Australasian Students' Surgical Association

Gender Equity in Surgery Guide

2020

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Introduction

Gender parity in medical schools has been evident for decades but has not translated into the medical workforce with representation in specialty fields and leadership roles most notable. In 2020, females outnumbered male medical students commencing at Australian universities (51.3%) and New Zealand universities (59.4%) [1]. This has been the overall trend for the past decade in both countries. In terms of medical school graduates, females have outnumbered male medical school graduates every year in New Zealand and 9 out of the past 10 years in Australia [1]. However women represent only 11% of consultant surgeons and only 12.8% of surgeons in Australia [2,3]. Furthermore, women of colour and gender-diverse people are even less represented in surgery and may face additional challenges regarding racism and stigma.

This guide is aimed at university surgical societies to provide information on the following with practical recommendations:

- Promoting gender equity
- Sexual harassment in surgery
- Supporting women of colour and gender-diverse students interested in surgery
- Role of males champion of change

Gender Representation in the Healthcare Workforce

Gender statistics in the Australian surgical workforce:Despite growing numbers, women have consistently been underrepresented in the field of surgery and its positions of leadership [4]. In 2020, women represent only 12.8% of surgeons in Australia, making it the medical speciality with the lowest proportion of females [5]. Encouragingly, this percentage has been rising slowly but steadily, seeing a 1.9% increase in women surgeons since 2016 [6]. However, some surgical subspecialties still lag behind others in terms of reaching gender parity, such as cardiothoracic, vascular and orthopaedic surgery. *Figure 1* illustrates 2015 data on the proportion of female and male consultant surgeons stratified by subspecialty.

Surgical Specialty by Gender

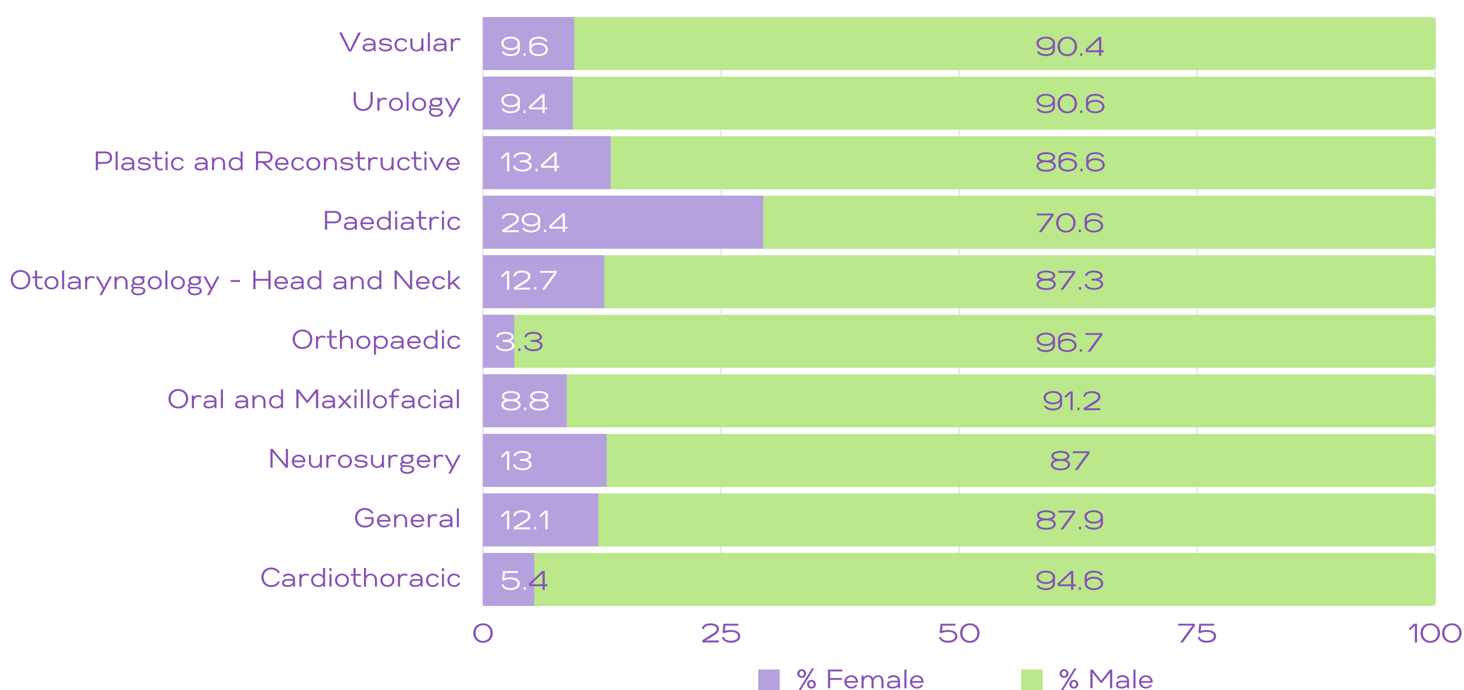


Figure 1 - Surgical Specialties by Gender [7]

Whilst the gender ratio of surgical consultants may not be improving dramatically, it is promising to see the ratio of females applying and being accepted onto surgical training is increasing (*Table 1*). Between 2013 and 2016, the number of female trainees increased by 20.9%, raising it to about 29% of surgical trainees [6]. In 2018, 33% of surgical training applicants were female and 35% of those accepted into training were women, a step closer to the 2021 target of 40%. Despite this, the proportion of women trainees as a percentage of total trainees has not improved [8].

Proportion of Women in Surgery over 2016-18

Year	Applications to Surgical Training	Accepted into Surgical Training	Total of Trainees	New Fellows	Total Active Fellows
2016	30%	35%	29%	22%	12%
2017	33%	31%	29%	22%	12%
2018	33%	35%	29%	24%	12.6%

Table 1 - Proportion of Women in Surgery over 2016-18 [8]

Women in leadership positions in surgery are also disproportionately low but showing trends of improvement (*Table 2*). Representation of women on RACS Boards and Committees are ahead of 2018 targets with 27% compared to a 20% target, with a desired rise to 40% by 2020 [8]. In 2020, both chair and vice-chair of RACS NSW were women surgeons, another promising step towards gender equity in roles of leadership in surgery.

Barriers to achieving gender equity in the surgical workforce

A discussion of the factors contributing to the observed gender imbalance in the surgical workforce relates to identifying the barriers faced by women in not only entering the surgery but in choosing to remain on the training program.

Women in Leadership Positions in Surgery over 2016-18

Year	Women on RACS Council	Women on RACS Council and Main Committees
2016	29%	21%
2017	32%	23%
2018	36%	27%

Table 2- Women in Leadership Positions in Surgery over 2016-18 [8]

Surgery is often described as a polarising career option; it is either the most popular option for the medical student or junior doctor, or the least popular [9]. It has been well researched in the literature that for women, the largest deterrents to pursuing a surgical career are the perceptions that the lifestyle and training pathways is incompatible with a rewarding family life, the lack of female role models and the presence of unconscious gender biases amongst several others. These harmful perceptions are often developed through negative personal experiences and informal cultural directives that make up the 'hidden curriculum' and perpetuate the masculine stereotype of a typical surgeon [10].

Lack of female role models

Having female role models and mentors is undoubtedly a significant positive influence on women and their early career choices [11], with gender being a consistent influencing factor over career choice for many medical graduates [12]. In the United States, the proportion of women on the surgical faculty in medical school is strongly associated with female medical students choosing surgery as a career [13]. Yet, the underrepresentation of women in the surgical workforce and women in roles of leadership, and hence lack of female role models, affirms the perception that surgery is a male-dominated field and acts as a deterrent for woman medical students and junior doctors from entering the surgical workplace.

This then prevents the resolution of the gender gap, resulting in a cyclic problem that will not change without any interventional action. Furthermore, in a discipline where the right relationships and networks with seniors in the field matter tremendously in uncovering the hidden curriculum and progressing one's career forward, such opportunities are not distributed fairly [9], with women who are more reluctant to approach male seniors being at an obvious disadvantage.

Unconscious gender biases

Whilst overt gender-based discrimination may not be as prevalent in the more recent years following large movement on this issue by RACS (e.g. Operate with Respect campaign), sexual harassment and unconscious gender bias persist within surgery. In a 2015 RACS inquiry into bullying, discrimination and sexual harassment in the workplace, 30% of women respondents reported having experienced sexual harassment, whereas the figure for males was only 2% [14].

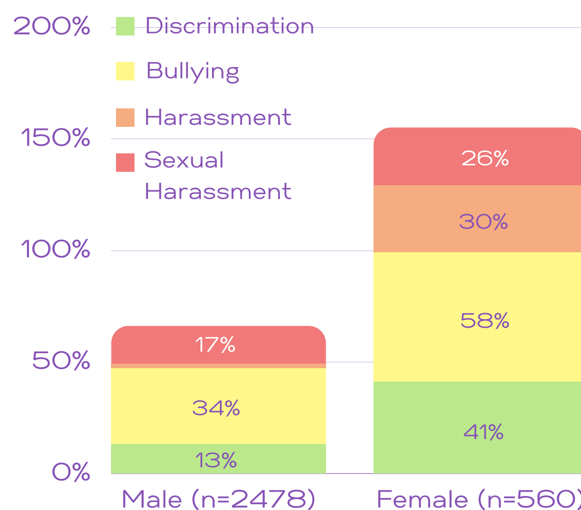


Figure 2- Behaviour Experienced by Gender [16]

Overall, women were more likely to suffer discrimination, bullying and harassment over their male counterparts (Figure Y). This may manifest as sexist comments, gender stereotyping and the pressure for women to 'fit in' to the notoriously-named 'boy's club' of surgery. Whether this be pretending to enjoy inappropriately sexualised banter in the operating theatre [9] or demonstrating masculine traits to be perceived as a more legitimate surgeon [15], women feel as if they have to hide their norm and femininity so as not to be discriminated against.

Lifestyle incompatibility

In the 2019 RACS survey of female medical students into the barriers and drivers for a career in surgery, the top 5 barriers reported were all related to lifestyle factors: (i) time for family & friends, (ii) current of future depends and children, (iii) time for hobbies and interest, (iv) time of vacation, annual leave, travel, (v) flexibility of SET.

Surgery is undoubtedly oftentimes viewed as a speciality incompatible with a healthy work-life balance, with the most detrimental perception being the irreconcilable discourse for a woman in surgery to be a good surgeon and a good mother, yet have the double standard to be both [7, 15]. This perception is perpetuated largely by the inflexibility of the surgical training program which leaves room for career penalties associated with maternity leave. Many normally valid reasons for requesting leave from work such as psychological distress, pregnancy, maternity leave and childrearing duties were often met with invalidity and labelled incongruous with the expected surgical norms [16].

Inflexible training program

Out of all the medical specialties, the SET training program is one of the hardest to be accepted onto and statistics show that women are less likely to be successful in applying for surgical training, with female applicants having a significantly lower success rate (31.8%) than male applications (42.3%) [4]. On the other hand, women are also leaving surgical training in higher proportions compared to men. Out of the 2008-2014 SET trainees, women were 2.5 times more likely to resign. In the RACS inquiry into trainee loss, two of the major themes identified were ‘inflexibility of the training program’ and ‘an unacceptable culture in which to learn’ [17]. Liang et. al. investigated this further with a focus on why women in particular were withdrawing from surgical training, with their qualitative study identifying further reasons including poor mental health, absence of interactions with other women in surgery, fear of repercussions and lack of pathways for independent and specific support [16].

What has been implemented to achieve gender equity in surgery

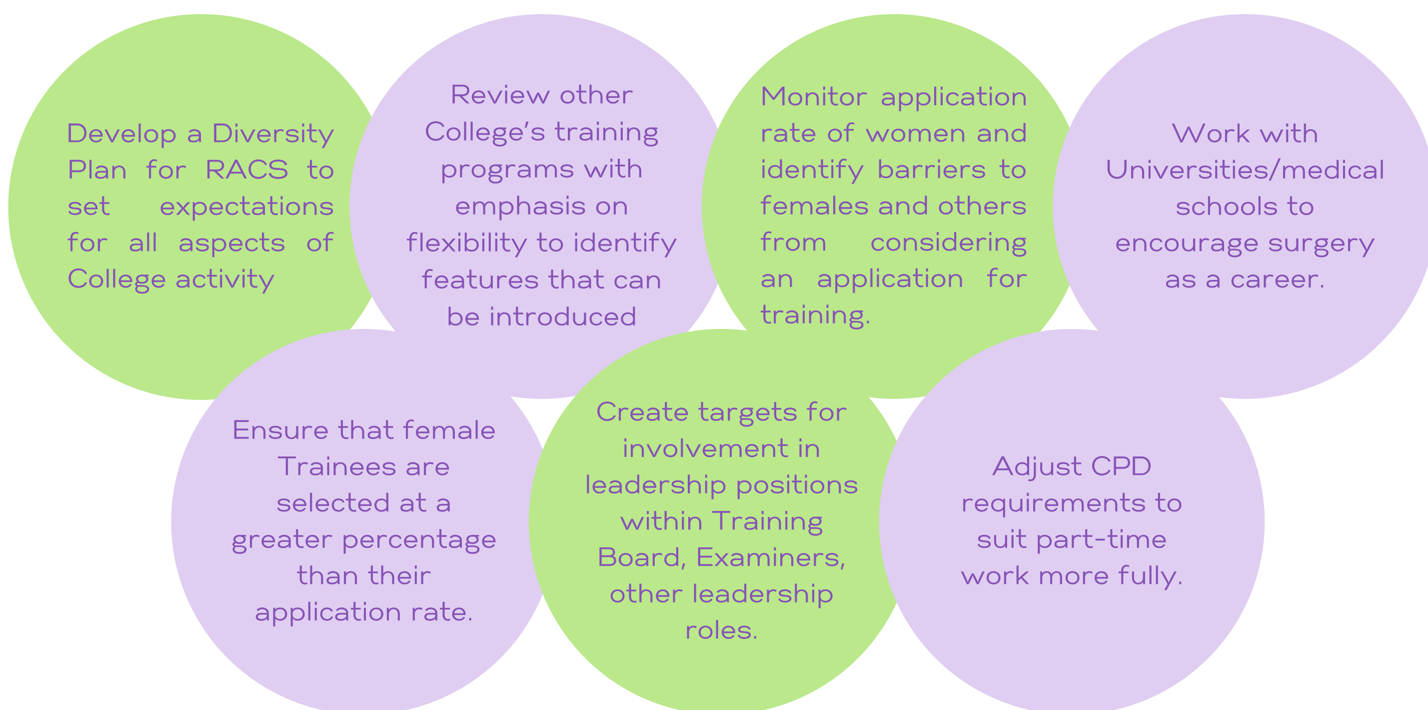
Several surgical organisations have developed plans to improve gender equity in surgery, including the Royal Australasian College of Surgeons (RACS), the Australian Medical Association (AMA) and the Australian Orthopaedic Association (AOA).

Royal Australasian College of Surgeons (RACS)

RACS is implementing a 'Building Respect, Improving Patient Safety RACS Action Plan on Discrimination, Bullying and Sexual Harassment in the Practice of Surgery' [18]

- Their plan is centred on three key actions areas: cultural change and leadership, surgical education and complaints management.
- One of their goals is to embrace diversity and foster gender equity by removing barriers to participation, providing flexible training options, promoting diversity and having targets for the number of women on Training Boards and in College leadership roles.

Their **key actions** to achieve this include:

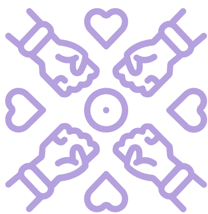


Initial evaluation of the Building Respect Action Plan's program was reported in 2019 [19]. Their survey highlighted a remarkably high level of support for the College's commitment to addressing discrimination, bullying and sexual harassment in surgery, with 95% of 1346 Fellows, 96% of 244 Trainees and 93% of 62 IMGs supporting the College's commitment.

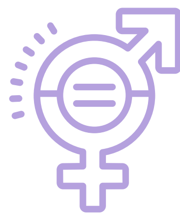
RACS has implemented a complaint-specific database in ANZ, RACS complaints hotline, published a complaints policy, manual and user guide, revised policies encompassing external oversight, new code of conduct, etc [19].

The complaints process is being revised as more than half of Trainees perceived it not safe due to a lack of confidence that it will lead to positive outcomes and the possible negative impact on their career.

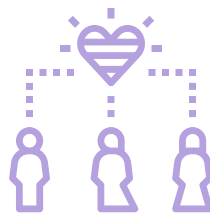
Representation of women is shown to be increasing towards gender equity targets as shown earlier in *Table 1*. The Diversity and Inclusion Plan created in 2016 did so by setting 5 objectives [20]:



Inclusive culture and leadership excellence



Gender Equity



Inclusion of Diversity Groups

Diverse Representation on Boards and Leadership Roles

Benchmarking and Reporting

The Women in Surgery Section has developed a Business Plan 2017-2021 with tangible indicators to improve leadership, role modelling, flexible training and advocacy [21].

Leadership

- Promote women's representation on training boards and RACS Committees 40% by 2020
- Promote women's representation on all training selection panels by 2021

Role Modelling

- Support female surgeons to attendance to medical schools events
- Sponsor medical students to attend WiSS ASC program
- Encourage WiSS members to act as mentors

Flexible Training

- Advocate for practical flexible training models across all Specialty Training Boards and jurisdictions by 2021
- Provide advice on successful flexible training models

Advocacy

- Contribute to 4 Surgical News features on WiS
- Develop and distribute WiSS resource packs
- Provide input submissions annually supporting flexible training posts

Australian Medical Association (AMA)

In 2019, the Australian Medical Association hosted a Gender Equity Summit resulting in key recommendations and commitments to be fulfilled to achieve gender equity in the medical profession and workplace [22].

The AMA has committed to:

1. Adopt a target of 40% women, 40% men for all AMA Councils, Committees and Boards with a gender diversity target of women holding 50% of Federal AMA representative positions overall by 2021.
2. Collate and report on gender data annually regarding leadership position composition within AMA bodies and committees
3. Develop an AMA Diversity and Inclusion Plan
4. Provide funding for breastfeeding mothers in Federal AMA representative roles

Australian Orthopaedic Association (AOA)

The AOA established a Diversity Strategic Plan 2018-2023 [23], with the following aims:

- **Culture and leadership:** remove diversity and equality barriers to create an enabling environment and to mentor and support women to leadership positions
- **Advocacy and engagement:** to promote flexibility and work life balance, support greater involvement of women in AOA activities and leadership positions, promote orthopaedics to medical students and JMOs
- **Flexibility:** to allow flexibility in the selection process, an individual's selection application, training and career so that structured barriers to a diverse workforce are removed

Progress results are as follows [24]:

Culture and Leadership	Advocacy and Engagement	Flexibility
• 2018 saw 23% penetration of female applicants • 23% of 2019 Intro to Orthopaedics trainees are female • 26% female trainees currently in the Intro to Orthopaedics program • 13.3% female trainees currently in core program • 2019 saw 40% of female Board members • Champion of Change Working group formed in late 2018	• In 2019, 26% of facilitators who led sessions during the UG workshop were female • Working with medical surgical societies and state hospitals for OWL workshops	• Guidelines and policies completed regarding flexible training • In 2019, 46% female interviewers in selection process • AOA policy Breastfeeding and Childcare facilities at AOA Events released in 2018 with ongoing implementation • Currently have 2 trainees approved for part time training All AOA sites with more than 3 AOA trainees must demonstrate how they will accommodate a flexible training post as part of their accreditation

Action Points for Surgical Societies

Mentorship

Clarify the mentoring program provided by the Women in Surgery Section for medical students or work with the Women in Surgery Section and relevant medical schools to develop and implement one

- A study by Faucett et al., (2017) ranked same-sex mentorship to be a significant positive influence on women in surgery and suggested early exposure to organizations that support women in surgery can positively influence career choices [25]

Events

- Surgical societies should reach out to the Women in Surgery Section (email: wis@surgeons.org) to help organise speakers and panel members for educational and networking events.
- Surgical societies should aim to have diversity in event panels and speakers in terms of gender and cultural background.
- Engage both male and female medical students interested in surgery to attend Women in Surgery events.

Education

The following are suggestions that surgical societies could help implement in partnership with their respective medical school:

- Provide positive female exposure to surgery i.e. lecturers, tutors, mentors [26]
- Complaints handling - having a confidential and reliable system of reporting gender-based discrimination and harrassment without fear of retaliation for medical students
- Seek out formalised pathways for research and surgical experience for female students to gain access to opportunities that will increase their preparedness and likelihood of success in being accepted onto a training program [26]
- Partake in transparent reporting of gender data to encourage increased accountability and awareness of ongoing inequalities in surgical education [26]
- Incorporate training in unconscious bias to raise awareness of thought or behavioural patterns that can disadvantage a particular group for students and academic staff.

Action Points for Surgical Societies

Committee

- Educate your committee on unconscious bias. This open-access course from the Stanford University School of Medicine describes the effects of unconscious bias in medicine and identifies strategies to correct these behaviors everyday.
- Assess and evaluate the diversity present within your committee. This isn't a matter of playing 'identity politics' or 'tokenism', but identifying where there may be underrepresentation, and developing strategies for avoiding this in future cohorts.
- Consider the introduction of a gender equity and/or diversity role within your surgical society.

Sexual Harassment in the Workforce

The current status of sexual harassment in surgery

1 in 3 Australians

Have experienced various forms of sexual harassment in their workplace.

This can be in the form of:

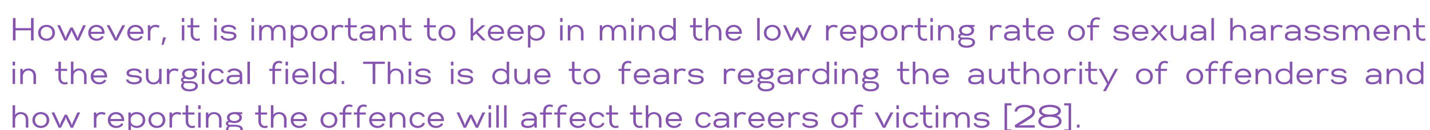
Inappropriate remarks

Unwanted touch

Request for sexual favours

There needs to be recognition that the impact of the behaviour on the recipient is what determines whether sexual harassment has occurred, rather than the motives of those responsible. Therefore, the offender's excuse that harassment was not intended does not minimise the severity of the problem. For example, saying 'I didn't mean it' cannot serve as an excuse. While both men and women experience sexual harassment, the issue is more severe for women (39 percent of women compared to 26 percent of men) [27].

Sexual harassment in surgery is also a prominent issue that has received media coverage and public attention. Survey data collected by an Expert Advisory Group commissioned by the Royal Australasian College of Surgeons (RACS) showcased that 7 percent of International medical graduates (IMGs), Fellows and Trainees have experienced sexual harassment in their workplaces. The most common offenders in half the hospitals were identified to be male surgical consultants and directors. Discrimination, sexual harassment and bullying by surgeons was reported in over 70% of hospitals within a five-year time frame. This emphasises the need for early education of male doctors regarding how to respectfully communicate and interact with women. More support also needs to be offered for victims to recover from incidents and protect them from backlash by offenders.



However, it is important to keep in mind the low reporting rate of sexual harassment in the surgical field. This is due to fears regarding the authority of offenders and how reporting the offence will affect the careers of victims [28].

What has already been done about sexual harassment in surgery?

While legislation banning sexual harassment has already existed for over three decades, numerous incidents still occur. This emphasises the need for open discussion and a change in mindset to create societal change. The recent #metoo movement reflects these ideals and encourages organisations to actively deal with unacceptable behaviour [27].

RACS recognises that the issue of sexual harassment needs to be addressed by building a culture of respect. Clear standards have been set by the RACS *Building Respect; Improving Patient Safety* program since 2015. Individuals who do not uphold these standards are held to account for their actions. The education of medical practitioners allows them to be better informed about the impacts of sexual harassment and what constitutes it. The program encourages maintaining professionalism and respect towards others in the workplace [27].

Action Points for Surgical Societies

Organise Events with relevant guest speakers to inform students about the impacts of sexual harassment.

Students can better understand how their seemingly harmless actions may affect recipients in serious ways. It would be especially effective in eliciting a strong emotional response in the audience if victims were invited to share their experiences. However, precautions need to be taken to ensure that the victim is emotionally and mentally comfortable with sharing their thoughts in front of large groups.

Consider Organising sessions and small group workshops for medical students on how to respond when they are being sexually harassed by colleagues.

This can include how to effectively remove themselves from danger and what services they can contact afterwards. For example, RACS and the Australian Human Rights Commission can both be contacted for further information and inquiries regarding sexual harassment. Complaints can be made about surgeons by sending them to a specific RACS email. (Email: complaints@surgeons.org)
Furthermore, there is a free RACS Support Program that is available for those that wish to speak to someone about their feelings of anxiety or depression. The family members of doctors can also utilise this resource at no charge.

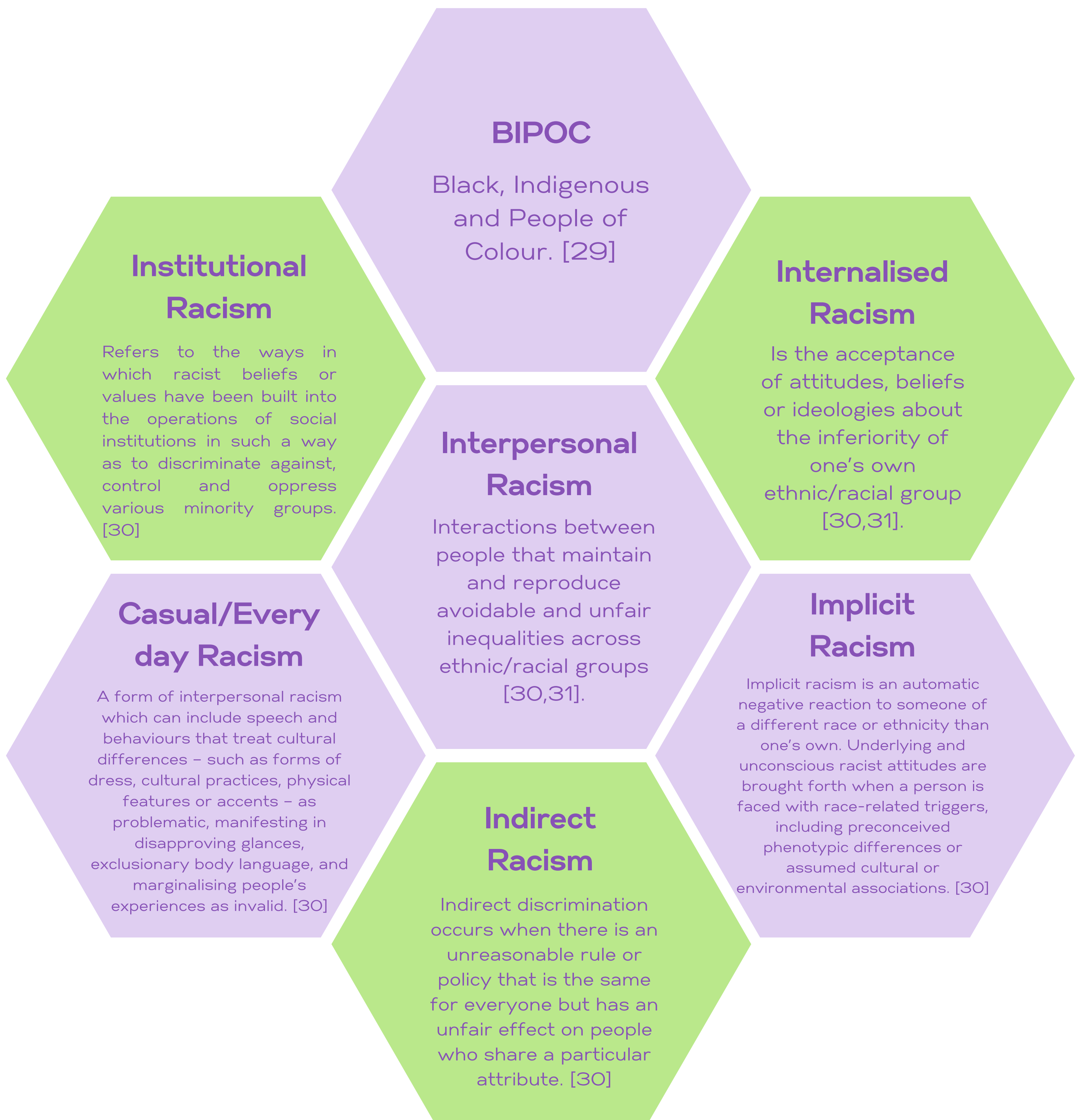
Develop educational resources on how to recognise sexual harassment and how to aid victims.

They also should be informed about what is considered inappropriate in a professional context, education about what is considered harassment and how to not unintentionally become offenders

Develop Sexual Harassment Policy and Reporting and Escalation Pathways to keep people accountable and safe within your Surgical Society

Ensure that there are pathways in place for people to report sexual harassment within your surgical society and clinical placements where possible.

Definitions



Racism Within the Healthcare Workforce

Recruitment and Selection Process

Recruitment, selection and promotion practices should be consistent with equal opportunity principles and should not be discriminatory in any way. [30]

Aboriginal and Torres Strait Islander Doctors

Racism experienced by patients in the healthcare system can have many negative impacts on mental and physical health outcomes. It may lead to delays in seeking healthcare, non-adherence to treatment and psychological stress. In addition to this systemic and interpersonal racism has been identified by the AMA to have a detrimental effect on the growth and retention of the Aboriginal and Torres Strait Islander medical workforce [30]. According to the AMA, results from the Australian Indigenous Doctors' Association (AIDA) 2016 survey of their members revealed that more than 60% of Aboriginal and/or Torres Strait Islander respondents had experienced racism and/or bullying every day, or at least once a week [30]. In addition to this AIDA identifies that racist behaviour has a detrimental effect on the motivation of Aboriginal and Torres Strait Islander people to join the medical workforce. [30]

International Medical Graduates and Students

The AMA has identified that International Medical Graduates make a vital contribution to the delivery of healthcare in Australia, particularly in rural and regional locations. In addition to this, international medical students represent a significant portion of students within the Australian healthcare system. For this reason, it is important that cultural differences are respected and considered.[30]

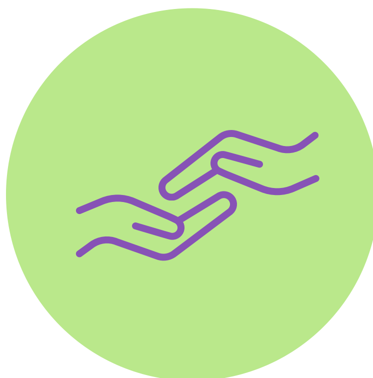
Patient Relationships with Doctors

Racism from patients to doctors and medical students is unacceptable. There need to be measures in place to allow medical students to report experiences of racism from patients whilst on placement. According to the AMA, the approach to patients exhibiting racism towards a doctor or student should be addressed with consideration for the patient's mental state and whether or not the patient has decision-making capacity, along with the impact on the doctor or student.[30]

Action Points for Surgical Societies [32,33]

Identify and utilise cultural symbols to promote diversity and inclusion

- Promote culturally sensitive practices in Surgery
- Use inclusive language



Promote Cultural Awareness

- Create and publish content promoting diversity with real life examples
- Create opportunities for discussions and experiences of inclusion for all diversity groups

Educate in cultural safety and competence

- Advocate for inclusion of cultural competence in curriculums

Identify and promote diversity champions

- Allocate the roles of diversity champions in various groups
- Provide communication mechanisms for the messages by diversity champions to reach as wide an audience as possible

Promote BIPOC surgeons as positive role models

- Communicate and publicise BIPOC in surgery

Investigate if there is an unequal representation of BIPOC application for committee roles

- Identify barriers to BIPOC members when applying for committee roles

Action Points for Surgical Societies

Achieve greater diversity within surgical societies and committees

- Ensure diversity through internal policies or by creating opportunities for under-represented groups

Encourage potential BIPOC candidates to participate in leadership roles

- This can be done both formally and informally

Provide support for diversity groups that already exist within medical schools

- Identify diversity groups at your university
- Provide support and/or collaborate for events and initiatives

Include anti-racist and anti-opression curricula at your institutions

- Seek out scholars from ethnic minorities doing this work and invite them to teach
- Ensure they are credited and remunerated for their work

Speak to racial justice groups and learn from them about how to engage in allyship

- Ensure you are committing to meaningful allyship by consulting racial justice groups

Identify and seek advice of AIDA representatives within each medical school

- AIDA is the Australian Indigenous Doctors' Association - seek advice on culturally sensitive initiatives
- Seek collaboration

Gender Diverse People in Surgery

Traditionally, conversations on Gender Equity have revolved around the traditional gender binary framework, which describes gender identity as a dichotomy (i.e. male or female) [34]. ASSA wants to acknowledge and respect all transgender and gender diverse (TGD) members of the surgical and/or medical community who do not identify within this constrictive framework and experience gender roles differently. In this section, ASSA aims to encourage true Gender Equity and Inclusion in Surgery by providing information, resources and suggestions on how to be more gender-inclusive as an individual, or as a part of an organisation (e.g. surgical society).

Statistics

According to the 2016 Census, there are 1,260 sex and/or gender diverse people in Australia, which accounts for less than 0.1% of all respondents [35], while New Zealand 2018's Census did not even include questions on non-binary gender identity [36]. However, figures collected are unlikely to be representative of all people in Australia who identify as sex and/or gender diverse not only because of barriers posed by the census itself, but also because if the stigma associated with being TGD preventing people from "coming out".

Stigma is an issue for TGD as well as LGBTQ+ people within medicine and surgery. The most common reasons for not disclosing TGD gender identity and/or sexuality are fear of discrimination from medical schools and residency programs [37]. While rates of harassment and ostracisation of physicians based on gender identity has improved in the past two decades, it still sits at around 15%, and gender-diverse healthcare workers often do not report instances of discrimination due to consideration on how their identity will be perceived by their superiors and/or the effects on their careers [38].

Stigma also affects TGD patients, who are under-represented in public health research and policy [37] and continue to suffer worse health outcomes when compared to cis-gendered Australians [39].

For these reasons, it is important for medical students and future surgeons to be aware of:

- **Barriers to surgery for TGD colleagues**
- **Social determinants of health impacting TGD patients**
- Ways to **encourage gender inclusivity in medicine and surgery**, both for patients and healthcare providers.

Action Points for Surgical Societies

Terminology

Terminology is a very important part of meaningful allyship towards TGD colleagues and patients. Figure 1 depicts the Genderbread Person is a widely used resource to understand the difference between biological sex, gender identity, gender expression and sexual orientation [40]. Encouraging the correct use of terminology is a form of respect and recognition.

Use Gender Inclusive Language

Gender Inclusive Language	Gender Binary Language
They	He/She
Humankind	Mankind
Distinguished Guests	Ladies and Gentlemen

Sensitive Collection of Data Regarding Sex and Gender

i.e. Including >2 options for gender in sign up forms, surveys, etc.

Ask someone's pronouns

Instead of assuming someone's gender identity, ask them what pronouns do they prefer.

Action Points for Surgical Societies

Events

As a Surgical Society, events are one of your main form of interaction with surgically-inclined students at your university. Here is a list of suggestions on how to make your Gender Equity events more inclusive:

- Organise events and/or activities aimed at raising awareness and improving inclusiveness of TGD people in the medical community
- Encourage discussion about barriers to surgical training for TGD members of the medical community
- Include TGD panelists during Gender Equity events (when possible)
- Collaborate with Gender Equity and/or Queer & LGBTQ+ MedSoc groups at your local university to plan Gender Equity events
- Organise events and/or activities to discuss gender inclusivity in surgical care, with TGD speakers and/or Gender Affirming Care surgeons

Action Points for Surgical Societies

Advocacy

Advocacy is the act of supporting a cause, and that can be done both at an individual or organisational level. Here is a list of suggestions on how to advocate for gender inclusivity at your University or within your Surgical Society:

Advocate for increased and better TGD and gender inclusive care content in the medical curriculum at your University

Gender Identity, especially if TGD can be a significant Social Determinant of Health. If there is not enough teaching on this particular issue, you can advocate for better teaching by:

- Getting in touch with lecturers, professors or Deans as an individual student
- Drafting an open letter to the relevant people in your Faculty and asking students to sign and support the cause
- Collaborating with Gender Equity and LGBTQ+ Groups at your University to develop a curriculum update proposal to present to your Faculty

Create Educational resources on Gender Inclusivity and Gender Inclusive Surgical Care

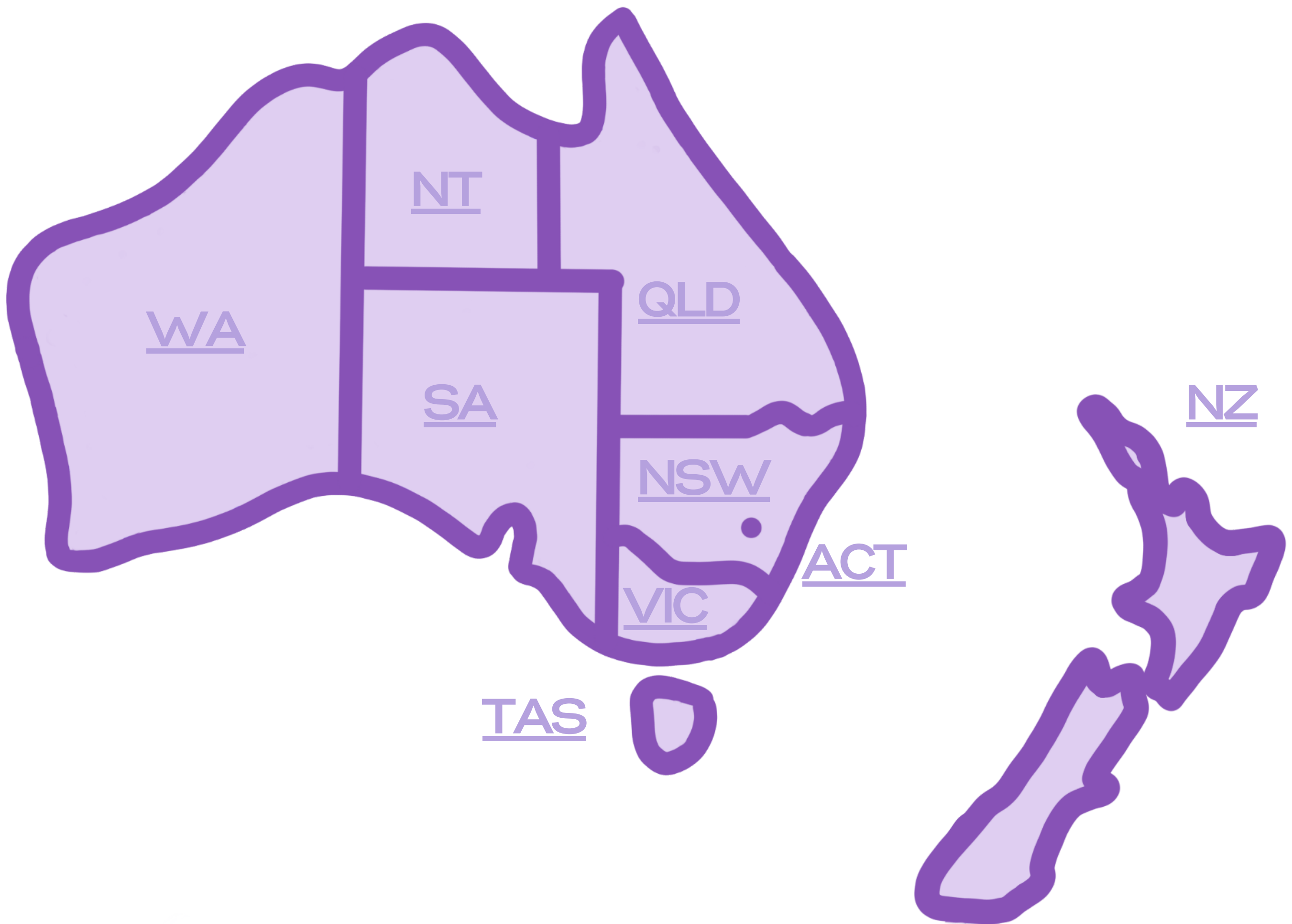
These can be in the form of Infographics, Instagram Posts, Modules and much more

Develop internal and external policies surrounding gender related issues at clinical placements

- Harassment and reporting
- Pronoun Use
- Dress codes
- Appropriate facilities (e.g. gender-neutral bathrooms)

Resources

Find below some helpful resources, including links to LGBTQ+ Advocacy Groups for each state (hover over the preferred state and click to access the link)



Additional Resources

Terminology	Education	Healthcare Staff Resources
Genderspectrum.org	Genderspectrum.org	LGBTQIA Health Education
Vic.gov	IHRA	LGBTQIA Health Education Center
Aus.gov		

Male Champions of Change

"Allies listen, co-create opportunity, and build a personal brand for accountability and trust. For us men, we aren't allies to women because we aspire to be, or because we say we are. We're allies only when specific women are willing to say to us and others, 'Here's an example of how you are collaborating with me, supporting me, making and keeping promises, and receiving from me in a two-way relationship.'"
Chuck Shelton

Male allies are needed more than ever to assist in gender equity. Male allies have been defined as "...a man who will advocate for women even when there are no women in the room" [41]. Whilst male allies come in many different forms, the key message is to be an advocate for gender equity, even when there is no one from another gender present. The benefits of gender equity include: improved clinical outcomes [42]; higher collective IQ [43]; improved business performance [44] but to name a few. Caring about gender equity is not only the smart thing to do, it is the right thing to do.

Many men consider a more gender equitable space as "the right thing to do" [45]. But confusion about where to start is a common problem. A report by the Gloria Cordes Larson Center for Women and Business at Bentley University beautifully outlines a strategy for male allies to get involved in gender equity initiatives [45].

The key steps are outlined below:

1 Define Concepts

- **Male Allies**
  - Men who associate with, cooperate with ,and support women
  - Comprehend fundamental concepts about and champion gender diversity to reduce gender inequities [46]
  - Will advocate for female interests, regardless of if they are present or not [41]
- **Diversity** [45]
  - Anything that makes an individual unique
  - Can be hereditary or acquired traits
  - Can be malleable or immutable characteristics
- **Inclusion** [45]
  - Diversity in action
  - Creates an environment of collaboration and inclusivity
  - Appreciates the breadth of backgrounds, perspectives and life experiences to enhance working environments

2 Listen to Learn

- Engage male employees and understand their ideas, concerns, and expectations

3 Educate to Create Awareness

- Create a safe environment to explore ideas and attitudes towards gender equity
- Answer the common arguments and questions with data-driven responses
- Explain the benefits for all involved

4 Address Barriers to Action

- Understand that there may be an intention gap for men who mean to advocate for gender equity but may be misguided in their efforts
    - Provide these men the tools to advocate effectively
- Understand that some men may fear that advocating for gender equity will reduce their opportunities in the future
    - Research has shown this is not true so make sure to educate them [46]

5 Move Male Allies to Action

- Encourage story sharing from male allies to rally more to the cause
- Consider an independent male ally group
    - Separate male ally groups provide a sense of ownership and must work in close proximity with other gender equity groups

6 Stay the Course

- Repeat and reinforce messages
- Recognise that change takes time

The report also lists a number of actions men can take:

1. Recruit women
2. Actively promote women
3. Correct unconscious bias
4. Share the housework at home and at the office
5. If you have workplace flex benefits and parental leave, use them.
6. Listen to women's stories...and share them.
7. Raise the number and visibility of female leaders.
8. Learn not to "manterrupt."
9. Call out injustices, even if they don't impact you.
10. Publicly pledge your support.

What can women do?

- Initiate the conversation using WIIFM (what's in it for men).
- Share your story.
- Have courageous conversations to address real or perceived hurdles.
- Open women's business networks to include men.
- Actively support and mentor both women and men.
- Be an ally to your male allies.

Gender Equity Scorecard for Surgical Societies

	Score
Does your organisation have a current gender equity policy/strategy?	
Does your organisation have a gender equity role?	
Does your organisation have any events that address sexual harassment in the workplace?	
Does your organisation have policies for gender-equitable recruitment? If not, is gender equality attempted when recruiting new committee members?	
Does your organisation have a variety of cultural backgrounds within the committee?	
Does your organisation actively promote gender equity through events, initiatives, advocacy projects and opportunities aimed at medical students of all genders?	
Does your organisation promote medical students who identify as male to act as "male champions of change"?	
Does your organisation actively attempt to apply a gender fluid framework (as opposed to gender-binary) to events/initiatives on gender equity?	
Does your organisation have procedures in place to ensure that there are cultural and gender balanced panels at your events?	
Does your organisation have a committee that is made up of at least 40-50% female or non-binary-identifying students?	

3 or less	4-7 points	8-10 points
There are areas where your organisation could improve - please refer to this guide for suggestions on how to do that.	There's room for improvement but keep up with the great work.	Your organisation is comprehensively addressing gender equality, outstanding!

References

1. Medical Deans Australia and New Zealand Inc. Student Statistics Report: 2019-2020 [Internet]. Sydney (NSW); 2020 [cited 2020 Aug 24]. Available from: https://medicaldeans.org.au/md/2020/08/2020_MDANZ-Student-Statistics-Report-1.pdf

2. Royal Australasian College of Surgeons. Surgical workforce 2018 census report [Internet]. 2019 [cited 2020 Aug 24]. Available from: https://umbraco.surgeons.org/media/4380/2019-08-06-pub-2018-surgical-workforce-census-full-report-final.pdf

3. Medical Board of Australia. Medical Board of Australia registrant data [Internet]. 2020 [cited 2020 Aug 24]. Available from: https://www.medicalboard.gov.au/News/Statistics.aspx

4. Mclain S, Cook V, Atkinson M, De Silva P, Mukherjee P. Barriers to women's participation in surgery: from student to specialist. ANZ J. Surg [Internet]. 2018 [cited 2020 Aug 30];88(S1):230. Available from: https://onlinelibrary.wiley.com/doi/pdf/10.1111/ans.14544

5. Medical Board of Australia. Medical Board of Australia registrant data [Internet]. 2020 [cited 2020 Aug 24]. Available from: https://www.medicalboard.gov.au/News/Statistics.aspx

6. Australian Government Department of Health. Surgery 2016 Factsheet Internet]. 2017 Oct [cited 2020 Aug 30]. Available from: https://hwd.health.gov.au/webapi/customer/documents/factsheets/2016/Surgeons.pdf

7. Walton, MM. Sexual equality, discrimination and harassment in medicine: it's time to act. Med J Aust [Internet]. 2015 Aug [cited 2020 Aug 30];203(4):167-9e.1. doi: 10.5694/mja15.00379

8. Royal Australasian College of Surgeons. Response to the Australian Human Rights Commission National Inquiry into Sexual Harassment in Australian Workplaces [Internet]. 2019 Jan [cited 2020 Aug 30]. Available from: https://humanrights.gov.au/sites/default/files/submission_207_-_royal_australasian_college_of_surgeons.pdf

9. Hill E, Bowman K, Stalmeijer R, Hart J. You've got to know the rules to play the game: how medical students negotiate the hidden curriculum of surgical careers. Med. Educ. [Internet]. 2014 [cited 2020 Aug 30];48(9):884-94. doi: 10.1111/medu.12488.

10. Ryan R, Black K, Cook V. The hidden curriculum in surgery says it's not for women. The Conversation [Internet]. 2016 Aug [cited 2020 Aug 30]. Available from: https://theconversation.com/the-hidden-curriculum-in-surgery-says-its-not-for-women-63109

11. Faucett EA, McCrary HC, Milinic T, Hassanzadeh T, Roward SG, Neumayer LA. The role of same-sex mentorship and organizational support in encouraging women to pursue surgery. Am J Surg [Internet]. 2017 [cited 2020 Aug 30];214(4):640-644. doi:10.1016/j.amjsurg.2017.07.005

12. Heiligers PJ. Gender differences in medical students' motives and career choice. BMC Med Educ. [Internet]. 2012 [cited 2020 Aug 30];12:82. doi:10.1186/1472-6920-12-82

13. Neumayer L, Kaiser S, Anderson K, et al. Perceptions of women medical students and their influence on career choice. Am J Surg [Internet]. 2002 [cited 2020 Aug 30];183(2):146-150. doi:10.1016/s0002-9610(01)00863-7

14. Crebbin W, Campbell G, Hillis DA, Watters DA. Prevalence of bullying, discrimination and sexual harassment in surgery in Australia. ANZ J Surg. [Internet]. 2015 [cited 2020 Aug 30];85:905-9. doi: 10.1111/ans.13363

15. Hill E. Solomon Y, Dornan T, Stalmaijer R. 'You become a man in a man's world': is there discursive space for women in surgery? Med. Educ. [Internet]. 2015 [cited 2020 Aug 30]; 49:1207-18. doi: 10.1111/medu.12818.

16. Liang R, Dornan T, Nestel D. Why do women leave surgical training? A qualitative and feminist study. Lancet [Internet]. 2019 Feb [cited 2020 Aug 30];393(10171):P541-9. doi: 10.1016/S0140-6736(18)32612-6

17. Forel D, Vandepeer M, Duncan J, Tivey DR, Tobin SA. Leaving surgical training: somes of the reasons are in surgery. ANZ J. Surg. [Internet]. 2018 Feb [cited 2020 Aug 30];88(5):402-7. doi: 10.1111/ans.14393.

18. Royal Australian College of Surgeons. Building Respect, Improving Patient Safety: RACS Action Plan on Discrimination, Bullying and Sexual Harassment in the Practice of Surgery [Internet]. 2015 [cited 2020 Aug 24]. Available from: https://umbraco.surgeons.org/media/1680/racs-action-plan_bullying-harassment_f-low-res_final.pdf

19. Royal Australasian College of Surgeons. Building Respect, Improving Patient Safety Action Plan Phase 1 Evaluation Final Report June 2019 [Internet]. 2019 [cited 2020 Aug 24]. Available from: https://umbraco.surgeons.org/media/3642/building-respect-phase-1-evaluation-report-2019-10-21.pdf

20. Royal Australasian College of Surgeons. Diversity and Inclusion Plan [Internet]. 2016 [cited 2020 Aug 24]. Available from: https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/reports-guidelines-publications/action-plans/diversity-inclusion-plan.pdf?rev=6e44407097ac4565809e89a54d77b19a&hash=8FE1F4F495257565DBB03F6D48B373DE

21. Royal Australasian College of Surgeons. Business Plan 2017-2021 [Internet] [cited 2020 Aug 24]. Available from: https://umbraco.surgeons.org/media/1008/177348_2017-10-25_pln_wis-bus-plan-v4.pdf

22. Australian Medical Association (AMA). AMA Gender Equity Summit Report 2019 [Internet]. Sydney (NSW); 2019 [cited 2020 Aug 24]. Available from: https://ama.com.au/ama-gender-equity-summit-report

23. Australian Orthopaedic Association. Diversity Strategic Plan 2018-2023 [Internet]. [cited 2020 Aug 24]. Available from: https://www.aoa.org.au/docs/default-source/diversity-strategy/aoa-diversity-strategy-landscape-v3-4.pdf

24. Australian Orthopaedic Association. Diversity Strategic Plan 2018-2023 Progress [Internet]. [cited 2020 Aug 24]. Available from: https://www.aoa.org.au/docs/default-source/diversity-strategy/diversity-strategy-milestones-_feb-2020_v4.pdf?Status=Temp&sfvrsn=56b1dc04_2

25. Faucett EA, McCrary HC, Milinic T, Hassanzadeh T, Roward SG, Neumayer LA. The role of same-sex mentorship and organizational support in encouraging women to pursue surgery. Am J Surg [Internet]. 2017 [cited 2020 Aug 24]; 214(4):640-644. Available from: https://pubmed.ncbi.nlm.nih.gov/28716310 doi:10.1016/j.amjsurg.2017.07.005

26. Ryan R, Black K, Cook V. The hidden curriculum in surgery says it's not for women. [Internet]. 2016. [cited 2020 Aug 24]. Available from: https://theconversation.com/the-hidden-curriculum-in-surgery-says-its-not-for-women-63109

27. Recognising and responding to sexual harassment [Internet]. [cited 2020 Aug 31]. Available from: https://www.surgeons.org/about-racs/about-respect/information-and-updates/recognising-and-responding-to-sexual-harassment

28. Crebbin W, Campbell G, Hillis DA, Watters DA. Prevalence of bullying, discrimination and sexual harassment in surgery in Australasia. ANZ J Surg. 2015 Dec;85(12):905–9.

29. BIPOC definition and meaning | Collins English Dictionary [Internet]. [cited 2020 Sep 1]. Available from: https://www.collinsdictionary.com/dictionary/english/bipoc

30. Equity Inclusion and Diversity [Internet]. Australian Medical Association. 2018 [cited 2020 Aug 31]. Available from: https://ama.com.au/equity-inclusion-and-diversity

31. Society for Health Psychology | [Internet]. Society for Health Psychology. [cited 2020 Sep 1]. Available from: https://societyforhealthpsychology.org/

32. Royal Australasian College of Surgeons. Diversity & Inclusion Plan [Internet]. 2016 Nov. Available from:
https://umbraco.surgeons.org/media/1232/2016_12_20_diversity_and_inclusion_plan.pdf

33. Saroo Sharda: We need to talk about racism - The BMJ [Internet]. [cited 2020 Aug 31]. Available from: https://blogs.bmj.com/bmj/2020/03/05/saroo-sharda-we-need-to-talk-about-racism/?fbclid=IwAR0FJKh9OKC7m0KD3D5p3m4i2DzK-DBVR3B64nix3nNR7GbHe0BNFVyu0xk

34. What is Gender Diversity? [Internet]. A Gender Agenda. [cited 2020 Aug 31]. Available from: https://genderrights.org.au/information-hub/what-is-gender-diversity/

35. Statistics c=AU; o=Commonwealth of Aou=Australian B of. Main Features - Sex and Gender Diversity in the 2016 Census [Internet]. c=AU; o=Commonwealth of Australia; ou=Australian Bureau of Statistics; 2018 [cited 2020 Aug 31]. Available from:
https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Sex%20and%20Gender%20Diversity%20in%20the%202016%20Census~100

36. Stats NZ Tatauranga Aotearoa. 2018 Census report on final content [Internet]. Wellington, New Zealand; 2018. Available from: from www.stats.govt.nz.

37. LevelMedicine.org. Gender Diverse Persons in Medicine [Internet]. Available from: http://levelmedicine.org.au/resources/completed-fellowship-papers/gender-diverse-persons-in-medicine/

38. Victorian Equal Opportunity & Human Rights Commission. Guideline: transgender people at work: complying with the Equal Opportunity Act 2010 in employment. 2013.

39. National LGBT Health Education Center. Affirmative Services for Transgender and Gender-Diverse People. 2020.

40. The Genderbread Person version 4 - It's Pronounced Metrosexual [Internet]. It's Pronounced Metrosexual. [cited 2020 Aug 31]. Available from: https://www.itspronouncedmetrosexual.com/2018/10/the-genderbread-person-v4/

41. Cavanaugh L. The Power of the Male Ally: Engaging Men, Advancing Women - Progressive Women's Leadership [Internet]. Progressive Women's Leadership. 2016 [cited 25 August 2020]. Available from: https://www.progressivewomensleadership.com/the-power-of-the-male-ally-engaging-men-advancing-women/

42. Tsugawa Y, Jena AB, Figueroa JF, Orav EJ, Blumenthal DM, Jha AK. Comparison of hospital mortality and readmission rates for Medicare patients treated by male vs female physicians. JAMA internal medicine. 2017 Feb 1;177(2):206-13

43. Defend Your Research: What Makes a Team Smarter? More Women [Internet]. Harvard Business Review. 2011 [cited 25 August 2020]. Available from: https://hbr.org/2011/06/defend-your-research-what-makes-a-team-smarter-more-women

44. The Bottom Line: Connecting Corporate Performance and Gender Diversity | Catalyst [Internet]. Catalyst. 2004 [cited 25 August 2020]. Available from: https://www.catalyst.org/research/the-bottom-line-connecting-corporate-performance-and-gender-diversity/

45. Men as Allies: Engaging Men to Advance Women in the Workplace [Internet]. Wit.abcd.harvard.edu. 2017 [cited 25 August 2020]. Available from: https://wit.abcd.harvard.edu/files/wit/files/cwb_men_as_allies_research_report_spring_2017.pdf

46. Engaging Men in Gender Initiatives: What Change Agents Need to Know [Internet]. Catalyst.org. 2019 [cited 25 August 2020]. Available from: https://www.catalyst.org/research/engaging-men-in-gender-initiatives-what-change-agents-need-to-know/

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