When merit is equal, but diversity is not, the surgical profession should select for balance.

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The idea that selection into the surgical profession is purely based on meritocracy has long been reassuring. It suggests that those with the strongest technical skills, academic achievements, and dedication will rise. In contemporary Australia and Aotearoa New Zealand, however, this belief overlooks a deeper truth: while candidates may reach the interview room with equal measurable merit, the structures shaping their opportunities have never been equal (1–6). More importantly, selection exists not to reward surgeons; it is about delivering better outcomes for patients (7). Early workforce modelling has long warned that effective surgical planning must be grounded in population need, geographic distribution, and future demand if access and outcomes are to be safeguarded (1,4,6–10).

When two candidates stand equal in their technical and academic abilities, the question should not be *"who is more deserving?"* but rather *"which candidate will allow us to deliver better care to our patients?"*. Diversity – in gender, ethnicity, sexuality, socioeconomic status, rural origin, refugee background, disability, or academic pathway – is not symbolic. It expands the repertoire of skills, insights, and cultural competencies within the surgical workforce. RACS' own Diversity and Inclusion Plan and Rural Health Equity Strategic Action Plan frames this in explicitly outcome-focused terms: excellence is only defensible if the College is serving *all* communities (6,11,12). These expansions can translate directly into safer, more equitable, and more effective patient care, and into a more economically sustainable health system (6,11,12).

The false dichotomy between merit and diversity disguises the real issue: merit is multi-dimensional. Technical skill is essential for safe surgery, but it is not the sole determinant of

high-quality healthcare. Patient outcomes are also shaped by communication, cultural understanding, empathy, adaptability, teamwork, systems thinking, academic curiosity, and alignment with community need (1,4,6–10). These strengths are not uniformly distributed across traditional surgical pathways. They are often cultivated through lived experience – through navigating marginalisation, speaking multiple languages, understanding rural hardship, or balancing caregiving roles alongside professional expectations (1,6,10,13–18). These qualities predict surgical outcomes, system performance, and longevity in the profession. Equal technical skill does not mean equal capacity to communicate with migrant families, to create safe environments for LGBTQ+ patients, to understand rural realities, to rebuild trust with Indigenous communities, or to redesign services through academic insight (2,5–7,15,16,18,19). When two candidates demonstrate equal operative skill, the profession must ask a deeper question: what additional strengths does each candidate bring that will improve outcomes for the diverse patients they will serve? Selecting for balance does not undermine meritocracy – it completes it. It allows the profession to choose the applicant whose presence strengthens the workforce's ability to deliver equitable, culturally safe, academically robust and geographically distributed surgical care.

The populations we serve are profoundly multicultural. One in four Australians were born overseas; nearly one in five speaks a language other than English at home. In Aotearoa New Zealand, Māori comprise about 17% of the population but only around 4% of the medical workforce and as little as 1.6% of surgeons (2,3,5). Qualitative work explicitly frames this as a mismatch: a surgical profession that does not yet reflect the communities it serves, and whose selection processes have not been designed around this (19). Those entering surgery from underrepresented communities are more likely to fill gaps in safety-net hospitals and regional or remote services, extending surgical care to populations the system often underserves (1,2,4,15,16,20,21). To insist on treating their equal merit as if it arose from equal conditions is to misunderstand what merit represents. More importantly for patients, the skills forged through overcoming structural inequity directly benefit those in their care. RACS itself has acknowledged that Indigenous underrepresentation contributes to inequities and has named increasing Māori and Aboriginal and Torres Strait Islander surgeons as a strategic priority, including through the RHESAP and Indigenous selection initiatives. There is clear evidence that diversity-sensitive interventions do not lower standards; they correct structural unfairness and give the system the Indigenous surgeons it urgently needs. Selecting

Māori or Aboriginal and Torres Strait Islander candidates at equal technical merit is not an advantage for the trainee – it is an advantage for Indigenous patients, whānau and communities who deserve culturally safe care.

Gender diversity is associated with greater emphasis on communication, shared decision-making and attention to work–life balance and team wellbeing (9,18,22). Emerging evidence highlight that female surgeons have similar or lower rates of complications and mortality for common procedures, particularly when caring for female patients (9,18,22). Ethnic and cultural diversity brings lived experience and cultural insight, and fluency in other languages, that can transform consent processes, end-of-life discussions, and engagement with whānau and families (15,16,23). Diversity in sexuality identity can foster more inclusive environments and challenge heteronormative assumptions that otherwise alienate both patients and colleagues (19). Socioeconomic diversity means some surgeons know first-hand what it is to navigate health systems while working multiple jobs, caring for extended family, or living in rural or overcrowded housing – knowledge that changes how they advocate for patients (15,16,23). Academic diversity, including surgeons with PhDs and research degrees, adds rigorous skills in critical appraisal, data analysis, quality improvement, equity research and system redesign (15,16,23). When technical and academic merit are equal, these additional layers of diversity are not “bonuses”, but distinct forms of value that their counterparts may not be able to offer. The layers of diversity are clinical assets that can aid in the improvement of postoperative recovery, reduction of postoperative complications, and strengthen long-term patient health outcomes.

If Indigenous equity is the moral argument for selecting for balance, rural maldistribution is the patient-access and economic argument. Across Australasia, data reveal a consistent pattern: despite large rural populations and strong early interest in rural practice among medical graduates, only a small minority of surgeons ever work in rural areas (3,6,10,13,20,24–27). Reports on rural surgical services further highlight significant workforce gaps, reliance on locum cover and the precariousness of small hospitals, with downstream effects including treatment delays and increased patient transfers (3,6,10,13,20,24–27). Workforce and economic data tell a clear story. Long-term rural practice is profoundly shaped by early influences: rural upbringing, early rural clinical

exposure and a training curriculum oriented toward rural service (3,6,10,13,20,24–27). Rural-origin graduates who complete extended rural placements are more likely to return to rural communities years later (3,6,10,13,20,24–27). RACS' RHESAP recognises this explicitly: selecting rural-origin and rurally trained candidates is one of the most effective mechanisms for improving access in underserved regions (12). A rural-origin trainee with equal operative skill does not simply "look different" on a demographic spreadsheet; they bring a much higher likelihood of practising in places where their urban counterpart will not, and a contextual understanding of rural life that shapes better decisions in and out of theatre. This is not "supporting rural trainees" for its own sake; it is deciding whether rural patients will receive timely, local surgical care at all.

Academic diversity also strengthens innovation and improves patient care system-wide (4). Clinician-researchers with PhDs and formal research training bring advanced skills in critical appraisal, audit, health equity research, and systems redesign (4). The RHESAP's GRiD concept (Global, Remote/Rural/Regional and Deployable) explicitly envisages post-fellowship training pathways that equip surgeons to work in resource-limited environments, redesign services and contribute to global and rural surgery (4,12). When technical merit is equal, selecting the candidate with strong academic and systems skills expands the profession's capacity to refine guidelines, evaluate innovations and advocate for policy change – shifts that benefit thousands of patients over decades (4).

A diverse workforce is not just ethically right – it is operationally smart (4). A workforce that mirrors society is linked with improved access, equity, cultural safety and patient trust (1,2,4,15,16,20,21). Without deliberate workforce shaping, training systems will fail to produce the surgeons needed for future demand (1,2,4,15,16,20,21). Selecting for balance is not special treatment. It is not a concession, a quota, or a dilution of standards. It is the surgical profession acknowledging that its responsibility extends beyond who becomes a surgeon, to who receives surgical care. When merit is equal, diversity reliably predicts better alignment with community need, greater willingness to serve underserved populations, and richer skills for providing safe, person-centred care. It is a workforce strategy, an equity intervention, and an investment in long-term system performance. The choice is clear: the surgical profession should, and must, select for balance.

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