

## Welcoming diversity in plastic surgery

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### OPEN ACCESS

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Those of us with two X chromosomes in a surgical occupation are increasingly asked to speak on the topic of ‘women in surgery’ or ‘women in plastic surgery’. Although the promotion of women in our profession is important, the broader principle that people and groups who have experienced disadvantage in the past should now be more welcomed is one that perhaps has a more fundamental basis and is, in some ways, less developed. The problem of categorising people as ‘women surgeons’ or ‘ethnic minority surgeons’ is that it puts emphasis on one particular attribute and pigeonholes people in a simplistic way.

This idea of homogeneous categories of disadvantaged people has been replaced in sociological peer-reviewed literature by the concept of ‘intersectionality’.<sup>1</sup> Intersectionality acknowledges that many people will have complex mixes of attributes that have led to historical disadvantage. I, for example, am an immigrant, a bit on the short side and female. While intersectionality is the academic, theoretical term for this idea, ‘diversity’ is the term used in its practical application in policy. Diversity is an apt term, as it encompasses all attributes, and in any combination of mixtures, rather than focusing on one particular classification of characteristics.

So, is it important to have diversity in healthcare staff? Although there are not many studies in this sphere, it is likely that parallels exist in different organisations. If we look at the field of law enforcement we know that if you live in a community that is predominantly black and from one ethnic group and the police force are nearly all white and from a different ethnic group there are terrible problems with cultural misunderstandings, violence and disharmony. Fundamental to this is

often a lack of trust. You may say that healthcare is not the same but doctors also have a need to engender trust.<sup>2</sup> Broad diversity among the surgical workforce is likely to provide a more open-minded service to the community. In turn, the community are more likely to feel welcome and to trust, a service that has a diverse staff.

If we look at the statistics for Australia, around half the population is female and half is male, and over one third was born overseas.<sup>3</sup> An informal audit of the demographics of the patients of the Flinders Medical Centre plastic surgery unit over the period of a year showed there were slightly more men than women, two percent Aboriginal patients and 25 percent born overseas. What was interesting was that those born outside of Australia came from 73 different countries. It is clearly absurd to suggest recruiting surgeons in proportionate representation to these countries but it is good to examine our own workforce and see whether they have some resemblance to the community we are treating.

In terms of ethnic and cultural diversity, there are no published statistics on plastic surgeons in Australia. Last year the Australian Bureau of Statistics did collect statistics on gender of surgeons and found that 18 of surgeons are female and 82 percent male, whereas non-surgical doctors show close to gender parity<sup>4</sup>—an enormous difference. In plastic surgery in Australia only 13.4% of plastic surgeons are female.

It is clear, then, that the profession of plastic surgery in Australia is not currently as diverse as the community we serve. Some may ask: Does this really matter? or Is diversity really that important? Meanwhile there will be some who would contend: Didn't the 'old boys' club system work pretty well? There is a real mindset that believes it is best to pick people with similar traits to oneself. It is not helpful to write-off this kind of attitude as just 'nonsense' and to do so risks alienating and disenfranchising colleagues who may hold such attitudes. It is important to acknowledge the rationale of this sort of selection. There is, in fact, some evidence that 'fitting in' is easier in a very homogenous group and perhaps team cohesion occurs more rapidly.

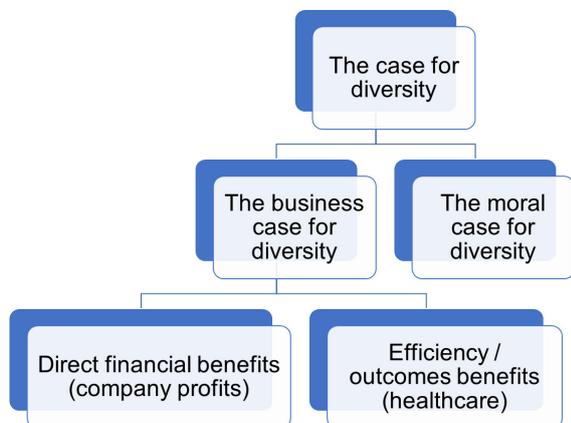
Cox and Blake, in their seminal paper on diversity, acknowledged that similarity is an aid to cohesion but they also pointed out that homogeneity has serious downsides in terms of decision-making and creativity.<sup>5</sup> Overall, they found that as long as there were core similarities, the pros of diversity significantly outweighed the cons.

Core similarities do not have to be demographic characteristics. In surgery, what can bind us all together is the set of common beliefs we share around patient care. The Hippocratic oath, the core competencies of the Royal Australasian College of Surgeons and the national code of conduct for health practitioners are all good examples. As a profession, we hold a set of professional cultural values that allow us to share common goals, regardless of backgrounds or gender, and this glue for team cohesion can work however diverse the team.

It is useful to analytically examine the 'case' for diversity. In fact, a well-established literature exists in this area.<sup>6-8</sup> In a theoretical framework the case for diversity can be divided into the moral case and the business case for diversity (**Figure 1**). The moral case is the argument that we should have diversity in the workplace for the reason that it is fair and equitable. The business case is that which states that diversity is good for business (or in the case of the healthcare sector, health outcomes and health economic indicators). There is more extensive literature on this in the corporate sector than the health sector but the results in this arena are compelling. Herring showed in a study of heterogeneous vs homogeneous teams<sup>8</sup> that diverse teams are better at problem-solving, decision-making and creativity, while more diverse commercial firms have more customers and are more profitable. A McKinsey report from 2011<sup>9</sup> shows that the companies in the top quartile of gender diversity were 15 percent more likely to have financial returns above their national industry median. Companies in the top quartile of racial/ethnic diversity were 35 percent more likely to have financial returns above their national industry median. Cohen and colleagues' examination of diversity in healthcare<sup>2</sup> suggest

that more diverse medical teams are more likely to be culturally competent, deliver better health care, improve access to healthcare for the underserved and broaden health research.

**Figure 1: Case for diversity**



Another argument for welcoming diversity is that it broadens the pool of talent from which surgical trainees are selected. If selectors in 1979 preferred white males for entry into surgical programs (Figure 2), they had around 60 per cent of graduates from which to choose. In more modern times, if selectors limit themselves to this same demographic (Figure 3) they would be choosing from only around a quarter of the graduates and hence will be less able to obtain the most talented graduates. This is not just a theoretical problem—Peel and colleagues<sup>10</sup> found that real-life experiences of discrimination as a medical student were a significant influence on career choice and that the number of applicants for surgical programs in several countries is declining.

**Figure 2: Flinders University medical school—class of 1979**



Photograph courtesy of Dr David Wattoo, consultant surgeon, Flinders Medical Centre.

**Figure 3: Flinders University medical school—class of 2016**



Photograph courtesy of Dr Jake Nowicki, resident medical officer, Flinders Medical Centre.

If we accept that diverse teams will reflect the community better, will problem solve better and deliver better outcomes, and that we are most likely to get the best and brightest if we attract a diverse group to surgery, how can we make it happen? There is no single silver bullet—diversity management has many different elements. It is about generating a welcoming culture, promoting education, supporting infrastructure for maternity and flexible working and reducing harassment and discrimination. Plastic surgery as a specialty must be making significant progress because although only 13 percent of consultants are female, nearly 40 percent of trainees are women. This suggests that plastic surgery as a specialty is improving in attracting women doctors to the specialty.

Figure 4 shows Lena McEwan, the first female plastic surgeon in Australia. She was born in South Australia and completed her initial training in Adelaide. The Adelaide Club at that time was strictly men-only, however, her male colleagues welcoming her to a fellows’ dinner at that venue is a perfect example of how a small act can really help someone to feel included. Likewise, I have received nothing but encouragement, support and mentorship from a series of wonderful white male colleagues. This perhaps is all the more remarkable when, for some of them, female surgeons were non-existent in their own formative years.

Figure 4: Lena McEwan



Image source: Archives of University College, University of Melbourne.

The act of pro-actively welcoming diversity is very different from simple tolerance of it.<sup>11</sup> A couple of years ago, within the plastic surgery unit at Flinders Medical Centre, it was decided to actively look for opportunities to welcome diversity and to commission a photographic exhibition to record this. The actions were small—ordering left handed needle holders to assist the left handers, making female trainees feel it was acceptable to get pregnant and have babies when they worked in the unit and even allowing one musically talented trainee to take gig leave. These small accommodations of individuals' needs made a difference and cost very little.

So why can welcoming diversity like this be directly good for your unit? It is because people who feel that they are allowed to be themselves perform at their best, whereas those who feel they do not belong are stressed and perform poorly. Studies in healthcare show that those who feel discriminated against in any way have higher rates of absenteeism and lower productivity.<sup>12,13</sup>

The next challenge is competently selecting for diverse teams.<sup>14</sup> The greatest barrier to this is the issue of unconscious bias.<sup>15</sup> This is the natural tendency of people to choose others who look,

behave and speak like themselves. It really takes active effort to recognise and suppress this. Having a diverse interview panel can definitely help. It is normal that we all want to think of ourselves as fair and unbiased but it is important that we step up and recognise that we all have unconscious biases that we have to actively work against and find mechanisms to counteract. Selecting for diversity does not mean ignoring merit but it is important to acknowledge that recognition of merit is often tainted by unconscious bias. Anyone who has seen the film or read the book 'Hidden Figures' would appreciate this.<sup>16</sup>

Surgery is entering a new era in which embracing diversity is the norm. It is important that our specialty of plastic and reconstructive surgery stays ahead of the curve.

### Disclosure

The authors have no financial or commercial conflicts of interest to disclose.

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