DOI: 10.1308/rcsbull.2021.xx

WiST and WinS across a surgical career

RCS England Council member Scarlett McNally describes her experience of WinS over the last 30 years.

SA McNally[1] Consultant Orthopaedic Surgeon
[1]Department of Trauma and Orthopaedics, East Sussex Healthcare NHS Trust, Eastbourne, UK

Over the past three decades, my career has been nudged by WIST (Women in Surgical Training), later changed to WinS (Women in Surgery) and I hope I have helped shape WiST/WinS intermittently too. I had just graduated as a doctor and finished my year as a house officer when WiST was created in 1991. The government had given a small amount of money to help the Royal College of Surgeons of England (RCS England) to set up WiST (Box 1).[1] Although many people have questioned my career choice, most surgeons soon knew about WiST and had something positive to say rather than being dismissive. It is difficult to unravel the multiple changes – in society, expectations and surgical practice. At the time, there had just been a female prime minister, Margaret Thatcher, and I sensed that people felt the battle for equality was over. Yet across many professions, a few women have always succeeded. We have only recently acknowledged the sacrifices or attrition of other excellent candidates.[2]

Cohort studies report that, in surgery, only half of women had children compared with men or other specialties, suggesting that women were choosing between career and parenthood.[3]

I followed the post-war generation. Strong heroic individualism was expected. Long hours prevented surgeons in training from having much work–life balance, yet this also meant acquisition of skills and recognition of your role from staff and patients. When I became a consultant in 2002, someone suggested that 'no-one checks your homework'. With new concepts of audit, Getting It Right First Time (GIRFT) and clinical governance, all that changed. As surgical outcomes opened up to scrutiny, so did decision making and team working.

At that time, lots of informal advice was given in the men's theatre changing rooms. With WinS, I have always had a tribe of people with whom to feel connected or exchange ideas (Figure 1). I applied and was appointed to the WiST committee and then the Opportunities in Surgery (OiS) Committee at RCS England in the early 2000s. As more women moved beyond training, WIST no longer seemed an appropriate title and we became WinS. This was a welcome new direction. There has been a good working relationship with the Medical Women's Federation, and we have a similar ethos of support, respect, clarity and role models.

I should probably credit my WinS credentials with my election to the Council of RCS England in 2011. I was the only woman standing and people were ready for a change. I was only the ninth woman elected to that role. I was appointed Chair of OiS and there was overlap between WinS, and medical student and SAS committees that OiS oversaw. I was briefly interim chair of WinS. We attempted to make clear what the requirements to be a surgeon were. Once you have passed the rigorous surgical exams, you should be in our club of surgeons.

Equality and diversity training in the NHS has changed little in 30 years. The training for selection panels is focused on equality legislation, ensuring that the organisation will not be sued if someone mentions a difference. Diversity could be argued as the opposite of equality. For diversity, one has to recognise the difference and, in a one-to-one discussion, listen and identify how to ensure that this unique person can deliver as well as they possibly can. Many women never get that one-to-one honesty.

There is a tension between expecting an individual to fit in and changing the culture. Women are sometimes advised to 'lean in'. There is also a tension around stereotyping. Data are useful. One woman may not feel discriminated against, yet women in general are less likely to put themselves forward to do an operation.[4] I wrote two papers analysing numbers of women applying to surgery. The first found a correlation between competitiveness of the specialty and proportion of female applicants.[5] The question of whether women wanted to apply but were put off was not answered. The next paper analysed

Box 1 Hansard parliamentary report 22 July 1991 on the start of Women in Surgical Training (WIST)

Mrs Virginia Bottomley: Earlier this year I launched the 'Women in the NHS' initiative to improve recruitment and retention of women staff within the National Health Service. A seminar was held on 25 June which considered a report from the Office of Public Management, commissioned by the NHS management executive, identifying the relevant issues. This concluded with an agenda for local action which will be followed up at three conferences in the autumn. Each regional chairman has nominated a non-executive member to take forward this work.

A retainer scheme has been introduced to allow staff to interrupt their careers for up to five years for domestic or other reasons, and includes refresher schemes, temporary employment and training courses. Health authorities are also encouraged to provide child care facilities which may include workplace nurseries, child care vouchers and holiday playschemes, as required locally.

In January, a report of a joint working party on women doctors and their careers was published. This made a number of practical suggestions to promote equal opportunities for women doctors in the NHS. In response, the Department is reconvening a working party on part-time training to look at the current arrangements for senior house officers and senior registrars. One and a half million pounds has been provided to fund part-time training posts and to set up a new scheme, WIST – Women in Surgical Training – to improve the representation of women in the higher grades of the surgical specialties. We have also issued a code of good practice to promote equality of opportunity in the recruitment and selection of doctors and dentists.

The recent agreement on junior doctors' hours has for the first time set an upper limit to the number of hours that can be worked--maximum hours per week and continuous spells of duty--and should reduce the difficulties of combining family responsibilities with a medical career.

Hansard 22 July 1991: https://publications.parliament.uk/pa/cm199091/cmhansrd/1991-07-22/Writtens-7.html

Figure 1 Group photograph of the Women in Surgical Training in 1991.

Figure 2 Author (second from the left) sitting with surgeons who brought their babies to a WinS conference in 2019.

application to surgical specialties and found 30% of applicants to core surgical training were female, suggesting that women were keen to do surgery. It also found that women were statistically significantly more likely to be appointed and a large drop-off between those applying to core and those applying to higher training.[6] This allowed complacency as it demonstrated no discrimination against women at the point of selection, but no impetus to change the system to be more welcoming. Qualitative research shows that women have a different, more off-putting experience than men.[7]

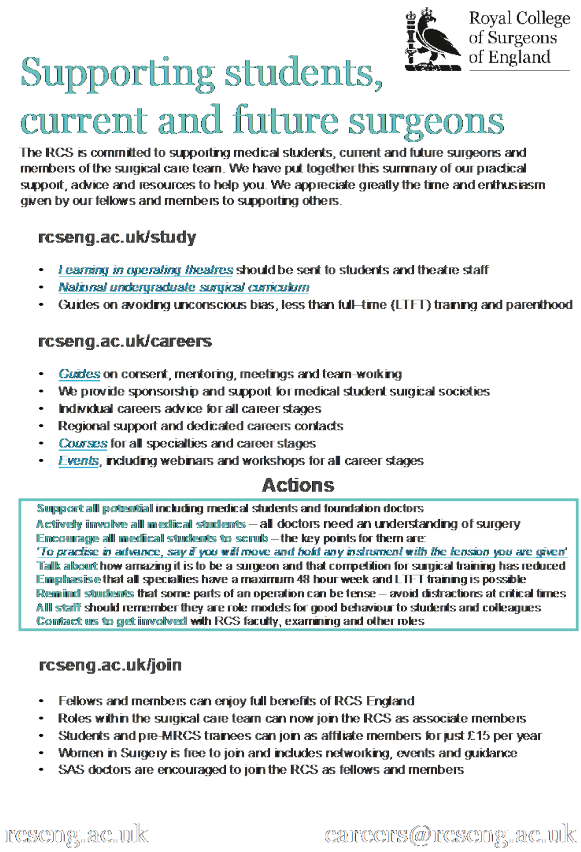
Mentoring has been suggested as essential for progression. We wrote a guide of clear expectations.[8] Yet the official model of mentoring is allowing the mentee to lead, whereas patronage and advice may often be more useful. WinS ran a successful pyramid campaign of mentoring (one consultant mentored two surgical registrars, who each mentored two surgeons in core training, who each mentored two in foundation years, who each mentored two medical students). We sponsored 'pizza nights' in surgeons' own hospitals or universities, to include a short slide show of information and then networking between grades, creating near-peer role models and sharing possibilities.

As the College's first female President, Clare Marx felt that senior women encountered blocks to progression and WinS increased its focus on this area. Bypassing those blocks requires management training (eg finance, human resources, governance) as well as leadership skills. It also requires listening at each point to what the next role needs, to adapt oneself to each opportunity, and asking for information, even formalising a request (such as making an appointment with someone's secretary) but not necessarily taking advice given. It is not appropriate for just the women to change. Trainers need to know how to interact, and organisations and training systems need to understand difference and diversity.

The most impactful decision I made was not to attend an event in London about women in different professions. I had a full operating list. I insisted that this was important enough to send a vice president.

There is a tension between expecting an individual to fit in and changing the culture.

Figure 3 Flyer to encourage all surgeons and surgical teams to support students and future surgeons.



John Getty attended, was converted to the cause and was instantly helpful. Other College Council members seemed unexpectedly understanding of the issues when their own daughters struggled with promotions. It increasingly feels that we need men as allies and that the College should change from within and should not expect women to lean in.

In 2015, Australian surgery was rocked by allegations of sexism, racism and sexual harassment. Half of surgical trainees reported having been bullied. WinS worked with the Royal Australasian College of Surgeons (RACS), who launched their 'Operate with respect' campaign (www.surgeons.org/respect) in 2016 at the Congress in Brisbane, as we launched 'Avoiding unconscious bias – a guide for surgeons'. This felt like a breakthrough. Before this, personality was felt to be set. The key seemed to be that surgeons did not realise how they were perceived. Many surgeons did not mean to cause harm or upset. Many were poor at dealing with below-average surgeons in training or other staff. Following my talk in Brisbane, there was a queue of surgeons keen to tell me about their experiences of being accused of bullying. Bullying is defined by how the victim feels. It is not just done by 'bad apples'. The perfectionism and presenteeism that surgeons value makes bullying more likely to occur by mistake. However, behaviour can be taught. It is possible to retrain surgeons to set a minimum standard, to ensure that it is met and to give feedback on the task, not the person. Setting clear expectations is key. Everyone should have a minimum understanding of legal requirements, some stock phrases of welcome and an awareness of where practical tips can be found.

Over the years, WinS has been involved with events, networking (Figure 2), newsletters, mentoring, advice leaflets (on pregnancy, parenthood, mentoring, learning in operating theatres), highlighting clear standards, sharing resources and slides (eg for pizza nights), websites, working with medical students, undertaking research about fitting in, data collection and running surveys.

Practicalities are needed as well as rhetoric. WinS has authored guides to pregnancy as a surgeon[10] and on learning in the operating theatre[11] to empower new staff and students. We have worked with companies to help them to produce cloth theatre caps embroidered with name and role, with options for women who wear a hijab or have Afro hair. This focus on making every moment as good as it can be helps staff development. My own experience of adapting opportunities for a male registrar who rotated through my firm included finding a box of size 9 gloves and identifying an easily accessible place to keep it. Paying attention to diversity means that individuals feel included.

Like other forms of change, such as smoking bans, wearing seatbelts or getting a cycle path along Eastbourne seafront, we can no longer expect one group to make the change. Culture can change rapidly but needs decision makers and organisations to see the detail required to achieve the goal. Over the years, WinS has managed to survive different expectations. It needs to be a support and advice network for women surgeons but also to normalise surgery being accessible to everyone. It needs to advocate simultaneously for women being different or having a different experience and for everyone to be valued in the same way.

The report into diversity at the College and within surgery shows there is a huge amount of work still to do.[12] The gender pay gap report singles out surgery as having the greatest discrepancies.[13] Reports from the British Medical Association, the British

Orthopaedic Association and others show that sexism and microaggressions are common and that every organisation needs to focus on respect at each moment.[14,15]

There are particular problems with surgical training, which is lengthy and often coincides with early parenthood, with additional difficulties of commuting, exams and covering rotas. We should push for better training structures for what is a short but essential time in a career. We should also demand shared parental leave to normalise men or the second parent being involved. This would help to ensure that non-work time and efficient use of work time are both valued.

Many surgeons (consultants, SAS, registrars and others) are inadvertently off-putting to medical students, Foundation doctors and other potential future surgeons.[16] Every surgeon should understand their role in supporting future surgeons.[17] In obstetrics and gynaecology, the specialty became very diverse very rapidly when it was less competitive.[18] It is likely that sought-after specialties have not seen a need to change or adjust to be more welcoming,[6] to the detriment of the specialties, as they are not recruiting from the widest pool of applicants and may thus be missing out on the best candidates. The under-representation of women in surgery needs all our members and fellows of any gender to help, to get the best possible surgical workforce for our patients. All surgeons should celebrate that every specialty is a maximum of 48 hours of work per week and that less than full time is possible.

A flyer highlighting these messages (Figure 3) for all team members to use is available at www.rcseng.ac.uk/study.

REFERENCES

1. Bottomley V. Women NHS employees. Written parliamentary answer. Hansard 1991; 22 July. https://publications.parliament.uk/pa/cm199091/cmhansrd/1991-07-22/Writtens-7.html (cited July 2021).
2. Liang R, Dornan T, Nestel D. Why do women leave surgical training? A qualitative and feminist study. *Lancet* 2019; **393**: 541–549.
3. Goldacre MJ, Davidson JM, Lambert TW. Doctors' age at domestic partnership and parenthood: cohort studies. *J R Soc Med* 2012; **105**: 390–399.
4. Cuming T, Farmer S, Evans R *et al*. Are there gender differences in general surgical operative experience? *Int J Surg* 2011; **9**: 578.
5. McNally SA. Competition ratios for different specialties and the effect of gender and immigration status' *J R Soc Med* 2008; **101**: 489–492.
6. McNally SA. Surgical training: still highly competitive but still very male. *Bull R Coll Surg Engl* 2012; **94**: 53–55.
7. Hill E, Vaughan S. The only girl in the room: how paradigmatic trajectories deter female students from surgical careers. *Med Educ* 2013; **47**: 547–556.
8. Royal College of Surgeons of England. Mentoring: A guide to good practice. London: RCS; 2018.
9. Royal College of Surgeons of England. Avoiding unconscious bias: A guide for surgeons. London: RCS; 2016.
10. Royal College of Surgeons of England. Pregnancy and Maternity. London: RCS; 2017.
11. Royal College of Surgeons of England. Learning in Operating Theatres. London: RCS; 2016.
12. Kennedy R. The Royal College – Our Professional Home: An independent review on diversity and inclusion for the Royal College of Surgeons of England: an exciting call for radical change. London: RCS; 2021.
13. Dacre J, Woodhams C, Atkinson C *et al*. Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England. London: Department of Health and Social Care; 2020.
14. Romney D. Report into Sexism at the BMA. London: BMA; 2020.
15. British Orthopaedic Association. Diversity and Inclusion Action Plan 2020. London: BOA; 2020. https://www.boa.ac.uk/about-us/diversity-and-inclusion.html (cited July 2021).
16. Sutton PA, Mason J, Vimalachandran D, McNally S. Attitudes, motivators, and barriers to a career in surgery: a national study of U.K. undergraduate medical students. *J Surg Educ* 2014; **71**: 662–667.
17. Twigg V. What can surgeons do to increase the appeal of a surgical career? *Bull R Coll Surg Engl* 2017; **99**: 320–323.
18. McManus IC, Sproston KA. Women in hospital medicine in the United Kingdom: glass ceiling, preference, prejudice or cohort effect? *J Epidemiol Community Health* 2000; **54**: 10–16.