**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**

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**Authors’ contribution**

Maria Irene Bellini designed the study, wrote the article and searched the literature and is the guarantor of the work; Anya Adair†, Christina Fotopoulou†, Yitka Graham†, Alexis Hutson†, Helena Mohan†, Scarlett McNally† and Stella Vig† contributed in writing and reviewing the article and literature search; Rowan Parks and Vassilios Papalois, conceptualized the meeting, reviewed the article and are on the executive of the ASGBI.

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**Abbreviations**

**ASGBI:** Associations of Surgeons of Great Britain and Ireland

**ASiT:** Association of Surgeons in Training

**NHS**: National Health System

**NCEPOD**: National Confidential Enquiry into Patient Outcome and Death

**WiS:** Women in Surgery

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**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 (Moberly, 2018), 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 (ASGBI) women in surgery (WiS) 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 amongst 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 (Bellini MI, 2019). Gendered language is at the basis of the unconscious bias pervading the reality of WiS 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 (Turrentine FE, 2019), 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 (RCSEng, 2016). It is not hard then to understand why a female might not recognize 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 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 (Women in surgery—if you can see it, you can be it, 2019).

# *Social media as a tool to provide support and gather evidence*

# The ASGBI launched a WiS Facebook group in 2017 (ASGBI Women in Surgery Facebook Group, n.d.). 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 ASGBI, facilitating the advancement of the science and art of surgery and promoting collaboration and research. Through the social media platforms of the ASGBI, 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 (Bellini MI, 2019). 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 (Peggs, 2005). 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. Whilst coaching is generally a short-term, moderately close relationship, focusing on acquiring skills, the mentoring relationship may be a longer, even life-long, 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 (Dossa F, 2018).

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 (Sinclair P, Collaboration, & Training., 2014) along with the realization 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 is a matter of concern for very long time, with trainees often not feeling supported during pregnancy. The surgical culture needs to be better, more supportive, 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 1 in 4 pregnancies. The lack of clear robust evidence makes it difficult to have evidence-based guidelines (Rogers AC, McNamara DA, 2017), 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 (Cohen, 2017). Active mentoring of returning trainees, adequate supervision and senior support, frequent meetings with an educational supervisor should be the minimum standard where “extra nurturing” is required.

*Work-life balance to prevent burn out*

Burnout is increasingly recognized and up to 50% of surgeons experience this (Dimou FM, 2016) 16. 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 organizational culture and perceived loss of control and meaning at work (Dzau VJ, 2018). All these factors might exacerbate more in women than in men, although luckily, there is a fixation and the general environment is improving, with a recognized role in the ‘new surgical norm’. This is slowly changing since 1997, when the National Confidential Enquiry into Patient Outcome and Death *(*NCEPOD*)*’s, “Who operates when”, showed that emergency patients who were operated on out of hours (the majority then) had worse results (NCEPOD (1997). National Confidential Enquiry into Perioperative Outcome and Death. Who operates when 1995/6? https://www.ncepod.org.uk/1995\_6.html). 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 hours/week. Furthermore, fighting burnout is about being part of something and personal attitude in addition to exercise and breaks/sleep have not negligible effects. Exercise (at a dose of 30 minutes 5 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% (Academy of Medical Royal Colleges. Exercise the miracle cure and the role of the doctor in promoting it, 2015) (McNally S, 2017) .

Once we accept the lack of perfection in ourselves, we value others more. Focus on the task, be clear on expectations and recognize 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 (Brown C, 2018). To encourage women to apply for senior academic and organizational roles, ignoring a self-imposed ‘imposter syndrome’, the following advices 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 (Kaps L, 2018) 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 below 40 years of age, to train and support them through multiple levels and engage what will likely be the future leaders in the field.

*The gender paygap in the NHS:*

Male doctors in the NHS earn £1.17 for every £1 earned by female doctors. Women are overrepresented in lower paid specialties, such as public and occupational health, whilst in male dominated, highly paid specialties, such as urology and surgery, there are the largest gender pay gaps (Rimmer, 2019).

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 paygap. As previously described, men often hold more senior roles, whilst women generally take time out to have a family and childcare responsibilities (Ward D, 2018).

For trainees, a first step could be a major consideration of the costs associated with childcare and training (O'Callaghan J, 2017), 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 ASGBI 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 NHS have to be considered for the wellbeing of every surgical trainee.

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