

The myth of meritocracy: What RACS can do to dismantle it by Denna Fryer, Australian National University

The concept of a meritocracy was coined by British sociologist and politician Michael Young in his 1958 essay, *the Rise of the Meritocracy*, in which he satirically described a dystopia whereby the old British aristocracy, based on birth right and lineage, was replaced with a new aristocracy, based on superior IQ and achievement.¹ He later lamented the uptake of his work with none of the negative connotations, stating “it is good sense to appoint individual people to jobs on their merit. It is the opposite when those who are judged to have merit of a particular kind harden into a new social class without room in it for others.”² The modern understanding of a meritocracy regards it as “a social system in which success and status in life depend primarily on individual talents, abilities, and effort.”³ Nonetheless, the social hardening described by Young is evident in Australia in the field of surgery, where women represent only 12.8% of surgeons despite being 51.3% of medical school graduates.⁴ This may in part be explained by the success rate of women’s applications to surgical specialities being as low as 11.2% to 44.4%,⁵ and these successful female applicants are 2.5 times more likely to quit than their male counterparts due to the program’s inflexibility and unacceptable culture.⁶

While the statistics on gender inequality in surgery are clear, those on cultural and ethnic diversity are less so, for example there are no statistics on the ethnic and cultural diversity of plastic surgeons in Australia.⁷ Both the statistics we have, and arguably those we don’t have, draw a picture of a surgical workforce that does not represent the diversity of Australian society; half the Australian population is female, and a third of Australia’s population was born overseas.⁸ This is despite studies highlighting how diversity of opinion leads to increased cultural competence, resulting in better health outcomes by “providing fair and equitable healthcare regardless of race, ethnicity, gender, or culture.”^{9,10} While much work has already been done by the Royal Australian College of Surgeons (RACS) to achieve both gender and cultural diversity through the *Diversity and Inclusion Plan* of 2016, this essay discusses four additional ways RACS can dismantle the myth of meritocracy.

Firstly, there should be a re-evaluation of the surgical training program selection criteria and the elimination of subjectivity. This would involve a clear definition of the merit criteria based on an intersectional review of the skills, attributes and characteristics required of a surgeon to best serve Australian society. Both service to, and reflection of, Australian society is key because merit is a concept relative to the context in which it exists; what is considered ‘excellence’ or ‘meritorious’ by one social group may not be by another. The development of a merit criteria is also a manifestation of power; power to convert “that which is abstract and socially constructed into a measurable ‘thing’.”¹¹ It is therefore prone to exclusionary practices and bias. This subjectivity is evident in the *2022 Guide to Surgical Selection*, which states that applicants are required to submit structured referee reports that highlight not only the applicant’s clinical aptitude, but subjective characteristics such as “workplace behaviour, and personal attributes.”¹² Here there is an implicit understanding of meritorious behaviours and attributes as constructed by those in power, but not clear to applicants. Where merit criteria are not overt, it is likely they continue to be based on what the 1998 *Brennan Report* identified as the male dominated culture of medicine that values “stoicism, machoism and workaholism, which if used as a basis for determining non cognitive ability will continue to select out many women (and men) from specialist training.”¹³ As such, there needs to be a re-evaluation and clear definition of merit criteria based on the characteristics required to build a diverse and culturally competent workforce, putting an end to the preservation of power status quos and ‘selecting out’ of diverse surgical applicants.¹⁴

Secondly, reevaluating the merit criteria requires reconsideration of the *Best Practice Framework for Trainee Selection* devised by the *Brennan Report*, to identify and resolve the unconscious biases that underpin assumptions of merit in the surgical selection criteria. One such unconscious bias is the focus of surgical selection boards on trying to recruit “the best and the brightest”, which implies the lack of diversity in the current surgical cohort is a reflection of merit. There needs to be a mechanism to differentiate applicants with a diversity of socio-cultural backgrounds, genders, and experiences in an environment where all applicants are highly intelligent and motivated. RACS could consider a framework where once a minimum academic threshold is met, other merit criteria designed to recruit a more diverse and inclusive surgical workforce are more heavily weighted.¹⁵ This framework could include the establishment of an equity and diversity (E&D) check or E&D Officer in any process of selection that may lend itself to subjective merit assessments, such as non-cognitive criteria.¹⁶ An E&D Officer would also be useful to maintain diversity of surgical trainees in certain workplaces known to lose them in higher numbers, by acting as an observer of workplace culture external to the hierarchy, as well as advisors on questions of equity and diversity in the workplace.

Thirdly, all selection boards should represent the diversity of the workforce RACS seeks to recruit, not the current workforce disparities RACS seeks to overcome. While written in 1998, the *Brennan Report* continues to guide the selection criteria for RACS and its constituent specialties. This is problematic because it notes that for “proprietary and legality... all panels should have at least one person from each gender” and “achieving gender balance for selection committees places an enormous burden on a handful of senior medical women.”¹⁷ Not only does this policy inadequately reflect gender ratios in Australian society, it also implies that any more than one woman on a board is both difficult to achieve and unnecessary. This is despite research that shows strengthening the gender, cultural and social diversity of assessors leads to greater diversity in admission.¹⁸ Where it may be difficult, or “burdensome”, to have representation from a diverse group of surgeons on selection panels, RACS could consider including other non-surgical medical professionals, or members of standing in the community with background and experience in selecting candidates according to a diverse and intersectional ‘merit’ criteria (i.e. Judges, Senior Executive Service Officers, etc.). This would force greater transparency onto the process, particularly if a position was made for an E&D Officer to oversee the process.

Finally, one of the most powerful things that can be done to influence diversity of future surgeons is to have a diverse group of surgeons visible as mentors and role models to medical students, junior doctors and surgical trainees.¹⁹ Changing the hero narrative of a white male surgeon to a more inclusive picture that junior doctors and students of diverse backgrounds can see themselves becoming is key to seeding a sense of belonging and a vision of themselves as future surgeons. Razack et. al (2020) state that “beneath the myth of meritocracy is the story of a hero's journey, personified in the male doctor, continually nourished from the narratives that sustain the prestige hierarchies of diseases and specialties.”²⁰ It is time to nourish a new hero story based on a new system of ‘merit’ that is inclusive and diverse.

The concept of a meritocracy was originally devised as a warning to society about the dangers of creating merit criteria achievable and protected by the socially elite few. RACS can dismantle the myth of meritocracy by re-evaluating the surgical merit criteria to eliminate subjectivity and incorporate diversity criteria, include an E&D officer or checklist in the selection process or in certain workplaces that fail to retain female surgical trainees, establishing a selection board that reflects a diverse future workforce, and changing the hero narrative of a surgeon to one that is more diverse and inclusive.

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