁹ We must recognize that issues such as infertility, pregnancy complications, and lactation needs will always be specific to women. Efforts to support women through such events are vital in acknowledging their role as important contributors to our workforce, and such progress is mandatory to ensuring that the brightest and best trainees comprise the future of our field.

Taken together, Stephens and Fiedler³ and Freystaetter and colleagues⁴ provide practical and complementary approaches to enhancing the success of women in cardiothoracic surgery. The big picture messages are more alike than discrepant: Recognize that women and men are not the same. Embrace those differences, so that we can look forward to a time when women are encouraged, enabled, and supported in their pursuit of a career in our specialty.

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WE HAVE MET THE ENEMY; THE ENEMY IS US

Reply to the Editor:

We appreciate Freystaetter and colleagues¹ for their correspondence regarding our editorial.² It is encouraging to see increased dialog about being a minority within our field. Even 5 years ago, proposing to examine potential disparities between minorities and the majority within training or discussing challenges minorities faced was frequently disparaged.

Freystaetter and colleagues¹ discuss, as we do in our editorial, conscious and unconscious bias, as well as gender differences, including the difficulty of being an effective female leader. We particularly appreciate their call for more robust data with regard to barriers faced by women and minorities in our field, and we wholeheartedly agree that more remains to be done in this area. In response, we highlight here key take-home messages from the current literature regarding women and minorities in surgery, of which all in our field should be aware:

1. A third of women in US academic medical centers reported experiencing sexual harassment and bias (vs 4% of men).³
2. Women in US academic medical centers earn 10% less, are promoted more slowly, receive fewer honors, and hold fewer leadership positions than men—even after adjusting for age, experience, specialty, rank, and academic and research productivity.^{4,5} People are less likely to hire a woman than a man with identical qualifications; less likely to give credit, including grant support, to a woman for identical accomplishments; and less likely to give the benefit of the doubt to a woman than to a man.⁵
3. Women thoracic surgical trainees described being given significantly less “meaningful autonomy,” given less access to career advice, given less effective mentorship and sponsorship, and feeling less ready for practice than men.⁶ This discrimination becomes more acute with seniority.⁵

We as a specialty are well positioned to use these objective data to make impactful changes, starting at the top. In 2006 the National Academies of Science advised all major societies to ensure that their podium, editorial, and leadership boards reflect their diverse membership. Cardiothoracic surgery has heeded this call, with formal professional career development programs, such as The American Association for Thoracic Surgery Cardiothoracic Careers College and Leadership Academy.

Although daily life as a minority in cardiothoracic surgery may feel like a “battle” against unconscious and conscious biases, “Battle of the Sexes” is a charged title that contradicts our opinion. “Battle” implies opposing, hostile parties

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fighting to obtain a prize. We believe that both sexes, and all other minorities, should support one another to continue to improve our field. There is no “prize” that one party is trying to obtain within cardiothoracic surgery and for which the opponent must be destroyed. We have a shared goal of creating a supportive training environment, enabling everyone to be welcomed, successful contributors. If there is any battle to be had, it would be a battle against our societal and specialty’s long-held expectations and norms. To quote Walt Kelly, “We have met the enemy, and he is us.” Courage is needed to examine carefully ourselves, our field, our culture, and the available data to root out impediments to progress.

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