See Article page 733.

Commentary: Winds of change? Not really...not yet!

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“When I’m sometimes asked when will there be enough [women judges on the US Supreme Court bench] and I say, ‘When there are nine,’ people are shocked. But there’d been nine men, and nobody’s ever raised a question about that.”

—Ruth Bader Ginsburg

The literature is flooded with studies demonstrating unequal representation of women as session leaders in national and international scientific meetings in all fields, including surgery.¹⁻⁴ In the current study, Shemanski and colleagues⁵ extend this well-established fact to cardiothoracic surgery. Their article is not just another study about the same thing. The authors highlight the pervasive and persistent nature of the problem through their descriptive study of the gender of session leaders at 4 cardiothoracic surgery organizations’ annual meetings from 2015 to 2019. They found that while women as session leaders trended positively overall for the 5 years, it was only because of the positive trend in proportion of thoracic female session leaders. There was no significant change for adult cardiac or congenital cardiac surgery, and there was no change in panel composition, with the majority of expert panels remaining men only. These findings reflect that of the regional and national society leadership from 2015 to 2019, as the percentage of women on board of directors and councils also remaining statistically unchanged. This lack of diversity is holding us back.

At this time, we have the opportunity to advance our specialty in far reaching ways. For years, the corporate world has shown us that prioritizing employee diversity results in greater profitability.⁶ Companies committing to 30% or

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CENTRAL MESSAGE

Cardiothoracic surgery has seen limited measurable change over decades in the equity and diversity of its leadership. Meaningful change requires focused efforts on implementation and accountability.

more women in leadership positions had greater net margins than companies that lacked this degree of female representation.⁷ Similarly, diversity in the physician workforce translates into improved health care outcomes.^{8,9} Acknowledging this reality, medical schools have achieved gender equity and women now compose more than 50% of classes. Surgical specialties had to adjust residency training as they saw their applicant pool diminish. In thoracic surgery residency, women now comprise 24.3% of residents through initiatives such as work hour limitations, I-6 programs, and focused national mentoring and scholarships.¹⁰ We need to build on this success and create diversity at all levels of leadership roles in our specialty.

Deliberate action toward gender equity in cardiothoracic leadership will positively impact our specialty. The authors appropriately argue that progress will require that leadership aim for goal demographics rather than accept representation that reflects the low percentage of women in cardiothoracic surgery currently. Committees for our annual societal meetings must set clear goals for panel and program planning composition that ensure diversity and inclusion. Quantifying this in terms of an actual number or percentage as opposed to an arbitrary recommendation would facilitate the process. Cardiothoracic surgeons must support these initiatives and hold leaders of our societies accountable to this expectation to improve our specialty. It is time to change the status quo.

“You are what you do, not what you say you do.”

—Carl Jung

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