Gender biases in surgery: Findings from a qualitative study.

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Background

2016: Funding for a three-year postdoctoral research fellowship:

Gender Biases in Surgery

- Surgical profession
- Patients (ASR Hip, Mesh, LDTs, ICDs)

This included the qualitative study

"What makes a woman surgeon?"

Qualitative study with women surgeons in Australia about their training and careers

- 46 in-depth, semi-structured interviews
- Women from all surgical specialties
- All career stages (trainees, fellows, consultants).

Recruitment supported by the Royal Australasian College of Surgeons, including ads in *Fax Mentis* and the RACSTA and Women in Surgery newsletters.

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Interview questions

- Personal story including significant people, moments, events
- Supports and barriers
- Interpersonal dynamics with:
  - Other surgeons
  - Medical specialists
  - Nurses
  - Allied health (dieticians, physiotherapists, psychologists etc)
  - Administrative staff
  - Patients
- Training: hidden curriculum, assessment, feedback
- What makes a good surgeon?
- Have you experienced any discrimination?

The data… and my focus.

46 surgeons
60+ hours of recordings
1000+ pages of transcribed data

Existing research mainly focused on explicit factors, such as:

- Sexual harassment, bullying
- Parental leave, family and life-balancing
- Mentoring and networks

My focus *when analysing the data* was on micro-inequities:

- Credibility deficits
- Credibility excesses
- Subtle biases

This presentation in context

- Overwhelmingly, participants were happy to be surgeons.
- Spoke positively of surgical sponsors, mentors and role models, male and female, who had supported their careers.

This presentation in context

Disagreement about

The prevalence of gender bias, bullying and sexual harassment:

> "The women who were making [harassment complaints] had one thing in common. They were all incompetent […] I don't think there was much basis to it."
>
> "– this is all in one frigging case in my entire career, so you can multiply it by a million times –"
>
> "if it's not carefully regulated you end up with some pretty toxic work environment full of pretty toxic people who haven't been nurtured […] a generation of people who have been damaged by their surgical training."

Disagreement about the acceptability of various aspects of 'surgical culture', including "black humour", competitiveness, and extreme working hours:

> "a lot of it was that kind of sexual banter that I thought was kind of funny and appealing, and I suppose at the time I felt kind of flattered by it. So I didn't at all feel uncomfortable, although I do recognise that it was highly inappropriate!"

This presentation in context

- Systematic analysis of the data for **patterns** or **themes**
- Experiences described by **multiple participants**, across **different career stages** and **subspecialties**, and often in **strikingly similar terms**.
- Illustrative quotes focus on **subtle** gender bias, with a **cumulative impact**.

NOTE: the data also includes less subtle gender biases, including examples of bullying, sexual harassment and sexual assault.

I have not focused on this, given previous reports commissioned by RACS on these topics.

Four types of bias

1. Workplace factors
2. Gender stereotypes regarding care and communication
3. Gender stereotypes regarding knowledge and skills
4. Objectification

Workplace factors

Disparagement of women who have families

“A female surgeon with children, they were talking about what a crap surgeon she is, and she’s off having babies […] So if you’re a female trainee standing there operating while the boss is talking about this, about another female consultant, of course that affects you.”

Lack of access to networks

“there’s this club in surgery, and you’re either in it, or you’re not […] that’s usually if your dad was a surgeon or you went to Boys” Grammar or you played rugby”

Lack of role models

“One of the problems for women is that we’ve got a paucity of good female role models, and at the same time we’ve got an excess of bad role models, both male and female”

Subtle harassment and bullying

“just sex jokes and things […] anything that would make you blush when you’re a medical school student […] they try and talk to you and try and get you involved in the joke, and I’d be embarrassed.”

Care and Communication

Expectations of peacemaking

“if there’s an angry patient they’ll want the girl to talk to them, and you have to do a lot more kind of – the talky-talky or the touchy-feely kind of stuff.”

Expectations of empathy

“Men who’d come in and they’re quite open to cry about the recent loss of their partner, or their dog […] because they know I’m probably likely to understand – in their mind, as part of the stereotype.”

Expectations of communication style

“I know that I can’t be as offhand as some of my male colleagues and just respond to something in a very male way, because patients are not going to respond to that. Like, some of my patients come and see me because they identify that I’m a female physician and they actually are choosing that”

Expectations of collegiality

“I felt it was a lot about working really hard and not complaining, and getting on well with everyone that you worked with […] I always got a lot of pressure to kind of get on with everyone as much as possible.”

Credibility – knowledge and skills

Failure to be recognised as a surgeon

“I’d had a great interaction with the family, and I’d explained what the problem was, and he’d agreed to surgery, and I’d consented him for the history, and as he was leaving, he turned around and said, “So, I’m just wondering. Who’s going to do the surgery?””

Knowledge questioned

“the nurses trust more just because they are male surgeons […] like not questioning what a male doctor asks them to do, and questioning what *you* ask them to do.”

Gender stereotypes about skill

“I think there must be some idea out there in the general practice world that ladies don’t do orthopaedics, don’t do hips and knees. They just do fingers, or something.”

Material recognition of worth

“I hate coming back to money, but to me that seems like it’s possibly the most objective way of saying how I think the patients see me. Are they willing to pay me?”

“patients going, “But I just saw the – she’s just a female doctor. Why is that really expensive?””

Objectification

Appearance

I've had feedbacks saying that at least it's a good thing you're a pretty face, surgeons like having a pretty face in theatre."

I lost a lot of weight at one stage, and I certainly think thinner people get treated better […] when I was more svelte and more attractive that I got asked to come in and assist in surgeries, and do things.

Clothes: conflicting views and messages

"you have to put on high heels because then you get taken more seriously"

"High heel shoes are not comfortable for ridiculously long shifts"

Sexualisation of the clinical encounter

"he had anal pain so I asked to examine him and he said – he started making all these weird jokes, like, "Oh, you have to buy me dinner first!""

I have had lots of instances where male patients on a ward round would have mentioned my body or something, and everyone had a giggle, rather than saying, "Mate, that's not OK".

So what?

- Cumulative effects of the biases described above
- Note: not all stereotypes are negative – care, communication, teamwork
- But, might still be limiting
- And, expectations/stereotypes can be self fulfilling
- Problem in training… shaping the next generation to have a gendered skillset?
- Tension between service provision and skill development during training (tendency to give trainees more of what they're good at?)
- Relative value (including material value) of technical vs non-technical skills

(apparent lack of) innovation and research

Sometimes research fell by the wayside in the attempt to juggle other priorities:

> "I had a plan. Three days work, one day mother, one day research. It's more than three days work, because you work weekends and evenings, but that was my plan. My research day died very quickly under clinical work"

Some women found academic roles were less supportive for women:

> "I think that the culture in the big ivory towers was not particularly conducive to supporting, you know, young women. And the culture down here was completely different. I mean, they were just happy that they'd got somebody in the country"

Or lacked confidence:

> "I was so insecure about my research."

Innovation was barely mentioned… is this because I didn't ask the right questions, or because of my recruitment strategy, or because not many surgeons innovate?

Or, does it reflect a gender bias or difference?

Bristol Study

- Funded by the British Academy
- Hosted by Bristol Centre for Surgical Research
- Qualitative study focused on motivations to innovate
- 27 surgeons who are actives researchers and/or innovators
- 12 women, 15 men

Three types of innovation identified:

Procedure innovation… development of new procedures or modifications of existing procedures

Device innovation… invention or development of tools or implants (often partner with industry)

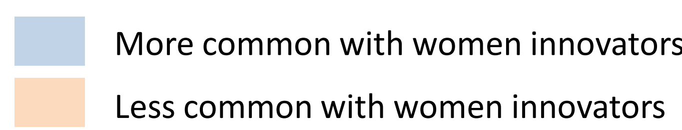
Innovations elsewhere in the surgical pathway (e.g. pre-op, post-op, delivery models)

Three sources of motivation:

Improving patient outcomes

Intrinsic love of investigation and discovery

Desire for esteem and pay



What next?

1. Untapped potential in the data

- Opportunity to explore questions RACS is interested in, insofar as they are within the scope of the interview questions.
    - Career shapes and pathways of women surgeons
    - Training experiences

2. New research questions

- Comparisons: e.g. with men, with other specialties, ….
- Innovation and leadership
- Industry engagement, devices etc
- Focus on specific specialities (e.g. orthopaedics, cardio-thoracics)
- Focus on strategies

Thank you

Funding

- Macquarie University Research Fellowship 2016-2019
- British Academy Visiting Fellowship 2018

Disclosures: None

Acknowledgements: Thanks to my research assistant, Dr Wendy Carlton, who assisted with data analysis.