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Changing the norm towards gender equity in surgery: the women in surgery working group of the Association of Surgeons of Great Britain and Ireland's perspective

Maria Irene Bellini[1], Anya Adair[2], Christina Fotopoulou[3,4], Yitka Graham[5,6], Alexis Hutson[7,8,9,10], Scarlett McNally[11], Helen Mohan[12], Stella Vig[13], Rowan Parks[2] and Vassilios Papalois[1,14]

[1]Renal and Transplant Directorate, Hammersmith Hospital, Imperial College Healthcare NHS Trust, London W120HS, UK
[2]Department of Clinical Surgery, University of Edinburgh, Edinburgh EH8 9YL, UK
[3]Gynaecologic Oncology, Department of Surgery and Cancer, Imperial College London, London SW7 2AZ, UK
[4]Charité University Hospital of Berlin, Berlin 10117, Germany
[5]Faculty of Health Sciences and Wellbeing, University of Sunderland, Sunderland SR1 3SD, UK
[6]Directorate of General Surgery, Bariatric Surgical Unit, Sunderland Royal Hospital, Sunderland SR4 7TP, UK
[7]Faculty of Medical Leadership and Management, London WC1R 4SG, UK
[8]Academy of Medical Sciences, London W1B 1QH, UK
[9]Royal College of Radiologists, London WC2A 3JW, UK
[10]Nottingham University Medical School, Queen's Medical Centre, Nottingham NG7 2UH, UK
[11]Eastbourne District General Hospital, Eastbourne BN21 2UD, UK
[12]Association of Surgeons in Training, London WC2A3PE, UK
[13]Department of Vascular and General Surgery, Croydon University Hospital, Croydon, Surrey CR7 7YE, UK
[14]Department of Surgery and Cancer, Imperial College London, London SW7 2AZ, UK
Corresponding author: Maria Irene Bellini. Email: Mariairene.bellini@nhs.net

Introduction

Competition ratios for surgical specialty applications have declined. To ensure that all individuals attracted to surgery are enabled to flourish and enjoy their surgical careers, we need to change the 'surgical norm'. This particularly applies for women, since currently 54% of the foundation trainees in surgery are female,[1] and even if most of the challenges to succeed in a high competitive field are common to both sexes, there are barriers, hidden or evident, peculiar to women.

We report the Association of Surgeons of Great Britain and Ireland women in surgery working group' perspective on changing the norm of the surgical environment, so that recruitment and investment in retention of surgical trainees of both genders could flourish.

Unconscious bias towards women in surgery and bullying

There is a perception among some women pursuing surgery as a career that they need to adopt or have male personality traits if they are to succeed, sacrificing their normal female role in society.[2] Gendered language is at the basis of the unconscious bias pervading the reality of women in surgery nowadays; therefore, we advocate for an identification of women becoming surgeons. Enhancement with reference to awards, achievement, ability and leadership are more often applied to males,[3] while comments on positive general terms (e.g. 'delightful') refer to female trainees. Looking at most of the walls of surgical colleges and departments, paintings and pictures of the good and great of surgery are rightly displayed with pride, but project the perception of the 'surgical folklore': male, Caucasian, busy, heroic, selected for perfection, sometimes grumpy when seeing sub-optimal performance in others, often inadvertently bullying.[4] It is not hard then to understand why a female might not recognise themselves in this type of role and decide not to pursue surgery. However, inappropriate surgical banter cannot be tolerated anymore and if there is offense or perceived sexual harassment, bullying or intimidation, the perpetrators have to be asked for correction. To slow down, to set clear standards, to say sorry, thank you and please; to listen, to acknowledge and give recognition, to not assume but working on solutions together.

In this way, the new surgical norm will reflect the increase of female medical students in

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Table 1. Recommendations to change the norm towards gender equity in the surgical environment.

1.	Flatten the hierarchy of our institutions, with a new norm embedding diversity for senior roles, visible for medical students and foundation trainees
2.	Established mentoring programs
3.	Remove the stigma that a career in surgery is incompatible with having a family. An individualised approach is fundamental to mitigate the challenges of pregnancy and return to work after maternity leave during surgical training. Childcare facilities should become routinely offered during conferences and in the workplace.
4.	Acknowledge the benefits that physical exercise provides for mental health. Gyms, swimming pools and other sport utilities should be at a short distance from the hospital and with discounts for workers before or after their shifts.
5.	Funding and grants to be more accessible for all the members in a department, to support early starter researchers to pursue an academic career.
6.	Acknowledge the existence of a gender pay gap. Educational bodies could provide additional support for achieving true equity and equality.

more senior positions: the surgical committees, panels and boards will represent the true membership that they represent. If you can see it, you can be it (Table 1).[5]

Social media as a tool to provide support and gather evidence

The Association of Surgeons of Great Britain and Ireland launched a 'women in surgery' Facebook group in 2017.[6] The aim of the group was to bring individuals together for networking and communication. One of the benefits of social media is to promote the aims associated with Association of Surgeons of Great Britain and Ireland, facilitating the advancement of the science and art of surgery and promoting collaboration and research. Through the social media platforms of the Association of Surgeons of Great Britain and Ireland, a survey of women working within the discipline of General Surgery was undertaken, to understand their current perceptions, provide insight into the practical day-to-day lives of female surgeons and to determine how to support action-oriented change.[2] The survey identified a current theme of constraints for women working within surgical practice in the UK, with lack of female role models and minimal mentoring seen as some of the main perceived barriers. Following this, a social media campaign entitled #HowIBecameAWomanInSurgery was created to shed light on the training pathways undertaken by female surgeons, and for inspiration, support and encouragement. The Facebook group aims also to provide long-distance mentoring and a free and easy to use tool for short exchanges and practical support.

The role of mentoring

What is mentoring? Great mentors provide a stimulating sanctuary in which people can take a helicopter view of their options.[7] It is to get the best out of people, build capability, help learners discover their own wisdom and work together with their own goals. There are differences to coaching, but both share the values of building a mutual relationship on trust, respect and support: listen, reflect, question and review. While coaching is generally a short-term, moderately close relationship, focusing on acquiring skills, the mentoring relationship may be a longer, even lifelong, interaction to broad perspective and horizons. What some surgeons have traditionally thought of as mentoring has involved seeing the mentee as protégé (patronage). The traditional surgical culture of 'Do as I did and you will do well' is unfortunately still very common practice in the surgical world when people try and 'mentor'. The norm needs to change and with developmental mentoring, mentees (surgical trainees) need to be encouraged to do things herself/himself, progressively decreasing the level of supervision. The mentee should remain in the driving seat and be given the voice to express his/her own goals, with the mentor encouraging autonomy and self-development, identifying and providing opportunities for development, to prevent imposter syndrome and facilitate career progress. Conversations should change in order to be more effective. The key lies on listening, waiting for your turn to speak without interrupting. This is essential to consider as women have been shown to be interrupted much more than their male counterparts, without being given the opportunity to express completely their view or during public speaking.[8]

Although there is much work to do to broaden access to formal surgical mentoring schemes, their value to nurture the next generation of surgical trainees is increasingly recognised[9] along with the realisation of meetings to facilitate interaction between mentors and mentees, particularly at an early stage of the surgical career. Mentoring training is possible and recommended to smooth female's attrition during career progression. The surgical conversation must be conductive to a healthy, nurturing environment alongside the rigor and standards appropriate to the acquisition of surgical knowledge.

Maternity and surgical training

The 'motherhood tax' on female surgeons has been a matter of concern for a very long time, with trainees often not feeling supported during pregnancy. The surgical culture needs to be better, more supportive and more inclusive to actively prevent pervasive gender discrimination. Female trainees must be empowered to be able to make decisions about their reproductive health and supported if they have pregnancies during surgical training. Women must be measured on their true worth, not their potential motherhood and discrimination and unconscious bias rooted out.

The traditional shroud of silence around early pregnancy can be very challenging as a surgical trainee, as sometimes due to symptoms, it is necessary to tell seniors early in order to be able to get the support that is needed. Pregnancy loss unfortunately is common and occurs in one in four pregnancies. The lack of clear robust evidence makes it difficult to have evidence-based guidelines,[10] but it is essential that training bodies try and develop some guidelines to protect trainees.

Another crucial time is returning from maternity leave. The Bawa-Garba case left many trainees who returned from maternity leave deeply unsettled, as the case highlighted the catastrophic consequences of failing to adequately support a trainee on return from maternity leave.[11] Active mentoring of returning trainees, adequate supervision and senior support, and frequent meetings with an educational supervisor should be the minimum standard where 'extra nurturing' is required.

Work–life balance to prevent burnout

Burnout is increasingly recognised and up to 50% of surgeons experience this.[12] It is about disengagement, lack of hope with blunted emotions and a decreased sense of personal accomplishment, driven largely by external factors: work-process inefficiencies, excessive work hours and workloads, work–home conflicts, problems with the organisational culture and perceived loss of control and meaning at work.[13] All these factors might exacerbate more in women than in men, although luckily, there has been a fixation and the general environment is improving, with a recognised role in the 'new surgical norm'. This is slowly changing since 1997, when the National Confidential Enquiry into Patient Outcome and Death's, 'Who operates when', showed that emergency patients who were operated on out-of-hours (the majority then) had worse results.[14] Before that, surgeons just kept operating all night. Teamwork became the new mantra, with staff they knew and appropriate back-up, as the professional poise is more likely to be maintained if it is only for 48 h/week. Furthermore, fighting burnout is about being part of something and personal attitude in addition to exercise and breaks/sleep have no negligible effects. Exercise (at a dose of 30 min five times a week) reduces a person's risk of dementia by 30%, breast cancer by 25%, bowel cancer by 45%, and stroke and depression by 30%.[15,16]

Once we accept the lack of perfection in ourselves, we value others more. Focus on the task, be clear on expectations and recognise when help is needed. Teamwork makes the dream work.

The academic career

There is evidence that men place more emphasis on their academic profile during training, achieving often a stronger profile.[17] To encourage women to apply for senior academic and organisational roles, ignoring a self-imposed 'imposter syndrome', the following advice could be offered. First, doing academic research does not have to be hard or scary, rather a consequence of a decision-making process, never too early to start and adaptable to follow the regulations of the various systems within different institutions. Second, networking and communication with the right key people are advisable to build the right pathways and supporting system over time; social media contribute to make these opportunities global and accessible to women from all backgrounds. Third, after choosing a topic and a field that inspires, preferably representing a clearly defined niche, it is important to keep constant focus on the assignment and vision, and identify a mentor[18] and a team. Paramount during this journey is to take advantage of the academic opportunities offered in the host centre.

Finally, International Societies play a crucial role in promoting and supporting young scientists, offering opportunities to collaborate and connect with international experts across the globe, providing courses and workshops, including those specifically for surgical specialties with hands-on cadaveric/animal courses. Most of these societies have trainee groups led by young scientists, usually aged < 40 years, to train and support them through multiple levels and engage what will likely be the future leaders in the field.

The gender pay gap in the National Health System

Male doctors in the National Health System earn £1.17 for every £1 earned by female doctors. Women are overrepresented in lower paid specialties, such as public and occupational health, while in male-dominated, highly paid specialties, such as urology and surgery, there are the largest gender pay gaps.[19]

Men and women undertaking different roles with positions held by women being undervalued within the patriarchal culture of surgery are some of the reasons of the gender pay gap. As previously described, men often hold more senior roles, while women generally take time out to have a family and childcare responsibilities.[20]

For trainees, a first step could be a major consideration of the costs associated with childcare and training,[21] with more economic support made available. The costs of mandatory surgical training could be covered by the local education and training boards, including the Joint Committee on Surgical Training fee and the costs of achieving mandatory training requirements. Reduced registration fees for the mentoring or other educational events along with travel bursaries could be another incentive to stimulate professional development.

Conclusions

The Association of Surgeons of Great Britain and Ireland encourages a change of the 'surgical norm' towards a more diverse and inclusive environment. Mentoring, support during and after maternity leave and time out for research in view of an academic career, facilitation of work–life balance and interventions to eliminate the gender paygap in the National Health System have to be considered for the wellbeing of every surgical trainee.

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ORCID iD

Maria Irene Bellini https://orcid.org/0000-0003-0730-4923

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