Diversity in surgery

Dr Richard Lander MBChB, FRACS
Orthopaedic Surgeon
Executive Director for Surgical Affairs (NZ)
Royal Australasian College of Surgeons
Wellington

Associate Professor Jonathan Koea MBChB, FRACS
Hepatobiliary and Upper GI Surgeon
Auckland

Mr Calum Barrett BA(Phil), LLB, MBHL(Dist)
Policy & Communications Officer
Royal Australasian College of Surgeons
Wellington

Dr Catherine Ferguson MBChB, FRACS
Otolaryngology, Head and Neck Surgeon
Wellington

Associate Professor Kelvin Kong MBBS, FRACS
Otolaryngology, Head and Neck Surgeon
Newcastle NSW

INTRODUCTION

The concept of diversity encompasses acceptance and respect. It means understanding that each individual is unique, and recognizes our individual differences. These differences can be along the dimensions of race, ethnicity, gender, sexual orientation, socio-economic status, age, physical abilities, religious beliefs, political beliefs, or other ideologies. These differences should be explored in a safe, positive, and nurturing environment. It is about understanding each other and moving beyond simple tolerance to embracing and celebrating the rich dimensions of diversity contained within each individual.[1]

Each and every doctor takes ownership of the environment in which they work. As surgeons we are the owners of the legacy of surgery, we work in today's surgical world and we will be responsible for the future of surgery.

Some say that the legacy of surgery is that of a male dominated, misogynistic community, closed to the outside world. Diversity in the surgical workforce is changing that legacy and today's surgical community is becoming increasingly diverse in keeping with modern social trends and demands. There is considerable evidence that diversity improves work culture as well as giving patients greater choice.

The Royal Australasian College of Surgeons (RACS) is actively embracing diversity in surgery by addressing the past inequities of women in surgery, and in Māori, Aboriginal and Torres Strait Islander representation.

WOMEN IN SURGERY

Currently 10.6% of surgeons across Australia and New Zealand are women, although this is predicted to change as 39% of current trainees are women, and 40% of recurrent successful SET applicants are now female. The College recognizes that lifestyle factors are important in choosing a surgical career, but interventions to improve diversity should be targeted at all trainees.

Factors that have been identified as barriers to diversity include; lack of flexible training opportunities, inaccessibility of leave and lack of independent and specific support, particularly family and career responsibilities.

In a recent 'Medicine in Australia: Balancing Employment and Life' (MABEL) research forum held in Melbourne in May 2016 speakers talked about the hurdles to flexibility in specialist training and found that specialists in training seem to have less flexibility than other doctor types (e.g. general practitioners, and hospital medical officers). This issue affects women more, and as a result, this is an extra hurdle in the path to specialization. Study results have found that women are more likely to temporarily leave clinical practice when they have a newborn or 1-2 year old child. When working they do not reduce their hours as much as other groups and usually remain more than 40 hours per week. It seems that an all or nothing approach to achieving specialist qualifications still occurs. Specialist registrars were found to be more restricted in employment by lack of childcare, as irregular hours do not match with traditional childcare hours of operation.

RACS and its training boards are currently exploring options for less than fulltime training, and are working closely with jurisdictions and employers to facilitate this. It is hoped that by providing greater flexibility during training, the surgical workforce will eventually come to reflect a more equitable gender balance.

MAORI IN SURGERY

In 2014, only 3.2% of medical practitioners in New Zealand identified as Māori (up from 2.7% in 2013). As the total size of the medical workforce in 2014 was 15366, this means that there were roughly 490 Māori doctors at the time.

In 2014, there were 34 Māori graduates from New Zealand medical schools. In 2015, 75 of the new medical students were Māori (about 15% of the total domestic intake of 503). Due to these increasing numbers, it is expected that Māori as a proportion of the medical workforce will continue to grow. The challenge for RACS is now to encourage these Māori students into surgery.

Unfortunately, Māori representation in the surgical workforce is relatively low. RACS' last Fellowship Survey has the number of active Fellows who are of Māori descent listed as 11. We do not know how many Māori trainees we have currently, although this is something we will be able to find out in the near future as this data is now being collected.

To address these low numbers, RACS has committed to developing the surgical workforce to be representative of Māori in New Zealand. As the number of Māori medical students is now higher than ever, it is hoped that

by providing greater access to resources and support, from medical student through to surgical trainee, more Māori will be encouraged and enabled to pursue a career in surgery. The Royal Australasian College of Surgeons is now actively working with Te Ora, the Maori Medical Practitioners Association to actively recruit Maori into surgical careers by presenting at medical student gatherings, offering scholarships to attend the College Annual Scientific Meeting and regional student events to encourage students to take surgical options.[2]

ABORIGINAL AND TORRES STRAIT ISLANDERS IN SURGERY

Aboriginal and Torres Strait Islanders comprise approximately 3 percent of the Australian population. In 2012, the admission of Aboriginal and Torres Strait Islanders to medical studies reached parity to the population statistics, that is just under 3% of medical students admitted to medical school were of Aboriginal and Torres Strait Islander descent! This was an exciting moment in Australian history and a representation of the strong future ahead. Unfortunately on graduation from medical school, Aboriginal and Torres Strait Islanders do not pursue a career in surgery in the same proportions as the non-indigenous population, despite showing a keen interest during medical school.

RACS acknowledges that Aboriginal and Torres Strait Islander membership of the Surgical Education and Training (SET) Program and of the Fellowship does not reflect either the demography of Australia or the general uptake of surgery as a career by medical graduates. Of the current Fellowship of over 6000, only two Fellows have identified as Aboriginal. There is a strong sense that the professional inequality should be addressed.

There are positive benefits to all the community in the areas of social advancement and indigenous health, but also the general community benefit from different perspectives, when indigenous peoples are represented in the medical workforce and in surgery in particular.

Based on 2013/14 statistics published by the Medical Board of Australia 5,422 registered medical practitioners had specialty registration in surgery, which is 5.4% of the total registration of 99,379.

The RACS initiative is designed to address the low participation of Aboriginal and Torres Strait Islander doctors in the surgical specialties that RACS trains in. RACS aims to increase the number of Aboriginal and Torres Strait Islander surgeons in the Fellowship.[3]

GENERATIONAL DIVERSITY IN SURGERY

There is no doubt that there is a generational diversity in medicine as a whole. The selection and training of surgeons and surgical leadership tends to be the responsibility of the older generation of surgeons (the baby boomers) and the stellar pool of applicants is from the "generation X and Y" populations. The older generation tend to have a work related life balance, are motivated by inspirational speeches, have an expectation of leadership roles and have a high work ethic. The younger generations on the other hand have a greater lifestyle focus, lead if necessary and are streetwise and tech savvy. By not accepting the changing attitudes and motivations of young trainees and medical students, the older generation of surgeons may disenfranchise a high percentage of potential future surgeons.[4]

In addressing the current inequity of diversity in the surgical community the Royal Australasian College of Surgeons aims not only to advocate for quality and high standards in surgery but also to produce a diverse and vibrant surgical workforce for the future.

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