An Unusual Team of Cardiothoracic Surgeons

Ina Ennker, MD, and Juergen Ennker, MD, Make Up a Husband-and-Wife Cardiothoracic Surgical Partnership.

Women cardiothoracic surgeons are rare, but Ina Ennker, MD, is particularly unusual. She is married to Juergen Ennker, MD, who is the chief surgeon at the Heart Institute in Baden, Germany, where they both work. Despite their hectic work schedules, they have a family of 3 children. Ingrid Torjesen, BSc, speaks to them about their life, work, and expectations.

While half of medical students in Germany are women, women comprise only 5% of doctors in cardiothoracic surgery. Ten years ago, that figure was only 2%. Against this backdrop, any woman embarking on a career in cardiothoracic surgery has to be determined, because she will face an uphill struggle and will have to be prepared to make compromises in other areas of her life.

Dr Ina Ennker, the only German member of Women in Cardiothoracic Surgery, has succeeded despite the overwhelming odds against her. She explains, “It is definitely harder for a woman to become a successful cardiothoracic surgeon, particularly in a leading position. Many female physicians are afraid of the long working hours and physical exhaustion that go along with cardiothoracic surgery. They stay away from this field, especially if they want to have children.”

She admits that the situation has improved in the last few years for women who are prepared to sacrifice a family life, but she acknowledges that it is still very difficult for women who want to have children. About 20% of the cardiothoracic surgeons in her hospital are now women, but she predicts that they, and other women surgeons like them, will not have large families. “Many of my colleagues won’t have children or will just have 1,” Dr Ina Ennker says. “If you do want to have 1 or more children it is very difficult, because you cannot work full time during pregnancy, you can’t do the night shifts, and you can’t work all day with 2 or 3 children to look after.”

Until 2 years ago, Dr Ina Ennker worked full time, and now she has a 70% commitment. Apart from a personal understanding of her situation, she says, working with her husband, who is chief of department, does not give her any benefits. “People always imagine that I have advantages out of this situation, but it is just the opposite.”

The 2 Dr Ennkers (they both shared the same surname even before marriage) met in the 1980s at the German Heart Institute in Berlin. In 1985, Dr Juergen Ennker, having recently finished his surgical training at Hannover Medical School, was asked by Roland Hetzer, MD, to move to Berlin and start the German Heart Institute with him. Dr Juergen Ennker says, “It was fascinating to learn how to bring up a brand new institution from the start and what difficulties had to be overcome. Also, I was born in Berlin and wanted to make a special contribution to this city, which was at that time still divided.”

Dr Ina Ennker came to the Institute to do a cardiothoracic rotation under Dr Hetzer as part of her surgical education at the Hannover Medical School. On graduating, she became a consultant in general and transplantation surgery in Hannover. However, the birth of her first son changed things. “I sacrificed my career in abdominal surgery in Hannover and moved again to be with my husband in Berlin so I could stay with my son and my family,” she says. Dr Ina Ennker could not find a post as assistant professor in general surgery in Berlin, so she began a further qualification in thoracic surgery in Berlin-Heckeshorn under Dirk Kaiser, MD. She later gave birth to her second child and the first of 2 daughters.

In 1994, the family moved to Lahr/Baden to the newly established Heart Institute, Dr Ina Ennker to take a post as a consultant in cardiothoracic surgery and her husband to take the post of chief surgeon—and they are still there. She says that she does not regret sacrificing her career in abdominal surgery. “I wanted to stay together with my family, and there were not so many options 20 years ago. There were not many female surgeons, maybe 3% or 4% in general surgery and none in cardiothoracic surgery. I was one of the first in Germany.”

The Heart Institute in Lahr/Baden specialises in off-pump coronary bypass surgery (see Figure). Although only 8% to 9%
of coronary bypass operations are done off pump in Germany, the Heart Institute treats more than half its patients using this technique, and in 2006 Dr Juergen Ennker operated on 94% of his patients off pump. He explains, “Nearly 10 years ago, my wife and I started doing bypass surgery off pump. We started with patients with neurological deficits and other special risks, because as you do not need to have an aortic occlusion, there is no surgically induced risk for stroke. We learned that actually all patients can benefit, and our philosophy is that all bypass patients should have the operation without a pump. There is a big advantage to this, especially if you use mammary arteries as the Y graft.”

Dr Juergen Ennker is also interested in stentless valve surgery in the aortic position. He and his team have used a large number of Medtronic Freestyle valves (produced by the Medtronic Company, based in Minneapolis, Minn) in the aortic position, and they use the technique in subcoronary versus total root replacement.

Meanwhile, Dr Ina Ennker is expanding her skill set into other areas of medicine, currently training in plastic surgery at Hannover Medical School. In the future, she wants to be able to combine her cardiothoracic and plastic surgery expertise to treat infective mediastinitis complications in cardiothoracic patients. “I want to focus on reconstruction and endocarditis,” she says. “Maybe I can help other cardiac surgeons who want to send these patients to special plastic surgery treatment. Maybe I can take over their care.”

Another of Dr Ina Ennker’s interests is the care of women patients. “Women are not so easy to operate on, and many of our male colleagues did not want to operate on women,” she says. “Only about 30% of patients in the cardiac surgery department are women, but there are more women dying of this disease, so there must be more reasons why females do not come to surgery.”

When it comes to their children, the Enkner’s would neither recommend that they enter cardiothoracic surgery nor deter them from doing so. Dr Juergen Ennker says that their children will obviously look at their parents as an example of life in the world of medicine. “But I will not influence them by any means,” he emphasises. “They have to make their decisions for themselves.”

Dr Ina Ennker agrees. “It is a very nice profession, and it is very satisfying, but you have to know that you do not have a lot of private life. My hobbies are my children, my family, and maybe the dog, but there is no time for friends. I do not go out for parties or anything like that. I drive my car, play with my children and the dog, and that’s it.”

Ingrid Torjeson is a freelance medical writer.

History of Cardiology: Sir John Parkinson, MD

All cardiologists have heard of Wolff–Parkinson–White syndrome, but who was the European amidst the 2 American physicians who helped to define this abnormality? Diane Berry investigates the English member of the trio.

Sir John Parkinson, MD, was born in Thornton-le-Fylde, Lancashire, United Kingdom, in 1885. He first attended Manchester Grammar School in England and later University College, London. Dr Parkinson’s medical training was at the University of Freiburg, Germany, and subsequently at the London Hospital, where he obtained his MD in 1910. He worked for a time as house physician at the London Hospital, and then he returned to Freiburg to work with Ludwig Aschoff, MD. During his time in Germany, he encountered the work of Sir James Mackenzie, MD, through reading a translation of Sir James’ book on heart disease. When an opportunity arose to take up the medical registrarship at the London Hospital, Dr Parkinson was delighted to become chief assistant to Sir James, who would have a considerable influence on Dr Parkinson’s life’s work.

Unfortunately, the outbreak of World War I interrupted Dr Parkinson’s further training; on joining the army, he was posted to a casualty clearing station in France. Although he regretted the interruption to his training and cardiac research, Dr Parkinson recognised his army work as essential, and he even wrote about some of the cases he saw. These included 2 patients with angina pectoris and 1 with acute nephritis. Fortunately, this keen young doctor remained in the forefront of the planning of Sir James, who outlined to Dr Parkinson plans for the use of 400 beds in Mount Vernon Hospital, Hampstead, London, for the study and treatment of cardiac cases among army personnel.

In 1916, the hospital in Hampstead became a special army research hospital. It was divided into 3 units, for which Dr Parkinson assumed responsibility. One of the main projects was research into effort syndrome or disorderly action of the heart, commonly known as soldier’s heart. Dr Parkinson took an active part in the research; in typical cases, he could find no evidence of cardiac disease. Rather, he thought the culprit was a disease of the nervous system. Assessments were carried out at the Military Hospital, Hampstead. As an author of an article later published in the British Medical Journal, he set out a specific group of symptoms and attempted a clearer definition of