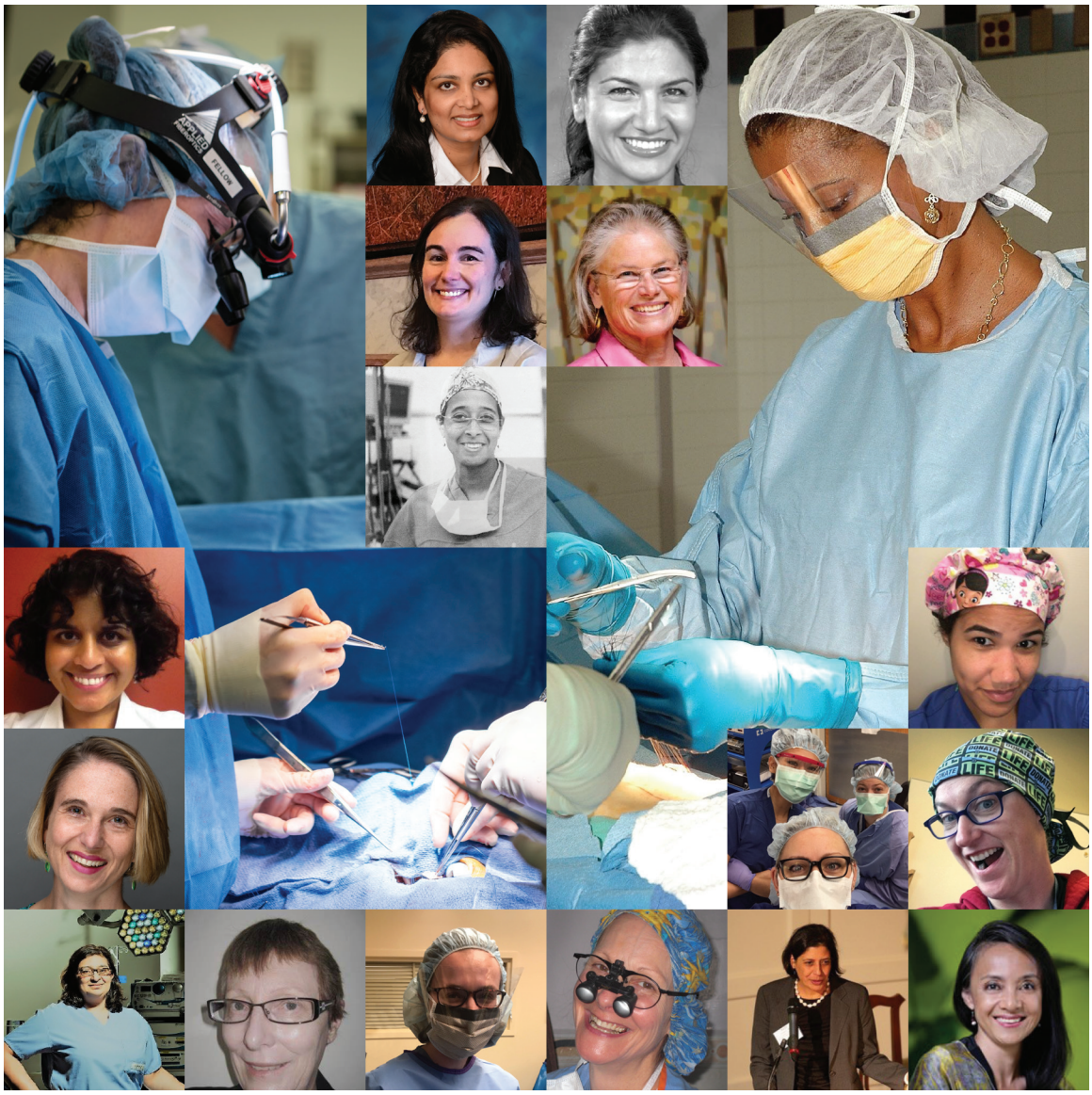
VOICES

PERSONAL STORIES FROM THE PAGES OF NIB

#METOO IN SURGERY:
NARRATIVES BY WOMEN SURGEONS



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Pringl Miller, MD, FACS for her belief in and dedication to this project and to all the authors for sharing their stories.

Introduction
#MeToo in Surgery: Narratives by Women Surgeons

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Abstract. This symposium includes 12 very brave and intimate narratives about the challenges associated with becoming a surgeon and practicing surgery as a woman. This symposium also includes three commentaries on the narratives written by 1) Patricia Dawson, MD, Ph.D., FACS, 2) Kelsey Medeiros, Ph.D, and Jennifer Griffith, Ph.D, and 3) Peter Angelos, MD, Ph.D., FACS. This narrative collection offers diverse female perspective on the impact of surgical training and practice, yet common themes emerge related to gender in the field of surgery. This symposium provides insight on surgical culture and traditions that are detrimental to surgeons in general, and woman surgeons in particular. It addresses how leadership and institutional changes must be made to equitably and successfully recruit, support, promote, and retain women training and practicing surgery. There is hope for the future of gender equity, diversity, and inclusion in the surgical workforce but only if its leaders adopt a zero tolerance policy against the range of gender-disparities identified and prioritize a culture of safety, dignity and equity.

Key Words. Medical Ethics, Inter-Professional Relationships, Women in Surgery, Gender Inequity, Gender Disparities, Gender Bias, Bullying, Gender Discrimination, Sexual Harassment, Surgical Culture, Diversity and Inclusion.

Introduction

Mary Edwards Walker is on record as being the first American woman surgeon. Dr. Walker was a feminist during the first wave of feminism as a staunch advocate for women's rights. In 1855 she graduated with honors from Syracuse Medical College, the first medical school in the United States to grant a medical degree to a woman, having matriculated as the only woman in her class. Dr. Walker's private practice in Rome, New York failed due to the discomfort patients had with seeking surgical care from a woman. At the time of the Civil War in 1861, Dr. Walker was unable to procure an active duty commission as a surgeon because she was a woman, so she agreed to volunteer and serve as a surgeon but be counted as a "nurse" on military records (Pass & Bishop, 2016). Subsequent to Dr. Walker's pioneering ambition, there have been many other brave women making history in the field of surgery, most succumbing to similar gender-related challenges even 158 years later.

The medical satire website *Gomerblog* published a story shared widely about a woman surgeon who out of frustration for not being recognized and respected as the professional she was, changed her first name to "Doctor" to circumvent the problem of being informally addressed by her first name at work (2018). Women surgeons frequently report being mistaken as a nurse even after introducing themselves as a doctor (or "the surgeon") and wearing a white coat and badge both displaying their professional credentials. Un-titling and de-professionalizing women surgeons in the workplace is a common form of microaggression (Devon, 2019). Women (and especially women of color) in surgery are still consistently being mistaken as nurses or anyone other than *the surgeon*. This pervasive gender-bias demonstrates how enduring and prevalent gender schemas and discriminatory practices remain in surgical practice today. A recent article by Arghavan Salles, MD, Ph.D. et al. studied the extent to which implicit gender bias exists in surgery and concluded that gender-bias is still common in interventional specialties (Salles et al., 2019). They found that on both the Gender-Career Implicit Association Test (IAT) and the novel Gender-Specialty IAT respondents had a tendency to associate men with career and surgery and women with family and family medicine. Salles has stated that women in surgery often experience "a number of unfortunate circumstances that have to do with microaggressions or bias, and are often made to feel as though they are overreacting or overly sensitive in those situations." This predicament is likely contributory to the disparity seen in the professional advancement of women when compared to men in surgery. Esther Choo MD, MPH the co-founder of Equity Quotient and Founding Member of TIME'S UP Healthcare has countered this contemporary situational reality by stating "Women need to be aware of the very serious possibility that they are awesome, and actually it is bias that has led to the blunting of opportunity . . ." (Fessler, 2018).

Reshma Jagsi, MD, Phil has studied the experiences of women in medicine for two decades (1995–2015). She hypothesized that times had changed since 1995 only to discover the inconvenient and disappointing truth that despite the passage of 20 years 70% of women clinician-researchers still reported gender bias, 30% of women reported sexual harassment classified as severe 40% of the time, and 59% of these women also reported an incident or incidents that had a negative effect on their personal and professional confidence (R. Jagsi, 2018; Reshma Jagsi et al., 2016)

The 2018 National Academies of Sciences, Engineering, and Medicine (NASEM) Consensus Study Report on Sexual Harassment of Women: Climate, Culture, and Consequences revealed that sexual harassment is more likely to occur in male-dominated environments, where organizational tolerance for sexually harassing behaviors is exhibited, where hierarchical or dependent relationships between faculty and trainees are enforced, and where training environments may be isolating (p. 65). The persistence of a hierarchical male-dominated departmental leadership structure and surgical workforce has permitted gender bias, bullying, discrimination, and harassment to continue (p. 65). The NASEM report also concludes that sexual harassment is associated with a reduction in job satisfaction, disinvestment in affiliated organizations, a change in careers, and early retirement, disproportionately impacting women in the workplace (National Academies of Sciences & Medicine, 2018).

The psychological impact of a toxic work environment that discriminates on the basis of sex is compounded by the already existing stressors and pressures of performing as a trainee in surgery and as a practicing surgeon. More recently the impact of gender-bias, bullying, discrimination and harassment has been correlated to self-doubt (Thompson-Burdine et al., 2019), lower self-confidence, imposter syndrome (Fessler, 2018; Pei & Cochran, 2019), post-traumatic stress disorder (Pei & Cochran, 2019), depression, anxiety (National Academies of Sciences & Medicine, 2018, p. 90), burn out, and death by suicide (Dzau & Johnson, 2018). Not surprisingly, despite the mounting evidence for gender-related obstacles for women surgeons, those factors have not been correlated

to unfavorable performance outcomes (Sharoky et al., 2018). In their qualitative case study entitled "Defining Barriers and Facilitators to Advancement for Women in Academic Surgery, Julie A. Thompson-Burdine, BA et al. stated "Many of our participants reported that surgery was an inherently challenging field where surgeons must find internal fortitude to succeed . . . participants often chose to subvert personal concerns and personality elements that might be perceived as incongruent with surgical culture expectations." The ability of women surgeons to overcome challenges—including detrimental extremes to themselves—and achieve superior outcomes in the service of their passion for surgery and their patients, is a true testimony to their strength, endurance, and resilience (Almendrala, 2017; Lou, 2017; Park, 2017; Reichel, 2018; Wallis et al., 2017).

Previously accepted surgical culture has been challenged by the #MeToo and TIME's UP movements, which are empowering women to unite in solidarity and amplify their voices pushing back against gender bias, bullying, discrimination, and sexual harassment. TIME's UP Healthcare is enlisting the support of all healthcare workers, professional societies, and healthcare systems, including HeFORShe men to advocate for a safe, dignified, and equitable workplace for everyone. Despite the existence of Title VII (1964) and Title IX (1972), women surgeons still encounter ethically inexcusable and illegal barriers related to sex (and race) in the workplace preventing professional parity with men. "When you have devoted your entire life to your career—especially in medicine, where training is arduous, and subspecialties create small communities, you worry about your professional identity being threatened by speaking out. Many women decide that the benefits of reporting simply don't outweigh the risks" (R. Jagsi, 2018).

In 2019, women surgeons continue to strive towards achieving gender equity in the workplace, much like Dr. Mary Edwards Walker did back in 1855. Like Dr. Walker women in surgery continue to suffer from gender-related inequities and injustices. The stories contained in this Narrative Inquiry of Bioethics symposium entitled, "#MeToo in Surgery: Narratives by Women Surgeons," are an elegant sampling of the volumes of stories brave women in surgery have to tell. In the hopeful words of Amalia Cochran, MD, FACS, the 2016 President of the Association of Women Surgeons, "I'm very hopeful that during the course of my professional lifetime we will reach a point where a woman surgeon is simply a surgeon."

The Call for Stories

Narrative Inquiry in Bioethics broadly distributed a call for narratives inviting interested women in surgery to submit a 300-word proposal based on the questions listed below, or focused on other gender-related challenges in their professional life. Twenty-seven proposals were received, and twenty women were invited to submit a 800-2000 word full narrative. Nineteen narratives were received of which twelve were selected for the print edition and an additional seven for online publication on Project MUSE: http://muse.jhu.edu/journal/521.

The following questions were posed for consideration to help direct the content of the narrative proposal and the full narrative. However, authors were given free rein to share other aspects of their professional lives as well.

- How do you think being a woman has affected the way you are treated in surgical practice?
- Do you modify the way you communicate in the workplace? If so, how and why?
- What do you perceive to be the critical barriers to women surgeons achieving equity with men in the workplace?
- Have you experienced gender bias, discrimination (either unintentional or intentional), or sexual harassment by a colleague, co-worker, or patient? How did you respond? If you reported the behavior, how was this handled by your department or by administrators?
- How has being a woman and a surgeon changed you? What role has being a woman surgeon played in your personal life and career choices?
- What changes need to be made in order for surgery to be more attractive to women? What advice do you have for other women surgeons or women considering a career in surgery?

The Narratives

We honor the courage of these women to share their stories and admire not only what they have achieved in their clinical and/or academic practices, and in their personal lives, but also in their strength and skill to transform untoward professional experiences into narratives accessible for the readership. Each surgeon's voice is creative, insightful, and expresses wisdom in shedding light on their unique experiences. These surgeons are teaching us about the power of perseverance, resilience, and acceptance. Most of these surgeons continue to practice in their respective specialties and challenging work environments while maintaining optimism for the future of surgery and women in surgery. These women have contributed greatly to their professional and personal environments by bringing their voices, gender, and expertise while simultaneously advocating for gender equity.

This compilation of twelve narratives is remarkable for its vision. The authors represent multiple ethnicities, a broad age range, different geographic areas, and surgical specialties. These narratives provide a realistic overview of experiences but should be considered the tip of the iceberg when considering how many women have practiced surgery around the world. The surgeon authors published in this symposium practice: Breast Surgery, Cardio-Thoracic Surgery, Congenital Cardiac Surgery, General Surgery, Gynecologic Oncology, Otolaryngology, Pediatric Surgery, Pediatric Orthopedic Surgery, Plastic Surgery, Surgical Oncology, Transplant Surgery, Trauma Surgery, and Critical Care.

The Commentaries

This symposium includes three commentaries, one co-authored. The commentaries draw out ethical and organizational psychological themes that compel us to reflect on and learn from the narratives so that we can understand the dilemmas and make structural changes to support and promote women in surgery.

Patricia Dawson, MD, Ph.D., FACS, is a retired breast surgeon who practiced at the Swedish Cancer Institute True Family Women's Cancer Center in Seattle Washington, where she was the Medical Director of the Swedish Cancer Institute Breast Program. Dr. Dawson is now Medical Director of Healthcare Equity at University of Washington Medicine. Dr. Dawson earned her Ph.D. in Human and Organizational Systems at the Fielding Graduate University in Santa Barbara California and is the author of the book *Forged by the Knife*.

Kelsey Medeiros, Ph.D., is an Assistant Professor of Management at the University of Nebraska at Omaha where she teaches courses in Organizational Behavior for both undergraduate and MBA students. She earned her Ph.D. in Industrial-Organizational Psychology with a minor in Quantitative Psychology from the University of Oklahoma in 2016. Her research focuses on complex problem-solving in the workplace, including issues related to gender, leadership, and sexual harassment.

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Peter Angelos, MD, Ph.D., FACS, is the Linda Kohler Anderson Professor of Surgery, Vice Chairman for Ethics, Professional Development, and Wellness in the Department of Surgery, Chief of Endocrine Surgery, and Associate Director of the MacLean Center for Clinical Medical Ethics all at the University of Chicago. Dr. Angelos is also a member of the American College of Surgeons Committee on Ethics. He is renowned for his pioneering efforts in establishing the field of surgical ethics and in co-authoring the American Surgical Association

report on Ensuring Equity, Diversity, and Inclusion in Academic Surgery.

Conclusion

Navigating the high profile professional identity and responsibilities of a surgeon is stressful and demanding. These narratives focus on gender-specific challenges that woman in surgery face alongside the intrinsic stressors and pressures of the work itself. These surgeons have cultivated a wealth of knowledge, expertise, and excellence in the face of adversity from gender bias, bullying, discrimination, and sexual harassment. Their shared experiences demonstrate themes such as perseverance, resilience, bravery, advocacy, endurance, and acceptance. In the context of the hierarchical male-dominated field of surgery, the voices of women surgeons have not historically been empowered nor embraced. It's time to change the narrative of who surgeons are by amplifying the collective voices of women in surgery. This narrative symposium memorializes "our" stories in history.

"'Having voice,' having one's reality witnessed by others, can open way for dissolution of pain, enhancement of understanding, and integration of meaning."
—Patricia L. Dawson, MD, Ph.D., FACS

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Personal Narratives

On Vulnerability

Sarah M. Temkin

When I interviewed for my last position in academic medicine I didn't expect to accept the position. I went because a colleague and mentor asked me to look at the job. He had gone to the Institution a few years before, and although he was in another department, the opportunity to work with him was a draw. During the interview process, I warmed to others in leadership. The Institution was in desperate need of my expertise and the Cancer Center pledged to support my research program.

In addition to the positives of the new position, there were potential negatives and risks. I was reluctant to re-establish my reputation with patients and referring providers in a new environment. I would have to prove myself with a new Department Chair whose expertise was outside of my field. This Institution had a history of high turnover within this division. The decision became more complicated when they decided to co-recruit my husband, who is also an academic physician. The offer we received now presented an opportunity for professional growth for us both. We negotiated, weighed our options, and ultimately accepted. For me, this meant becoming the director of a surgical service.

Upon my arrival, many pieces of my recruitment package were missing. Construction had not yet started for clinic space that was supposed to have been built before my arrival. Some of my colleagues and many of the support staff assigned to work with me had less commitment to quality patient care than I was comfortable with. I quickly understood why previous practices within the Institution had failed.

Many of the glaring deficiencies were related to my surgical practice. The operating room equipment that had been promised had not yet been ordered. No one had informed the OR staff that a new Division Director had been recruited and I was left to introduce myself without context. The "surgery scheduler" who was assigned to my service didn't actually speak to patients. She took pieces of paper written by the house staff and put the information into the computer. I tried to meet with her and set up a time for her to come by my office. She was a no-show at the first meeting; ignored the second meeting; and I ended up walking to her workspace to introduce myself. Looking back, I should have packed up and left after the first month. But we had left old jobs and sold and bought a home in a new city. I opted to make the most of this situation and got to work.

One of the biggest obstacles in front of me was the lack of OR staff dedicated to my service. Being part of a goal-oriented group dedicated to a task was one of the things that had attracted me to surgery in medical school. Teamwork remained a large part of why I enjoyed being a surgeon. But in my new Institution, a different circulator and scrub tech showed up for each case. In or out of my block time, there were few familiar faces. Because I'm a gynecologic oncologist, the staff that rotated with me was most often gynecology staff who had little familiarity with cancer surgery. Oncology specific equipment—the Bookwalter, hemoclips, Singley forceps—were unfamiliar. Waiting for instruments became routine. The pace of my OR and the complexity of the cases was unfamiliar to this staff. Frozen sections, bowel resections, bleeding often resulted in panic. Not having staff that returned from one day to another made developing rapport much less constructing a team seem impossible.

I spoke with the nurse in charge of my OR service line; then the nursing lead for the OR. I sat down with physicians who had influence within the operating room. I waited for someone to act on my request for dedicated staff, which I framed to them (and believed) to be a patient safety issue.

An OR technician began assisting regularly in my room. She liked working with me, and I was relieved to have found consistent and competent assistance. Within a few weeks, however, I started to understand why she was available for the "new doc." Her communication style was casual, and she overshared details of her personal life during cases. After a few weeks, the OR chitchat crossed a line and became unpleasantly informal. She started shouting phrases like, "*Here's my bitch!*" when I'd

walk into the OR. I feared retaliation from nurses who controlled OR staffing if I complained and was concerned that alternate staff might not keep the fast pace of my operating room. So, I decided to leave the disruptive behavior alone and hoped this phase would pass.

Instead, things escalated. One day, after finishing surgery for the day, this tech watched me change out of scrubs in the locker room and leered—she licked her lips and commented on my body and my clothes. Her supervisor was there and laughed along. I spoke to this supervisor the next day about my discomfort with being catcalled while changing but was unaware of subsequent disciplinary action. Noticeable behavior change did not follow. I started changing in my office. I did not report the incident. I didn't want to distract leadership from the many issues related to patient care that my service needed help with.

Later that month, a patient was anesthetized and in lithotomy position when I entered the OR. This same scrub tech was standing between the patient's legs fingering her vagina. Residents, nurses, and an anesthetist all went about their routines while this was happening. She turned when I walked in and then commented on how it felt. Nausea crept over me and I thought I would faint or vomit or both. A silent pause ensued before she removed her hands then removed her gloves. I was stunned. The only word that came out of my mouth was "*Boundaries!*" I instructed her to scrub.

The images of this pelvic exam under anesthesia were seared into my brain. I asked a few trusted colleagues for guidance on how to manage this incident. As embarrassing as it is to admit, I considered saying nothing. I had so few allies in the operating room or in the Institution and hated the idea of losing favor with someone who talked loudly and often about how great I was at surgery in the hallways and the cafeteria.

By this time, my relationship with my department had become frosty. There had not been much sympathy displayed around the difficulties I was having within the operating room. The questions that I had raised about other patient safety issues (e.g., lost specimens, complications and deviations from standard operating procedures) had, I believe, created insecurity and defensiveness in others about the surgical care provided. I had been accused of being overly fastidious about patient care. I viewed my colleagues as generally unsupportive. In retrospect, I suppose that unflattering stories about my character had already begun to be told in meetings of men in hospital leadership. The words I imagine being used were "abrasive" or "bossy" rather than "direct" or "decisive."

I made the request for an in-person meeting to discuss this incident. The meeting was short, as my request for an intervention was denied. "You're the chief of this surgical service," was what I heard. I was instructed to talk to the nursing staff in the operating room myself if I felt strongly that something should be done. In a final request for assistance, I emailed a few articles from the medical literature about the pelvic examination under anesthesia. There had been a medical student who had written a highly publicized commentary in *Obstetrics and Gynecology* about his discomfort with this rite of passage through an OB/GYN rotation during medical school. There were Canadian guidelines describing the ethics of supervision and consent for pelvic examinations under anesthesia. I suggested that these could be reviewed with faculty and house staff to raise awareness and improve the culture to prevent any similar future events.

I reported the incident as had been suggested. Unsatisfied with that exchange, I spoke with the nursing supervisor's supervisor. And then to her supervisor. And I returned to the physicians with influence within the operating room. It took some time to report this up through the hospital chain of command. This tech was removed from my cases, but I still saw her in the hallways and the cafeteria. Her previous affection towards me had turned to contempt. I felt as though I could hear and feel her and her buddies gossiping and spreading rumors. When women bully other women, there is no shouting or screaming or physical threats. The volume of everyone's voices actually goes down.

I sensed retribution for having complained. For the several months, there was hardly a recognizable face within the operating room. The technician and circulator were different and new to me in all my block time. When I identified staff who I worked

well with, I started requesting they be assigned to my room, but these appeals were not heeded.

One day, I was called to an urgent meeting in the hospital executive suite that I assumed would be to discuss this pelvic examination incident. Instead, the meeting opened with a question, "do you think you have problems getting along with other people?" My understanding was that my troubles in the operating room had become evidence to hospital leadership that I was overly selective about staff and "difficult to work with."

I jutted my chin out in front of my skull to obtain composure while I shook with anger inside. I provided my perspective. I was a surgeon working within a department of mostly non-surgeons. While my OB/GYN colleagues operated once or twice a month, I had two full days a week with cases as complex as the surgical oncologists. My clinical service was woefully understaffed. As a gynecologic oncologist, in addition to surgery, I was prescribing chemotherapy; and managing more patients than most medical oncologists. And I was running a clinical research program. I described what I perceived as hazing from nursing and staff inconsistencies in the operating room, and the trouble I was having finding advocacy for the infrastructure that I needed in order to care for my patients. I desperately wanted an OR team to help me perform at my best. I then described my love of my work and pleaded for empathy for my patients who were amongst the most vulnerable in the hospital. I repeated the words "patient safety," hoping they would be buzzwords and instigate action in this office.

When I was done and it was my turn to listen, however, I was told how, in this Institution, people exchange pleasantries. I was encouraged to smile more. To close the meeting, I provided assurances that I would work on using more "please" and "thank you" in my communication with others. I should have known then that the Institution and I were terminally mismatched.

The stories about my terrible character continued to circulate as gossip amongst the women and whispers amongst the hospital decision-makers, who were mostly men. I presented objective data: improved patient satisfaction; decreased length of stay; increased surgical volume; elimination of surgical site infections; a burgeoning research program. But I was judged on a perception of likability amongst the physicians I was reporting to (not by the patients, the staff that reported to me or the physicians I worked with daily).

When I left the Institution two years after starting, the men in charge took two weeks to undo the work that I had done towards building a person-centered, regionally excellent subspecialty surgical service. My clinical practice was distributed among four physicians from different specialties. My research program evaporated.

I grieved for the program and for the patients who lost access to specialized care. I wondered what I could have done differently and whether this story would be different if I were a man. I did not, nor do I, question my standards for my work: "Patients come first," with or without a smile.

Championing A Surgical Career: Success in a World of a Thousand Cuts

Nora L. Burgess

During my seven years of training in general and cardiothoracic surgery, 1977-1984, women were beginning to graduate from medical school in significant numbers. Few women surgeons had yet to complete training, however, and I knew no role models in practice. My experience in a progressive medical school was that hard work and strong clinical skills speak for themselves, so initially, I was confident I could establish my credibility.

My first realization that this premise was naïve came during my 1977–1978 general surgery internship at a large pyramidal university-based training program in south Texas. The program had never graduated a woman, but they did have two women out of about 35 general surgery residents, one in the 2nd year and one in the 4th. My first internship

rotation was months on Urology at an affiliated hospital, effectively rendering me invisible to the general surgery program attending staff. When I tried to address this disadvantage directly by seeking supplemental visible work, I was told there wasn't room, and the system didn't work that way.

The deadline came and went for identifying interns who would be promoted to the second year. I had received no feedback on my performance to date, although I had not been invited duck hunting at the Chief of Surgery's hutch, rumored to be a prime endorsement that a resident had a job the next year.

So, it seemed natural to me that I speak with the training program director and figure out what was the situation. The first thing he said was that, obviously, having asked to meet with him, I must be aware I was not doing well. He went on, stating I was "not competitive enough" to be a surgeon.

With the die cast, almost more furious than disappointed at this teaching vacuum, I was no longer biddable and compliant. I started confronting OR staff directly when I overheard my nickname, "the whore." I stopped accepting extra call nights—an ongoing hazing test to see if I was a "real" team player. I explicitly pressed for my fair share of operative cases and ICU experience. And I found a senior resident willing to teach me, who I still regard with gratitude. My campaign to raise visibility and speak out on my own behalf became crucial to a gradual recovery of my self-esteem and my future surgical education.

The internship turned out to be a scam. I was accepted under the ruse of participating in a teaching program solely to meet temporary staffing needs while a male resident was on leave. Perhaps this also contributed to the aloofness of the other 2 women in the program from me, although they carefully kept a distance from each other as well. I later came to see this as a pattern—pioneer women are often wary, and often treated with caution, in turn, creating an isolation that limits mentoring opportunities.

For years after, I always sought out this dishonest program director at professional meetings to re-introduce myself and update him as I competed successfully to become a cardiac surgeon. I wanted to remind him that he failed to erode my spirit.

The Chief of Surgery at my medical school helped me find a new surgical training program, and in the course of my rotations, I became seriously interested in cardiac surgery. Some troublesome characteristics of this field are that the work is relatively high-risk and, being high-profile, it is often politically complex. In addition, there is the personality profile of many cardiac surgeons themselves. "You're killing my patient!" does not provide a lot of educational insight, and it is hard to learn from surgeons that are both self-absorbed and non-verbal and whose work entails frequent clinical crises. But it is very interesting and very rewarding to be part of a high-performing team. The anatomy is beautiful, the feedback about success or failure immediate, and the decision-making intellectually just as challenging as the technical craft.

I applied to a string of cardiothoracic residencies with strong letters from a cardiac surgeon mentor [a man] and from my general surgery training program—but the going was tough, and time after time the interviews felt perfunctory. I was made aware, usually by the thoracic residents themselves, that I was being interviewed out of curiosity or an obligation for the program to appear "open" to women. There was only a handful of women in cardiothoracic training at the time—when I passed my Thoracic Boards in 1986, I was one of the first few to have done so.

At my 14th interview, I sat listening, for what felt to be the millionth time, to inquiries about my stamina, whether my husband supported me, was I planning on getting pregnant? What if I got pregnant, what if I was tired, or what if I needed to walk the stairs to the 8th floor ICU because the elevator wasn't working? Not once did the Chief or Program Director talk about their clinical opportunities, patient case volumes, research opportunities. Suddenly, it became clear that I had done my best, but I was done. I could no longer stand the ridiculous dance anymore as they confirmed their prejudices. I stood up and said I was not interested in their program unless they could talk about what they

could teach me, and I walked out. I didn't yell, I wasn't rude, but I was firm.

I walked down the hallway to the elevator banks. To this day, I recall standing at the elevator, rehearsing how I was going to spin this to my husband waiting in the first-floor lobby. I was silently trying out, "Doing hernias and bowel resections is still really helping people," or "Maybe I should apply for a trauma residency?" As I was waiting, however, the Program Director walked up to me saying, "Wait, just wait a minute, and come back with me." Realizing I now had a real opportunity, we returned to the Chief's office. As soon as I entered, the Chief offered me the position on the spot. I didn't even have to apologize. They were as surprised as I was that I had the nerve to walk out, and I think they were suddenly reassured by my grit. My thought later was, if only I had thought of walking out on residency interviews earlier maybe I would have had some other offers. Who knows?

There was one critical detail that had been overlooked on that interview day—an important, very talented, very busy cardiac surgeon had been absent. As we were later introduced on my first workday, he immediately announced he had no intention of training a woman, and he wished me "good luck." This was not mischievous small talk. What followed was a hazing period of over two months in which I was assigned the most onerous, tedious, non-operative tasks on his patients that could be devised to drive a post-graduate-year-6 surgeon to distraction.

And then one day he assigned me to the role of operating surgeon on a three-vessel coronary bypass. It went well, despite his cold stare from the left side of the table. The OR observation windows revealed a rotating queue of curious anesthesiologists, surgeons, nurses, and techs. Later, in the middle of the ICU, with a new audience leaning along the nurse's station counters, I stayed with the patient and made sure that nothing was amiss.

A short time later, he came to stand next to me, eyes glaring up at me. I wondered what world of trouble was coming and waited. But he didn't lecture me. Instead, he asked, "Where did you learn to operate like that?"

This was, for him, a greater compliment than I knew at the time. To his credit and my good fortune, there was a complete reboot of our relationship. He was capable of being unforgiving over the short term, demanding, enigmatic, arbitrary, rude, and a natural misogynist. I gave him as good as I got, within bounds that were frequently explored, and with time, things settled down. He overcame some of those flaws and took his role as my teacher very seriously. He made his knowledge available to me, gave me hundreds of cases, and I learned a lot from him. As I completed the residency, he gave me a second compliment: he was tired, and well rid of me so he could go get some rest.

I had learned, over the years, how to manage the petty sexual harassment by male surgeons, such as arms errantly rubbing against my breasts—in these cases, I usually stepped on the owner's toes, making everybody move. But one case was different: as a cardiothoracic surgery resident, I experienced an aggressive sexual assault. One man, older in age to me but junior in the hierarchy when I was the chief resident, assaulted me in a call room, pushing me against a wall and attempting to molest me. Luckily, I was able to kick him off, breaking free enough to throw a salvo of full yogurt cartons at him from a nearby refrigerator. He ran out, having to exit through a busy ICU, dripping yogurt and fruit jam. I followed and loudly ordered him to clean up the mess, hoping to show I was the one in power, not him. I neither reported him nor answered questions by others about it—and I continued to direct his work just as any chief resident would do. But I was also lucky: the call room was along a busy ICU hallway, not in a remote deserted location where it could have been far more difficult for me to remain safe, and there were multiple witnesses as he fled.

After my residency, I was hired by a growing adult cardiac surgery program as an attending, where I worked for three decades. In this realm, there was still hazing, but with a new emphasis on my personality traits. In addition to issues around whether I could be a good surgeon, there were now issues around if I demonstrated enough personal empathy with patients and was I sufficiently

"likable" in a way totally different than what was expected of male surgeons. A lot of people expected me to relate to patients as if I was their nurse, not their surgeon. My role as a surgeon was thought to be different from that of men in other ways as well: one of the senior partners promptly told me I was hired so he could defer care of his ICU patients to me. I adopted an "early and often" clarification policy of what was my proper role, so I did not comply with this attempt to define my role as "His Girl Friday." (In the classic movie "His Girl Friday" the film's female protagonist makes it known that she is not a servant to the leading male character but rather an equal.) Another classic behavior was to promote the idea that I was not "ready" to perform certain preferred procedures so they could be hoarded by the men. None of the male surgeons were subject to these behaviors.

These are examples of the "death by a thousand cuts" forms of gender-based harassment often used to undermine the credibility of woman surgeons. And they continued for years by some of the surgeons with whom I practiced, no matter the quality of my outcomes or the high regard in which I was held. Kindness is not highly valued in cardiac surgery, and a surgeon is perceived to be only as good as their last outcome. The surgical mantra "you eat what you kill" still has a hold on the culture. It takes a lot of stamina to keep a cool head and manage around predatory behaviors day in and day out. Efforts by early- and mid-career women to establish their surgical reputations are still challenged by these sorts of innuendos in a way that is distinctly different from their male colleagues.

Ten years into my surgical career, I was appointed Chief of Cardiovascular Surgery, one of just a handful of women cardiac surgeons in the US to hold a departmental Chief position at the time. My assignment was to transition the program from an annual volume of 750 cases to over 1400, and fear about the changes necessary to do so led to vehement objections by some fellow surgeons. Amazed at my audacity, one colleague blurted out in surprise during a heated discussion, "You're ambitious!" revealing how strongly he felt that I did not know my proper place.

As a leader, I learned I needed to speak in a lower tone of voice when leading meetings, sometimes deliberately speaking quietly, so my colleagues had to stop talking to each other in order to know what was happening. I found the male surgeons tended to personalize controversial topics, so I stuck to the facts, not to the emotions, as the groundwork for constructive disagreement. I also publicly called out destructive behaviors when necessary, so it was clear I was not afraid of describing what they were doing.

As a matter of surgical anthropology, I hope the skills for success I had to adopt will be less necessary as more women—and younger men—enter cardiothoracic surgery and perceptions around gender norms shift with the new pool of talent. There are now hundreds of women cardiothoracic surgeons, and although they still constitute only about 5% of the full number of cardiothoracic surgeons, the trend is clear.

Even with all my hard times, of which this short essay is but a small sample, many good men entrusted me with their surgical patients and committed many hours to teaching me what great care looks like. I remain in their debt.

Ready, Aim, Fire: Ending Sexual Harassment of Women in Surgery

Anonymous One

I was sexually assaulted by a senior anesthesiologist in the preoperative holding area at the start of a long OR day in the presence of staff, learners, my patient and her family. I had no intention of reporting the assault. I know how the world works: nobody would ever believe me. However, a close friend—who had also been sexually assaulted at work by a colleague—encouraged me. With his assault successfully managed through the termination of the offender, he asked if he could come forward on my behalf. I agreed, feeling supported yet hesitant.

A meeting was called, comprising Medical Staff Office members, Human Resources and my department chair. "We have learned about a situation in which you were involved. We need you to tell us what happened." Everyone stared at me, eagerly awaiting my response. I described my experience in painful detail, layering information to validate my story: location, people, times, situation, dialogue. Once I finished, the questions flew through the air like a spray of bullets.

"Did anyone say anything to you?" No.

"Do you think anyone witnessed this event?" I don't know.

"Did you talk to anyone right after it happened?" No.

"He was supposed to be in your OR all day. Did you request another anesthesiologist?" No.

I was challenged by my chair, a man highly respected for his razor-sharp focus on surgical quality and safety. His position was that my ability to perform surgically was potentially impaired and I created an unsafe environment for my patient. I was asked repeatedly why I didn't say something in that moment to the anesthesiologist. Why did I allow the case to move toward the OR, knowing I would be trapped in my room with him all day? Why didn't I request another anesthesia provider? This was a near-miss, a disaster waiting to happen, under my watch and for which I had full responsibility. I responded calmly and confidently to his concerns: while the assault had the potential to impact my surgical performance, it didn't. As a surgeon, I have faced various types of disruption in the operating room, including confrontation, marginalization, disrespect and sexism. Despite this, I uphold a high professional standard and consistently elevate my abilities to overcome. I spoke deliberately, defensively, recognizing criticism for my actions and decisions in the midst of reporting an illegal action against me. It all seemed incredulous.

Another round of ammunition was loaded as they discussed the next steps in the investigation and my options. This group would meet with him and explain that I made a formal complaint against him for sexual harassment. They would interview him and the other staff that was present in the pre-operative holding area that morning to "fill in the gaps" of my allegations. Since the anesthesia group was independently contracted by the hospital, the overseeing party had no jurisdiction over where he could work or with whom. Recommendations would be made, but the decision of how to handle my perpetrator was ultimately at the discretion of the head of anesthesia. It was immediately evident that there was a level-setting process to protect him, the accused. He is a physician, and as such, he is dependent on work for his livelihood. He should be expected to continue to work in order to earn an income. He shouldn't suffer financial punishment just because I am making an allegation against him. I would want the process to be "fair" if it were me in that situation, right? In the midst of reporting this assault, I was expected to have empathy for this criminal, to align with his need for support and protection. My armor pierced, I was painfully aware of the depth of my vulnerability.

In light of the support for him to continue working, I was given the option of leave with pay during the investigation. In that moment, I was enraged. I did nothing wrong. Yet, in order to shield me from interactions with this anesthesiologist, I was being asked to abandon my patients, my learners, my practice. While the duration of the investigation was anticipated to be short, all I could think about was my fully booked surgical schedule and all of the patients who were counting on me to perform their operations. It simply wasn't acceptable to go into hiding while the investigation preceded. I would not sacrifice my professionalism or compromise my patient-centered care because a colleague sexually harassed me. I made the choice to continue working.

A few days later, I was eating lunch in the hospital's cafe, crammed into a small table in the middle of the crowded room, when the Human Resources representative from the meeting walked up to my table. She sat down, uninvited, and began talking about my "accusations." I explained that a public area was not the proper venue for such a sensitive discussion. She agreed but noted that we were both busy professionals and, due to the importance of the case, we should talk now. My harasser has been

notified of the report and is participating in the investigation. In addition, the head of anesthesia decided to allow him to continue working at the hospital. He would be assigned to different operating rooms than the ones where I was typically assigned and instructed not to interact with me. She then politely but insincerely inquired as to my wellbeing, which I quickly brushed aside with the social obligatory "I'm doing well under the circumstances." She curtly acknowledged the difficulty of these events then launched into a request. Could I please provide written documentation of the event, essentially penning my story on paper, and send it to her as soon as possible? When I agreed, she stood to leave. Her parting words—that emotional support could be elicited through Employee Assistance—were perfunctory and sterile.

Shortly after this impromptu interaction, I was antagonized by the anesthesiologist's continual presence. His institutional footprint was expansive. He was everywhere. He knew everyone. I was forced to co-exist with him in the PACU, a common community space for surgeons and anesthesiologists. Between cases, we were frequently alone in the hallway. He walked directly toward me, indifferent to my distress, his gaze piercing, his stance defiant. He took breaks in the surgeon's lounge, holding court in the middle of the room with other anesthesiologists and surgeons. In my company, he was gregarious, arrogant, flamboyant. He was the quintessential man's man. His jovial demeanor sucked the air out of the only retreat I had between cases. I felt my world shrinking, my safe space reduced to the women's locker room. However, he never uttered a word directly to me. His silence was compliant; his physicality was oppressive.

In the following weeks, I met with the medical staff representatives and my chair for an update on the status of the investigation. They stated that he was informed of my allegations and provided his response. He vaguely remembered the morning and "our interaction." He admitted touching me, but vehemently refuted any sexual assault. In addition, they interviewed staff who worked in the holding area that morning, none of whom witnessed "any inappropriate behavior." Despite this offense occurring in a busy and populated place, no one could corroborate my allegations of sexual assault. I feared the veracity of my claim, my reputation, was being called into question. They asked me to recap the details of that morning, forcing me to relive the interaction in the face of his denial. I did, pulling the sharp edges into focus, bored with the rhetoric but surrendering to the demand, believing this request was a simple formality before they dismissed the case. However, through staff interviews, the investigation committee learned about other unprofessional conduct. They could not share details of these events or characterize the behavior, but acknowledged that he breached professional standards for the organization. Therefore, a decision was reached between hospital leadership and the anesthesia group to reassign him to another hospital. Effective immediately, my perpetrator would no longer work with me.

I should have been exhilarated, relieved. While the medical staff recommendation ended my professional experiences with him, it, unfortunately, punctuated the beginning of another form of workplace hostility, one that is impossible to navigate. I was ill-equipped to manage the passive-aggressive behavior of other members of the anesthesia group. Whether these behaviors were rooted in retaliation, or merely a stance founded on morbid curiosity and stoked by gossip, questions regarding the status of this anesthesiologist were asked in my presence, but not to me.

"Do you know what happened to Dr. so-and-so?"

"I heard he was being himself and it upset a sensitive surgeon."

Perhaps it was my overwhelming desire to be professional, to be a person of integrity, to "take the high road," or to not fall victim to the rumor mill by chiming in to this conversation. In truth, it was simply that I was uncomfortable with how to respond. Terms—gender harassment, sexual assault, intimidation, bullying, retaliation—are definable on paper, but remain elusive when applying them to human behavior. How does one prove these questions answered with condescending, snotty words, stem from the investigation or its decision? Prove motive. Prove intonation. Prove

chronology. Prove association. Prove "sensitive" equates to misogyny. I narrowly made it off the battlefield from the last time I used my voice and now risked walking in front of a firing squad. So, I said nothing.

But why should I suffer this experience in silence? Silence is another form of subjugation. The sad truth is that a sexual predator violated the physician code of conduct and was quietly ushered from one hospital system to another. This criminal was protected—financially, professionally, reputationally, legally. By contrast, the accuser was assaulted, doubted, threatened through risk of patient abandonment and financial loss, faced aggression through daily interactions with the accused, and revictimized by the clumsy process and ignorance of those leading the investigation.

Years later, I still reflect on this experience. I wonder, if I could do it over again, would I do it differently? No. In the current configuration, I know my response was appropriate. What I would insist on is a different path, a different outcome. Health care remains littered with insulated harassers and ineffectual leaders. Those in power are shielded from the consequences of inappropriate behavior, sustaining and amplifying the existing power differential. In response to the National Academies of Sciences, Engineering, and Medicine (NASEM) report on the sexual harassment of women, health systems have an opportunity to transform existing policies to protect victims, guide leadership through the process of investigation, and outline a clear penalty for perpetrators. We are on the threshold of a radical culture change in medicine, one that is long overdue. It's time to pull the trigger and end sexual harassment.

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Strength Without Armor: Reflections from a Woman and a Surgeon

Karyn Butler

Pass the baton. . . .

As women we stood together, passing information as if in a relay.

"Make sure you wear a t-shirt under your scrubs so Dr. X. doesn't look down your shirt."

"Do not get pregnant."

"Forget about your relationships if you want to make the cut."

Pass the baton. . . .

"Stay away from him."

"He tries it with all the women."

"Don't meet with him alone."

I was different, I thought. I was careful, I *never* wore pastels, *never* let my long hair down, *never* wore 'dangly' earrings, *never* wore skirts or heels . . . *never*. My femininity was well-concealed under the armor of the pursuit of success. I thought that was enough to protect me.

My first contacts with him were as I expected. I was prepared for cases with him; I answered his questions correctly about anatomy and disease, I stayed as late as needed to ensure his patients were ok after surgery. I 'fell on my sword' when my junior resident removed a drain prematurely—I told him I would do better.

He showed interest in my career, said I was a very good surgeon, that I excelled in the OR and that he believed I could accomplish whatever I set my mind to. He said he would help me, and that whatever I needed him to do, he would do.

He asked me to meet with him over dinner to discuss my career aspirations.

I said yes—I couldn't, or didn't, see it. The invitation seemed so genuine.

I was lucky: I had someone who did see, who was incensed at the thought of the invitation.

Someone who said, "Why do you *think* he's asking you to dinner?"

Shame on me for not recognizing it myself. Then I thought, 'How stupid am I.'

I thought he cared about my career, about the grounds I could level by excelling as a female

surgeon. I was wrong. That uncertainty, that shame stayed with me throughout my career.

How could I ever be sure that I would be seen as just a surgeon?

Pass the baton. . . .

As a woman, the decision to become a surgeon changed every single aspect of my life. In the very beginning, during interviews for residency as a fourth-year medical student, I was asked questions that male applicants were not asked: "How do you know you're strong enough to become a surgeon?" "What will you do if you have children during residency?" These are questions that are illegal today. They were questions that paradoxically fueled my ambition to become a surgeon but also, somewhat unbeknownst to me, set a backdrop of ensuring that I never 'showed up to work' without my 'armor.' That armor took many forms including minimizing my femininity, consciously focusing on my body language, my verbal presentations, and my hand gestures all in an attempt to be seen as a surgeon and not a 'woman surgeon.' This distinction is crucial to understand as, with the passage of time, I have finally become proud of being a woman and a surgeon.

My memory is long regarding the inequities that I confronted during my training and my career. These experiences did not diminish my enthusiasm to succeed. In fact, they invigorated my passion to excel in academia and aligned with my personality of 'going against the grain.' The choice to become a surgeon, however, came with a price tag of failed relationships and anxiety, balanced only by the personal satisfaction acquired from academic success and the joy of raising two wonderfully independent children.

Over two decades ago, it would have been impossible to predict that the face of surgery would become more diverse and more feminine. Over two decades ago, the benefits of gender diversity in surgery were not recognized. Over the course of my career I experienced gradual acceptance that, as a woman and a surgeon, I bring a different perspective to the care of my patients and their families, a different view for my students and residents, and a different face for the community that I serve. My journey has shown me that strength should be defined by unyielding empathy and compassion, by a genuine drive to empower others, and by an unwavering commitment to speak up when the right thing is not being done.

As a woman and a surgeon, I have often been in the unique position of serving as the singular role model of a 'woman surgeon' for male and female trainees and faculty. This expectation placed significant stress on my personal and professional life, as there was the constant feeling of being under the magnifying glass, of always being 'watched,' probably being critiqued, and clearly always standing out. This has become an interesting dance; when I speak up, several people turn around to see who spoke. I then walk away wondering if I said the 'right' thing or should have framed the comment differently. I am literally always second guessing myself based on the body language from others. The curious thing about this dance of 'being in the spotlight' is that I am '*in the spotlight*,' and therefore I can serve as a role model for others who want to succeed in surgery.

Interestingly, during the early phase of my career, 'being in the spotlight' was seen as a necessary evil to advance my career. I have come to appreciate how imperative it is for trainees to see someone who looks like them so that they too can achieve their dreams. I know this has been an important contribution to those who I have had the privilege of mentoring; their comments of gratitude over the years have humbled me. The presence of role models in my life and career has been the single most important factor in any success that I have achieved, and I am proud of finally understanding the important life lesson of internal (self) validation.

I believe that for surgery to be more attractive to women, more women have to be visible. More women have to be 'in the spotlight' to lessen the fear, to reduce the anxiety, to increase the support, and to promote change. That said, it was not easy for me to step into this role. Over time I have come to understand and appreciate the significance of it, but it has always come with a balancing act between my individual need for perfection and my history of hiding my vulnerability. What women and men in surgery must see is that vulnerability makes us better surgeons; it allows us to connect

with our patients, to empathize with families, to stand in the center and admit that we were wrong, that we are sad for an outcome, that we care about our patient's pain. This is a transformative skill to possess, and one that only comes with truly being confident in and kind to oneself. We have to change the definitions of power and strength from the traditional masculine traits of aggressiveness, confidence, and assertiveness to include wisdom, kindness, compassion, and empowerment. We owe it to the next generation of surgeons, of patients, of families, and to the daughters and sons of surgeons to change the narrative.

If I could have given my 20-something-year-old self advice when asked the question, "How do you know you're strong enough to become a surgeon?" I would tell her to say "I know I can become a surgeon because I have internal strength, an external source of love and support and the skills of compassion, gentleness, diplomacy, resiliency, and prudence. Is there something else I might need?"

Pass the baton. . . .

A Woman Surgeon's Determination Despite the Barriers to Career Progression

Deborah Verran

I have numerous stories that I can recount from a surgical career that has spanned just over 30 years, spread across 4 countries. Along the way, there have been many moments of joy, along with a sense of significant professional accomplishment. However, I am left with some disquiet over occasional events. For the sake of brevity, I have encapsulated my thoughts into a paragraph for each stage of my life.

I was fortunate to be born into a family where my parents expected me to pursue a university qualification, so by my middle school years, marine biology was my goal. This fascination with marine life came about from having avidly watched all of the Jacques Cousteau television programmes, along with snorkelling at the beach every summer holiday. Back then, school careers counselling was limited and tended to focus on the traditional career pathways for women, i.e., either nursing or teaching.

During my first year of University, whilst undertaking a Bachelor degree, I realised that I was not enjoying the course and that my career prospects were limited. I spent time in the University café, debating career options with other students who were in a similar position. When Medical School was mentioned, suddenly this career path ticked all of the boxes. A careers counsellor confirmed that this was possible if I obtained certain grades in the end of year examinations. The next thing I knew, I was accepted into medical school. Dad's only concern at that stage was that perhaps I would like to be a vet instead because animals do not complain like humans. (In retrospect, he knew something!)

Medical School was really enjoyable and, as the class was close to 50 percent female, many of us assumed that career progression would be reasonably straightforward. No specific mention was ever made of the challenges faced by women professionals in the workplace. It was only once I had commenced hospital clinical attachments that I noticed the discrepancy between the numbers of male versus female specialists. If you said that you wanted to become a family practitioner or a paediatric specialist, then everyone was supportive. However, if you said you wanted to be a surgeon, well—that elicited mainly negative responses. I found this puzzling in light of the numbers of women graduating from medical school. What was going on here?

My early post-graduate years were spent undertaking general rotations in the hospital system because there was no direct entry into specialty training (not like in the United States). We all worked extremely long hours, and no allowances were made for gender. This led to illness on a couple of occasions including a dental abscess from an impacted wisdom tooth (diagnosed by a ward charge nurse, as my face was swollen). The career paths the women were expected to follow

were reinforced frequently along with the 'Do not complain about the long hours' adage (which came from a surgical superintendent, no less). I will never forget the conversations I had along the way with two senior male surgeons (both in positions of authority). One stated I was not cut out to do surgery (and ensured that this happened by blocking my career progression within one major hospital). The second tried to talk me out of it, despite the fact that his own daughter was a classmate of mine in medical school. His opinion was that women doctors should work part-time in less demanding specialties.

Faced with such major barriers, I turned to two trusted mid-career male surgeons who I had dealt with professionally, as there were no women surgeons. They helped me map out a pathway via which I could undertake an unaccredited training job in another city. This new job was a breath of fresh air as poor behaviour in the workplace—i.e., being yelled at, derogatory comments, et cetera—were far less common. Ironically, doctors in other specialties—not the surgeons—were the perpetrators in this new workplace. Through determination and support of my then bosses, I was finally accepted into a general surgical training scheme. This necessitated another move to yet another city.

Once in formal training, things seemed a little easier, particularly in the larger hospitals. The limited time off led to unexpected crises at times, including on one occasion when the car engine blew up. Poor professional behaviour still occurred but was not limited to the specialist doctors. Most nurses were reasonable to work with, but not in all cases. One example comes to mind. During one rotation, the nurses in the operating room were all charming and attentive when my male boss was present. However, the minute he left, they reverted to being barely civil with me. Yes, the dichotomy of behaviours on display in the workplace was clearly evident. There was no point complaining, as complaints were not appreciated (and could lead to a backlash, which peers had warned me about). I also became life-long friends with two other women in surgical training (as we supported each other).

To achieve my goal of being a Sub Specialised Surgeon, I realised that I would have to spend time overseas. On the advice of one boss, I set about securing a fellowship in the United States. In the interim, I commenced a short-term contract as a specialist general surgeon in a large hospital. As this role also had an academic component, I was for the first time fully exposed to academic politics of the type that besets a division under poor leadership. It was eye-opening and also extremely troubling, to the extent that I knew I could not return in a similar role to that particular institution.

I commenced my fellowship in a large program in the United States. My boss was also the Chief of Surgery, which protected me from most of the unpleasant workplace behaviour that I had previously witnessed. I still found at times that not all of the male surgical residents were helpful, and some of the attendings were less likely to allow me to undertake significant parts of the various surgical procedures than others. I carried the Chief's office landline number in my pocket so that whenever there was any significant issue I could always resort to the 'How about I phone Dr. X and ask him about this?' This worked extremely well. A number of the patients in the lower socioeconomic grouping all thought that I was an English nurse. However, they all accepted me operating on them! Despite this, the overall clinical experience compensated for issues in some areas.

Whilst in the United States, I realised that I would benefit from another year of training in order to secure a position back home. This meant moving from the United States to Canada to undertake a second surgical fellowship. Again, I picked up on some of the internal academic politics but, as I was not staying on, I could keep my head down. The standard of professional behaviour in this particular institution was overall extremely good and was a testament to the leadership. I was then offered a post as a breast surgeon back home, but as this did not align with my career goals nor my training, I turned it down and looked elsewhere.

Eventually, I secured a position in yet another country as a specialist surgeon. I felt that this was a good opportunity after I made some preliminary

enquiries. Somehow, I initially believed or expected that having 'made it,' I would now be exposed to very little in the way of unprofessional behaviour. Unfortunately, hope never triumphs over reality!

My initial enthusiasm, optimism, and preparation to work hard was no match for the internal politics of my new organisation, nor the engrained patterns of behaviour (a hierarchical patriarchy). I endeavoured to become involved in basic scientific research of a collaborative nature but gave up after 5 years. I did manage to undertake some ongoing clinical research, albeit with limited support. As a full-time surgeon, I ended up doing a lot of the committee work as well as teaching. I kept up the teaching for close to two decades but then ceased it due to lack of recognition. I put my hand up for formal leadership positions on several occasions and was afforded an acting role at times but nil else.

On one occasion, I made a formal complaint over written defamatory statements about me being circulated within the organisation by one of my seniors. This led to 5 years of legal wrangling and an unsatisfactory outcome. In another instance, I tried enlisting the support of a senior women physician to assist in dealing with one-on-one aggression from a Head of Service. However, no one was prepared to act. Instead, one senior individual blamed me for the problem! I approached the then Academic Head of Surgery for assistance only to be told that it was my job to get on with the individual in question. I never spoke to him again.

When the aforementioned Head of Service heard about my concerns about his behaviour towards me, his response was to deflect the blame by enlisting the help of anyone who was prepared to find fault with me. I had previously politely requested that this particular individual not speak to me the way he did on more than one occasion. Once the hospital administration became involved, I formally sought legal advice in order to successfully put a halt to a series of ongoing unfounded complaints. What then ensued was an ongoing sniping campaign both within and outside the organisation (some of which at times got back to me). Subsequently, a different Senior Academic Professor mis-stepped badly one evening by making an abusive phone call to me, not realising that I had left work early and was at home. My partner heard every horrible, abusive word and refused to then attend any work functions with me following this episode, as he did not want to be in the same room as these people. I informed several people at work about this particular incident, but no one was prepared to act due to the individual concerned holding a leadership position.

A handful of women surgeons have been appointed following me, but to date, none have attained a significant position of authority either in general surgery or its related sub specialities. Within the institution, several colleagues (not all in the same specialty), have petitioned the hospital management on occasion to try and counter the negativity. When I have travelled to international meetings, peers have asked me why I am not in a formal leadership role—'internal politics,' I reply. The impact of all this on my career trajectory is clearly obvious to some. My family members remain to this day simply astounded. The external professional advice back in time was that I should leave this workplace, but the sacrifices involved for both my partner and I were too high. I have toughed it out but, when the day comes to leave on my own terms, I will not be looking fondly back over my shoulder. My professional achievements speak for themselves.

Can this type of culture change? Yes, but it requires dedicated, committed, and sound leadership with a strong focus on equity in the workplace. This also involves educating all of the young doctors on appropriate norms in the workplace (so that career progression is not a black box), advocating for equity, and insisting on employers in the healthcare system being part of the necessary change. Plus, the scene needs to be set for women professionals to be viewed as equal contributors within the hospital system, as are the men. This means that hospital administrators, professional societies, and regulatory agencies all have a role to play, as well. Finally, women need to support each other and not accept the status quo!

No Hothouse Flower

Marguerite Barnett

To be a woman is a rich and dangerous job. I experienced this in my mother's womb, she who created me out of hope and love, which transcended betrayal and racism. I sensed this as I watched my adoptive mother subsume her identity to a soul-sucking concept formed at the confluence of culture and religion. But I didn't really learn it until I began the path that led to my current identity as a surgeon.

I should not have survived any of this, and I say that with a sense of wonder and gratitude.

I was born to a Japanese woman in postwar Japan, who met my father, a US military doctor, at a USO dance. He did not wear a wedding band, but he did not try to hide her. He took her to "nice" restaurants where Japanese women were not usually taken, so, at nineteen, she thought they were having a grand love affair. She did not realize he already had a wife and child back in the States. She was so naïve she did not know she was pregnant. She had morning sickness, and he smuggled her into the base hospital for testing. She found out when he sat her in the office chair and said, " I have a Japanese doctor friend who can fix this." The way that he said it made her realize "this" meant she was pregnant, "fix" meant an abortion. Something was wrong—he should be happy they were having a child! I do not know why she didn't have an abortion. Abortion was not frowned upon in Japan, but having a mixed blood, unwanted child certainly was. Most unusually, she kept me without any support. The combination of youth, poverty, and lack of support left her vulnerable, and she lost custody of me when I was trafficked by a babysitter at age one. Ultimately, I was adopted by an Army chaplain and his wife, who provided a stable upbringing despite the constant movement of military life. This conservative and fundamental religious upbringing primed me for marriage and a life of being a "helpmate" to a husband.

There were some warning signs that I might not take the expected path. I knew I wanted to be a doctor even though, at that time, I knew nothing about my natural father other than his nationality. I did not want to be a nurse. I thought it was because I was a failure to thrive, which, in retrospect, I think was because of my refusal to eat when separated from my mother. But the fact that I had a heart murmur and got ill very easily led the doctors to conclude that I had a bad heart and would not make it past my fifth birthday. It was so bad my adoptive mother said she could not hang white sheets on the clothesline lest I thought it was the doctor coming to give me a shot! The warning signs became red flags, and I ultimately hit a brick wall when I chose to attend an Ivy League Medical School to be with my then fiancé. I did not realize how a liberal "heathen" institution such as the one I attended in the 1970s could destroy me. This was the time of widespread student protests against the war, Timothy Leary was urging everyone to "drop out and drop acid," and Patty Hearst had been kidnapped and brainwashed into a gun-toting radical. For my crimes, I was disowned by my parents, and the shock of losing their support was compounded when my minister molested me. I do not know how I survived those dark days.

My fledgling marriage fell apart under the pressure, and I was abandoned in the cold north in a program not known for its supportive nature. Desperate, I joined the military scholarship program, but it only paid for books and tuition. The financial aid package provided by the school did not cover living expenses. It should not have been a surprise that the final injury—caused by my lack of financial security, expressed in such seemingly minor things as unsafe housing and transportation—was getting raped and not being able to afford any counseling to deal with these issues. I was by then in full-blown PTSD, and one of the mercies of that condition is poor memory. My core had disintegrated, and there are many curious memories I do not understand to this day. For example, I was unable to go to my laboratory job after the rape, and no-one ever called to check on me. Did school notify them? I had notified the school because I needed medical attention, but other than that and an offer of counseling at a reduced rate of $15 per hour (which might as well

have been $1500 per hour since I made an average of $2.30 per hour and had no time to go to counseling). I heard nothing from them. I went once to counseling, but the therapist was Freudian trained and kept asking me about my poor relationship with my parents in a way that made me feel as if I somehow had caused all these misfortunes. All these things together made me believe that I was nothing, would be nothing, and the future was nothing.

I would like to be able to say that this story has a happy ending, but that would be too neat and tidy. If one heals from such things, and I cannot with certainty say one does, it is a long and arduous process. There must be miracles, there must be the compassion of strangers for a broken woman, there must be the unmistaken conviction that there is no way out, only the way forward. There must be genetics, that wildly mysterious process by which one utilizes psychological defenses such as denial, repression, and sheer life force. There must be humor.

I think full-blown PTSD was an excellent way to go through surgical training of that day. The lack of trust saved me from more than one unpleasant run-in with skirt-chasing attendings (unfortunately, one of them was the main one interested in teaching). The isolation prevented me from forming any close relationships that might have seduced me from my goal. The reckless behavior certainly convinced my colleagues that I had a confidence I didn't, and hypervigilance, insomnia, and anger were advantages in my testosterone-driven training program. There was also the kindness of nurses who warned me when the chief resident wrote orders to awaken me at 2AM for the sole purpose of harassing me, and janitors who saved my books from the trash. Luck played an astronomic part; when the chief became unbearable, he was stricken with both acute epididymitis and cholecystitis in short order. While his plagues were epic, I am certain he never suffered the indignity of his direct orders being refused by underlings or being called a dyke in front of patients. I think it is telling that, of the three training programs I went through, the only one in which I did not face or note any kind of sexual harassment was the one run by a person who identified as transsexual.

Humor, luck, and psychological defenses only go so far. I would be brought down to earth in ways as mundane as attending my first surgical conference and being excluded from the perks of dinners and cruises on the bay because I did not look like a surgeon, or being mistaken for a hooker at my nice hotel. Once I walked into a talk on the ideal qualities of residents and was shocked when the presenter claimed that females scored higher in such "negative" qualities as caution and reluctance to operate! A professor visited from the medical school I attended and other residents urged me to introduce myself to him. When I shook his hand and told him I was an alumnus 1979, he frowned and said, "1979! X was dean then. We alumni hated him; he let everyone in; blacks, women, minorities!" The thousands of micro and macro aggressions drained me and kept me in pure survival mode.

In the long run, PTSD is not a way to live a happy life and is not healthy for my patients or me. I decided I had to find a more stable life, so I left the military with great sadness. I loved the sense of esprit de corps I felt there, the sense of mission, the purity with which I could provide patient care without concerns about insurance, but I could see the writing on the wall. I was being passed over for promotions, awards, and assignments in favor of men who were not as qualified. When the lone female colleague I had was forced to go for psychological evaluation because she was found weeping in the lounge after her parent's death, I knew I needed to find security, and if I could not find it in an organization, I must find it in personal relationships, which were hard to maintain with constant transfers.

Imagine my surprise when I found that my lack of success in personal relationships could not be blamed on the military. The sexism of the military, which was so in-your-face, I found easier to deal with than the subtle variety of civilian life, which manifested itself in much more damaging ways, such as a refusal to make referrals no matter how good a job I did and exclusion from the fraternity. I am not complaining. My life has been full. I have achieved more than anyone could have expected from an orphan immigrant. Besides the Ivy league education and specialized honors, I double-boarded

in general and plastic surgery and recertified twice. I did a Hand fellowship, microvascular training, and burn training at an Army Center. I have been honored with two terms as county medical society president, over a dozen to the state society and three to the AMA delegation. I have the ideal practice, mostly elective, self-pay non-cosmetic procedures on grateful patients who are willing to wait months for a consult with me without any advertising. I repaired my relationship with my adoptive parents, tracked down and made peace with my natural ones, and did the work to recover myself and create a version of a stable family for myself. I have broken down barriers and done firsts all my life. So what do I want? More! It was never about just being safe myself. It was about helping all people about teaching, creating a legacy. These are traits I share with all humans, and at that, I have felt thwarted.

My niece just graduated from medical school, never burdened with any of the traumas that afflicted me. She will achieve great things. I know that she will inevitably hit those barriers that keep us from our full potential. I know that future times will be more perilous for all of humanity, with challenges no-one can currently foresee. It will take all of our energy as a species to survive and create a world that works for us all. I know that this cannot be done if we do not include the feminine half. I believe that many of the direct failures of our life we see today stem from our shortsightedness regarding allowing women full involvement.

"What unites people?" asks a character in a recent cultural phenomenon show *Game of Thrones*. It was neither armies, gold, or flags. "Stories. There is nothing more powerful than a good story. Nothing can stop it. No enemy can defeat it." This is why I tell my story. If it can help one person realize they are not alone in their experience, if it can convince one person of power to extend mercy to one below, if it makes one recognize a part of themselves in another, then my goal will be attained. I and others like me are ready with hearts open and helping hands out. We are not hothouse flowers. To be a woman is a rich and dangerous job.

My Story as a Female Surgeon

Amy Wandel

I graduated from medical school in 1983. I told my school assistant dean that I loved my surgical rotations and wanted to do a surgical residency. He advised me to look at pediatrics or OB/Gyn residencies because "women did not go into surgery." Disregarding this advice, I applied and was accepted into a general surgery residency in the U.S. Navy. There were 20 residents total and I was the only female. It was a lonely five years for me. I was not an outgoing person and did not feel completely accepted by my male peers. Most of my running mates were polite to me, but very few were actually friendly and none were inclusive. I learned it was safer to keep quiet and speak only when spoken to. In retrospect, this behavior isolated me even more from my fellow residents.

The staff surgeons were supportive and treated me very fairly. One was a wonderful mentor to me, teaching me what it took to be a great general surgeon and how to critically assess my performance in order to improve. I was also very fortunate to work with the one and only female surgeon, a cardiothoracic surgeon. She taught me how to communicate effectively with my male colleagues and how to survive in a tough, very male-dominated field.

After completing my residency, I spent two years in Subic Bay, Philippines. My time in this remote hospital was very educational and I had the opportunity to grow as a surgeon and a person under the guidance of my male partner. I left the Philippines for Plastic Surgery residency. I found a very different culture in my civilian program. In the military, I always felt that I was evaluated by my performance and not by my gender. In my civilian residency program, I did not feel this same sense of equality among residents. My program sought to hire a female and a male every year, but there was a culture of male favoritism. The female residents responded to more ER calls and tended to do more of the scut work. I was frequently told by the emergency room staff that my male counterpart "would never come in for this type of call." Neither I nor my predecessors complained about this arrangement.

There were stories of female residents who had complained about this and had been labeled as "troublemakers."

I responded by working harder and trying to remain cordial to my running mate. I felt this was the way to be successful as a female surgeon and gain equal status. One event really changed my perspective on what I faced as a female surgeon. There was one staff surgeon who was known to be "quick-tempered" and very demanding in the OR. He was also known to be overly critical of female residents, frequently "losing his temper" and yelling at them in the OR. He was much friendlier with the male residents, often joking with them during surgery. He was an excellent surgeon, so all of us wanted to work with him and learn. When I worked with him, I was extremely quiet and focused on the case. I worked at being well prepared for the expected "grilling."

One day will remain a turning point for me. It dramatically brought home how poorly the women in my program were treated. I was the senior resident at the time. I had just walked into the doctor's lounge when an OR nurse approached me. She told me that a staff surgeon had just thrown a chair at the female resident assisting in the case. She explained that the surgeon had lost his temper, had started yelling at the staff, and then had thrown an instrument down onto the surgical field. The resident had picked up the instrument in an attempt to deescalate the situation and complete the case. Instead, this seemed to enrage the surgeon, and he picked up a chair and threw it across the room, barely missing the female resident. I was horrified and went to look for the resident involved. When I found her in the locker room, she was noticeably shaken. She initially did not want to talk about it, but I persisted and she finally broke down and confirmed what the nurse had told me. I told her that this was totally unacceptable behavior and that this surgeon had put her in harm's way. As senior resident, I felt it was my job to protect the resident, and I wanted to go to our department head and report this surgeon. I wanted him to be held accountable for this extremely dangerous behavior. She begged me not to report the incident. She did not want to be labeled a troublemaker. I finally agreed to this but my decision haunted me the rest of my career.

This experience really changed me. I had always believed that I would be accepted in this "man's world" by keeping my head down and working hard. But this one day showed me I was wrong. I realized that the environment in which I had chosen to work was hostile towards me as a woman and the only way for me to truly be accepted in my career was to change the culture. Emotionally, I changed as well. For a long time, I avoided any personal interaction with my male colleagues, discussing only case-related information. Professionally, I pursued opportunities for leadership and professional development. My goal was to become a force of change. I became involved in programs within ASPS that provided mentoring for young female surgeons and educational forums that provided tools to empower them to change their own situation. I joined similar programs within the American Medical Association and the American College of Surgeons. I personally mentored several female medical students, residents and fellow young female surgeons. I have tried to provide them with the tools to become successful and inspire them to work to change the culture. I believe this work has helped other female surgeons, but it has also driven my own growth as a surgeon, leader, and as a person. The sense of satisfaction this work has given me has positively influenced my personal life as well. I am more relaxed and confident in social situations and have been a much better partner to my husband.

When I retired from the Navy and joined a large medical group, I truly felt valued and respected. I felt safe and supported by my fellow surgeons. I have made lifelong friendships. I know this was possible because of changes in the world in which I work but also because of who I have become.

Our society as a whole has moved toward more equity in the past 20 years. In my career, I have witnessed a slow change in the house of surgery. It is much less a male-dominated world where women are at best discounted and at worse intimidated. There have been many changes within the plastic surgeon community specifically. Women are more

often now in positions of leadership, where they influence change within the plastic surgery community. They are more often treated as an equal. But cultural change is slow, and I still am disheartened when I hear a male colleague disparage a female surgeon because she is outspoken or forceful. So there is still work to be done.

What Doesn't Kill You, Makes You Stronger . . . or Does It?

Claudia Emami

I didn't decide to become a surgeon until my first surgery rotation as a third-year medical student. I didn't know much about surgery and had never worked with surgeons or known any. I subscribed to the general stereotype of surgeons being tough and serious, and mostly male. I had to mitigate my desire to pursue a surgical career with the intense fear of what the training would entail or how it would change my life. Like many in my shoes, I was naïve and managed to overlook all the important stuff such as the nature of surgical training and its effect on me as a woman.

The reality bites, and it bit hard during my internship. I was bullied and berated, mostly because I was considered to have a "big mouth." It meant I wouldn't let people berate me without at least trying to defend myself. I was called a "Persian princess" because I had opinions and dared to express them despite the expectations that interns must shut up and follow. My seniors assumed that this was a result of me being Persian. The princess part was yet another stereotypical assumption based on what people considered my "snobby attitude." No one ever complained about my work—in fact, they were worried that I was too confident and too quick and efficient in performing my tasks. During my intern year evaluation, Dr. X, one of my senior attendings, asked me to try and pretend that I was having a harder time at work. He said that other residents were offended that I "don't look miserable enough" and I "don't hang out" with them much to commiserate the way interns are supposed to.

I admit that I was very efficient and in total shock of why, collectively, everyone around me was always unhappy and complaining. The general misconception was that you must not work hard enough or care deeply enough about your patients if you didn't look or act exhausted. Our chairman was a deeply religious man, and his training philosophy was one of "total submission." In fact, he believed so much in the process of giving up your personal life as trainees that he and some faculty on his service, would go home for dinner and keep the entire team waiting before they did PM rounds. If you complained about how ludicrous this process was you would be considered lazy because, as one of the fellows would say, "If I am here, you're here."

My big mouth as an intern gave me a specific reputation and, as all would tell me, once your reputation is set as an intern, you can't shed it easily. I was supposed to stick around, head down, tolerate the treatment for at least a year, and most of all, not outshine my seniors, especially in front of the attendings. I was supposed to work on having allies amongst staff and seniors and play along with the rules. As such, I was deemed a bit of a "rogue" resident. If I was properly aware of the way this game was supposed to be played, I would have done what was necessary to get from point A to point B in pursuit of my ultimate goals and stayed out of trouble.

My gender only became a prominent factor once I realized certain factions were not happy with me projecting confidence and stealing the spotlight, which traditionally did not belong to someone like me: a Middle Eastern woman and an immigrant without any connections or associations with anyone at the medical school or the department. It occurred to me, as the story progressed that the expectations of behavior from my gender did not match the way I was behaving. That made it hard for men such as Dr. X to respond and relate to me in a neutral way, as he would to a male resident. Especially since he didn't believe that women had a role in the world of surgery.

That lack of knowledge was my fault. I should have studied psychology and diplomacy and learned to handle myself with more tact, without becoming a walking target for gossip and judgment. I should have been low key until the system accepted me as worthy of speaking and being listened to. I learned that just because there were women around, it didn't mean they had influence or power. It simply meant, in many situations, that they were there to check a box. The traits of assertiveness and direct communication, common amongst many male residents, were considered norm shattering in a female. I wasn't one of the guys, and as I grew in my profession, I realized I didn't want to be one of them or behave as such. Eventually, the "feminine" traits turned out to be more effective in pursuit of my goals by learning to soften my deliveries.

In my story, I was caught in the crosshairs of some powerful people in my program, mostly as a result of my unconventional behavior. Midway through my residency, a series of events on one rotation led to a talking to with Dr. X, who was a very influential attending in my program. As a known misogynist, he had a history of disruptive behavior and anger management issues. He inspired fear in many residents and staff and therefore was the last person on earth any of us wanted to have to deal with let alone argue a point with.

As residents, we were torn between wanting to take the best care of our patients independently and needing supervision. The senior residents acted more like staff and projected what I now know to be dangerous overconfidence, mostly because they had to. Asking for help meant you didn't know what you were supposed to do. I was given a lot of latitude as a third-year resident, and I was doing what many celebrated residents back then did, which is to manage complicated cases without much supervision. However, there was still some bare minimum requirement that at least the attendings would have to show up to the operating room, even briefly. Nevertheless, there were a few infamous ones who were chronically absent.

I got in trouble with Dr. X because I took care of a critical patient despite not being able to find the attending on call after multiple pages and calls. Although that wasn't so uncommon, I did something that others wouldn't do—I spoke out about it the next day during sign out. When evaluation time came, Dr. X told me that he was tired of the "word of mouth" he was hearing from some residents about me—that I was a "snob" and that the male interns were "scared" of me. It was a surprise to me because up to that point in my training, I had never been written up, disciplined, failed a rotation or gotten anything other than excellent evaluations. None of that mattered since I was another "female resident" with personality issues, as it was communicated to me afterwards.

The criticism would have been effective if it was used to improve me as a trainee. But instead, Dr. X tried to get me to accept that I had failed as a resident on that rotation and have to make up time for it, at a great potential cost to my future career plans, all to prove his point. As I found out later, the program was short a resident because of the restructuring of our combined plastic surgery residency, and they conveniently assumed that my career aspirations are not relevant and therefore they can use me to fill in the coverage gap. Again, maybe being a female had something to do with it? I still don't know until this day. Faced with Dr. X's wrath, I was advised by my mentors that I would have to make a choice, either rollover and take it or fight it and risk retaliation and isolation. I chose to fight it and I did get isolated. Most of all, it affected my reputation. It was said at the time that, the mere fact that I was disagreeing with the plan showed that "everything said" about me was correct.

The callousness with which my career was dealt with in this story, is what affected me negatively the most. It didn't matter that the situation was unfair and that the consequences of these actions could have seriously damaged my future. I would like to believe that it wasn't bias that lead to their lack of regard for me, but deep down I know that it was. Plus, I was told that fact, point blank. I was told that because they had previous problematic female residents that were considered "bitchy," I wasn't going to get away with this behavior for my "own good." Even though, day after day, we had

disruptive behavior in the cadre of male residents that went unnoticed or ignored. Examples were residents getting into physical altercations with ER docs, throwing pagers across the ICU at interns, fighting with anesthesia residents and on and on. They were held to a different standard.

The stress, in the end, was too much. I felt backed in a corner with nowhere to go and no one to save my career from falling off a cliff. Hence, I decided to take a different approach. After an intense back and forth, I settled on a plan with my program. I would go on my research fellowship and we would revisit the issue after a year so I could show how well I do in research. Three years out on research, multiple awards and presentations and scientific papers later, the program and Dr. X decided that I could move on with my residency and that they would let the past go. I graduated with awards and matched in a competitive fellowship that had a 50% fail rate. Dr. X supported my application by writing a glowing letter of recommendation and giving my graduation speech.

The damage, however, was done. Others, without knowledge of the facts, assumed the worst about me and took the labels to be true. I have succeeded, and I am happy with what I do and where I am. But even now, over a decade later, I still hear people make references to me as someone who is "hard to work with" without ever having worked with me or been involved in my training. The gossip has lived on and has cost me some opportunities that would have made transitions easier. I have since changed my approach to others and my awareness of my surroundings and work environment, or my overall "emotional intelligence" as its referred to these days.

I know full well now that gender bias is real and implicit bias permeates our work environments. I also know full well that as women, we are held to different standards. As female surgeons in power positions in the health delivery hierarchy, I believe we do need to adapt and look at it as the glass half full. We have made gains and changed the order. We have more female role models and they have more power in the systems we work at. But there's still much left to do. The leadership we provide as women can't always emulate the traditional characteristics of male leadership. We can't just be factual or work hard; we also need to get "buy-in" and manage others' emotions before we can be assertive. The cost of power for women in society is high, but without women in charge to emulate and elevate, we cannot fully level the playing field. I agree that we shouldn't have to change who we are because the system is biased. But I also believe that we should choose our battles carefully. Our flexibility is our strength because this is a long game, and as a woman surgeon I've learned to bide my time.

Cooperation and Support of Both Men and Women Are Required to End Workplace Discrimination

Anonymous Two

I grew up on a farm, driving machinery, using power tools, and doing whatever work needed to be done; never thought twice about it. I was the valedictorian of my rural Midwestern high school, and yet I grew up surrounded by relatives who say things like, "No God-damned girl needs to go to college!" I hated manual labor as a kid, so I focused on academics, convinced that an education would elevate me out of the misogyny and sexism of rural America. I finished my undergraduate degree in 3 years (despite not having any advanced placement credit). I had earned a Master's degree by the time I was 23 years old and entered the business world. I excelled there, too, managing multi-million-dollar projects, but was unfulfilled. I went on to complete my pre-medical requisites at night while continuing to work full-time. My performance in pre-meds was so good that I was invited to teach both as an organic chemistry teaching assistant and as an MCAT prep teacher. I was accepted into medical school and decided to complete a Master's in Public Health simultaneously. I am a hard worker. I expect a lot out of myself. I

accomplish goals. And yet, I am on the verge of abandoning my chosen career because of the sexism, misogyny, and gender discrimination, not to mention the downright unprofessional and unethical behavior that I've experienced in the nearly 20 years since starting down the road to becoming a physician and a surgeon.

Perhaps I was naïve to believe that hard work and a good brain were enough to be successful. Perhaps I was foolish to believe that everyone with higher education would be enlightened about gender issues in the workplace. What continues to surprise me is that much of the discrimination and harassment I've experienced has come from my peers, not from the "old guard." The first overt sexism I experienced was during medical school when a male classmate (who was also hoping to garner a coveted orthopaedic training spot) cornered me in the anatomy lab. He said, "Girls shouldn't be orthopaedic surgeons because you're going to get pregnant and leave more work for the rest of us." For the record, I have never taken maternity leave. On the other hand, I have covered *every* instance of paternity leave since I started training (and there was a lot). During training, I was put on call for every major holiday and every department party. One resident's excuse for making me cover the holidays was that "the guys have families," completely missing the point that I, too, have a family—one to which I do not go home every night. One peer refused to take call during our last rotation because he needed to study for our upcoming board exam, completely ignoring the fact that I, too, had to take the same exam. Rather than dumping the extra call on the junior residents, I absorbed the extra call. I passed the boards, none the less. One senior resident refused to do cases with me—a key part of my learning and development—simply because he wanted to do the cases with his buddy, his fellow senior resident. I was literally denied learning experiences in favor of the good ol' boys' club. As a board-certified attending, I'd spent hours with a particular family, explaining over and over again that the only way to fix the child's problem was with surgery. No, you do not *have* to have surgery. Yes, if you want the problem fixed, then you need surgery. No, physical therapy will not solve the problem, et cetera. Eventually, I suggested the family obtain a second opinion, certain that any colleague would back me up and reassure the family that my recommendation was sound. Instead of saying, "Your doctor is absolutely correct; have the surgery with her," my partner booked the patient onto his own schedule. (At the time, new to the practice, my surgery schedule was wide open, while his was overbooked.) He informed me later that "I think they were more comfortable with a male surgeon."

Gender discrimination doesn't only come from male colleagues. Women are often guilty of misogyny toward other women. On the first day of my ICU rotation as a PGY-1, a (female) nurse looked me up and down, sneered, and said, "*You're* ortho?! Where are all the cute guys?!" I once overheard some (female) clinic staffers complaining that the female residents were "stuck up," always introducing ourselves as "Dr. So-and-so," whereas the guys were more "friendly," using their first names. The staffers don't realize how often patients, families, and staff assume that we are nurses or physician assistants (PAs). The only way for us to combat that assumption is to introduce ourselves as "Doctor," and yet, that makes people think that we are putting on airs. One clinic nurse has an eerily close relationship with a fairly young male surgeon; consequently, she is given remarkable levels of authority within the hospital. When a female surgeon asked for xyz to be done, the nurse refused. Her reason: the male surgeon hadn't told her to do it. The nurse actually refused to do her job for a female surgeon! Another nurse, when asked by a female surgeon to perform a simple clinic task, responded with "I'd rather you did it," but that nurse has been known to perform the same task for male surgeons in the practice.

Another category of gender discrimination that we frequently face happens in the settings of meetings or education. During morning resident teaching or journal club, two of my three male partners would literally act as if I had not even spoken. They would look right past me as if I were not in the room. They would talk over me. They would disparage the input I offered. And yet, residents,

PAs, and primary care doctors would frequently seek me out after the fact, asking *me* to clarify the topic, to re-teach a concept that my male colleagues had failed to communicate clearly. These male colleagues would disparage my (world-renowned) training program, in front of the trainees, in an effort to discredit me and my surgical opinions. This marginalization and unprofessional behavior became so pervasive that I eventually stopped attending morning sessions. Given the fact that I have two advanced degrees (in addition to the MD), as well as significant work experience outside the medical field, I have unique expertise and observations—and yet, I was not invited to development meetings where my expertise could've been informative.

Gaslighting is a form of psychological abuse in which the abuser simply denies observations or experiences of the abused. For instance, I once observed a very poorly handled emergency patient situation. In an effort to start a conversation about how to improve the process for the future, I said to my boss, "Well, that was chaotic." He replied, "No, it wasn't." And turned his back on me. End of discussion. Another example: I had conducted a lengthy consult with a pair of very anxious first-time parents. Their child had a flexible, benign foot deformity that did not require treatment. I spent extensive time and energy with that family, answering their questions, providing documentation, et cetera. Nonetheless, the family requested a second opinion. My male colleague, who provided the second opinion, could've said, "Your doctor is absolutely correct. Your child is fine. Keep your follow-up appointment with her." Instead, rather than spend the time and energy to reassure the parents, he *treated* that child for a condition she did not have. (That family subsequently wrote a nasty online review about how I had refused to treat their child.) Our boss later had the opportunity to intervene; instead of redirecting the patient care, he continued the unnecessary treatment, completely ignoring the fact that I had originally seen the patient and completely ignoring the fact that the child did not require treatment.

Even more damaging than the daily gender discrimination has been the blatant sexual harassment to which I've been subjected over the years. In 1991, Congress amended the 1964 Civil Rights Act, acknowledging that sexual harassment violated a woman's right to earn a living and work in a non-hostile atmosphere, and yet, it continues virtually unabated. During residency, fellow (male) residents would talk loudly and openly about the various nurses' tits and asses. One fellow resident, during our weekly teaching session, thought it was funny to show me a picture of his genitalia; the other residents thought that was hilarious. During residency, an attending physician stalked and harassed me for *years*. He would hide around the corners of hospital hallways, waiting to accost me. He would hover over me at communal work stations when he would spot me before or after surgery. He would send nurses after me, to tell me I was a bitch or a slut or a whore. He would show up at my house at 3 am, wanting to talk. During morning rounds, he would page or text or call me incessantly, until my own attendings—believing I was ignoring something important—would scream at me to answer it. At one point, severely depressed and literally afraid to go to work at 2 of the 4 hospitals through which we rotated, I finally asked my residency director for help. His response: "You should call your mother." (My mother was dead.) When I found the strength to finally ignore the harasser, his next tactic was to write to my residency director, demanding my expulsion from the program. This triggered a mandatory investigation by the university. Thankfully(?), I was not expelled from the program, but his abuse tainted my entire 5 years of training and haunts me still.

Gender discrimination and sexual harassment are both alive and well in medicine. I often hear the refrain that we need more women in medicine—more women in surgery—in order to improve the situation. While I believe that is true to some extent (women don't always support other women as well as we ought), I truly believe that we have to first understand the scope of the problem. Historically, women in surgery have kept our heads down, kept quiet, and just tried to do our jobs. We don't, after all, want to be labeled "difficult to work with," which is code for "stands up for herself." Many

female surgeons don't even realize the extent to which they have been tortured and abused. In order to begin to tabulate the extent of the problem, we need to first educate program directors, attending surgeons, surgical residents, and medical students of both genders about what, exactly, constitutes sexual harassment, gender discrimination, microaggression, and gaslighting. Once everyone has a clear understanding of what behaviors are not acceptable in a professional workplace, then we can begin to count the incidents. Finally, we have to empower people to stand up against it. In most cases, we need *men* (who constitute 94% of practicing orthopods) to stand up against the unprofessional behaviors. When my peer showed me the picture of his genitals, for example, if even *one* other resident had spoken up on my behalf, told the perpetrator "Hey, man! That's not cool!" it would've made a difference.

I currently interact with many first- and second-year medical students from multiple universities. I repeatedly hear the refrain that they're interested in surgery but are shying away from it because of the toxic work environment. My advice to them—to anyone choosing a medical specialty—is that they have to love what they're doing at the end of the day. Medical training is too long a road to dislike your specialty at the end of it. I encourage them to enter surgery with their eyes open wider than mine were. I encourage them to speak up—seek help—sooner than I did. I encourage them to cultivate trusted mentors to whom they can turn at any time to ask for help or guidance if they ever find themselves in some of the situations I've experienced. As a profession, we need to do a better job of developing (and advertising) "safe havens" where trainees or practicing physicians can turn for help in the setting of abuse. We need to start calling out the perpetrators, stop giving them promotions, stop giving them podium time, and stop giving them trainees.

After nearly 20 years of harassment and discrimination, I was ready to quit the profession. But I'm not a quitter. I am an excellent physician, a careful surgeon. There are patients who need my hard-won skills. There are students and trainees and colleagues who need to know they are not alone. For the sake of those who will come after me, I am no longer willing to stay quiet.

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Success in Spite of Evaluation

Priya Chopra

I was invited to a meeting with three surgeons, including the General Surgery program director. No reason was given for the meeting. The note was given to me by my senior resident. He had no idea what the meeting was about. Now two months into general surgery residency, I was a month or so into Vascular rotation. I was post call, had 2 admissions and ORs were still running, but I scrubbed out and headed to the office tower. I thought the meeting was a standard check-in partway through the rotation.

I was ushered into the office and was politely greeted by the doctors. I remember feeling like this was a residency interview. One surgeon quickly took over the reins of the meeting. He was the older, more revered, slightly cranky surgeon who was known for teaching by humiliation. They asked me how I 'liked' my surgery rotation so far. I replied that yes, I did enjoy it. I stated that it was a bit difficult managing OR and patient volumes combined with the 18 on-call shifts I had done in the month previous. They asked if I had been studying for my cases in the OR. I reflected on the OR one day earlier, when they had asked me to describe the steps in a vascular groin dissection. Unfortunately, between exhaustion, fear of saying something incorrect, and

sheer intimidation, it all came out as "umm, possibly," and "kind of." Certainly not the definitive answer they had expected. I hadn't yet learned the art of bull-shitting my way through a question by answering with full confidence and arrogance. Even if the answer was incorrect, presented in this manner, often one could get away with it.

I finally responded to their question by stating that I had studied up on vascular a few weeks ago before the rotation had begun. The next question caught me off guard and left me astonished. The older surgeon asked if I was married, engaged or dating anyone. After a pause which felt like an eternity, I responded by saying that I was not currently involved in any type of relationship. He was so elated, and he exclaimed, "That's great because those things take away from the capabilities of female residents!" The other two doctors joined in with his chuckle, and I was then told that I needed to read up more for cases. The meeting was then over. I left and headed straight to the washroom. This was my haven, only the pager could bother me there. I cried, almost vomited, cleaned myself up and returned to the OR.

My next rotation was scheduled at another hospital where the Chairman of the Department of Surgery and the famed transplant team awaited me. On arrival at my new rotation, I met with the Chairman. He was a kind but stern old-school surgeon with traditional values. He stood tall and even with his advanced age, his red hair shone brightly in the glaring hospital lighting. I was told that I needed remediation after my last rotation, where the surgeons felt "they weren't sure if I was meant for general surgery." I wondered if that translated to the fact that I was a woman of colour and didn't fit with their stereotypes. This Department of Surgery could certainly use at least one female staff or even a single person of non-Caucasian descent—it was 1996 after all! I told myself there wasn't any point in assuming the worst and trod on. The ORs were not fun at all. The senior transplant surgeon was very famous—he was very kind to the medical students and his patients loved him. He taught only by identifying mistakes in the OR. The way he pointed out the mistake was by yelling, hitting, cauterizing or head-butting the operating surgeon. I was much shorter than him, so I was happy that the last option was not possible. I left that rotation with only one or two cautery burns on my hands, and I felt very fortunate to have learned so much from him.

My second year of GS residency was beginning, and once again I arrived at my next rotation under a high level of scrutiny. By now, most of the other residents were aware that something was going on. Interestingly, no resident or staff had addressed any concerns formally with me. What were the surgeons saying casually to the other residents, I wondered? I found myself feeling more unsure of myself, but only on GS rotations. The cardiac surgery team was thrilled with me after my rotation in the ICU, where they coached me through insertion of an intra-aortic balloon pump on the phone and didn't have to come in at night. I didn't even know what an IABP was! I had a great Orthopedic rotation, and, without me asking, they had offered to let me transfer into their program if I wanted.

With the usual stress of 100-hour work weeks, severe lack of sleep, and a deepening sense of loneliness, I began to think intensely about how this situation could be remedied. I reached out to the Post-Graduate Medical Dean, who offered no help or advice at all. He said it was an internal problem in the Department of General Surgery. I wish he could have told me that on the phone—it took 2 months to get an appointment with him. I obviously couldn't reach out to the Program Director or Chairman as both of them already had formed rather 'shallow' impressions about me. My co-residents didn't want to become involved and in fact, to this day, don't know most of this story. I really did enjoy General Surgery. However, I felt that the opinions formed about me in the first 12 months of residency were going to stick. I could not handle another 3 years of this kind of scrutiny, pre-judgement, and frank discrimination. So, I began to look elsewhere.

I contacted the GS program directors at 3 universities. Two programs were not interested at all. It only takes one yes . . . I interviewed there, gave 2 weeks of notice and 28 months into my residency, I switched to another GS program 8 hours away—far

enough that the surgeons didn't know each other at all. Far enough that their cultures couldn't be more different. There was some diversity, but no women. But there was no pre-judgement, violence, threats, or frank back-stabbing. That behaviour was not tolerated, even from the Chairman of Surgery, who left a few years after I arrived due to being socially outcast due to this type of behaviour. It just didn't fit! I began to meet more surgeons who were kind, truly interested in teaching and developing residents. I felt like a colleague rather than a slave. I was allowed to thrive under supervision. I worked hard to earn my stripes. Changing general surgery programs was the best decision I had ever made. The Program Director of this GS Program, although quite soft-spoken, had high expectations. His decision to allow me to transfer to this program essentially changed the course of my life. #HEFORSHE moment 1.

I went on to fellowship. My Program Director had advised against it—he felt I should go and work in the community—but I insisted, and he eventually supported me. In retrospect, he was right. The surgical group in my Fellowship Program were almost as tyrannical as the first residency program. I just couldn't learn and work hard for people who behaved like bullies and used the 'teach by humiliation' technique. I lasted a year and then felt suffocated. What was I to do now? I was a fully trained general surgeon with a year of fellowship as well. Surely I could find some work. I called around the hospitals near my parents' home, to which I was planning relocation. It only takes one yes . . . The Chief of General Surgery at one hospital was an old colleague of one of the surgeons I worked with in residency program #2. When I called, he said to come and meet him a week before I was to start. He asked if it was okay if I was put 'on call' the July 1st weekend. He and my old preceptor spoke presumably as a reference. I was hired as the first locum the hospital ever had. #HEFORSHE moment 2.

Four years later, the same Chief of General Surgery felt I should be hired full-time and, by shuffling OR resources internally, a new opening was created. I was hired as a full-time general surgeon. I was thrilled, as were my colleagues, nurses, family and friends. #HEFORSHE moment 3.

That was 18 years ago. In the interim, I have married, had 2 children, gained weight, and my hair has greyed. I currently am the Physician Lead for the Diagnostic Assessment Programs for Breast and Lung Cancer at my Hospital Corporation. I have served as the Site Lead for General Surgery. I have experienced events of disruptive behavior, lack of collaboration and frank disrespect from Division and Corporate Chiefs. We are all from the same surgical generation. These behaviours were reminiscent of Residency program #1. I was targeted for refusing to sign a statement agreeing to use only half a day of OPD time. All of the other, more senior, male, surgeons signed the agreement to get the Chief off their tails. I declined, as I felt it was not necessary and was not coming from the administration. Subsequently, I was removed from a complicated ICU case and asked to step down as Site Lead. Through all of this, my immediate Division Chief supported only the CC so *she* would not suffer any personal consequences. *She* knew the CC was behaving unprofessionally but would not stand up to him. *She* supported him fully. Interestingly, both were removed from their positions within the Organization by the next Corporate cycle. #TimesUp moment 1.

Reflecting on all of these events over 25 years, a few thoughts come to mind. I wonder if my residency had been 2005-2010 rather than 1995-2000, would things have been different? Maybe not. The culture of the organization dictates most what is expected of each individual. In the business world, culture outweighs strategy in its influence on the organization. Revelation #1. This was particularly true in the most recent example. I am happy to work in an organization in which disruptive, harassing behaviour is not tolerated. Furthermore, women do not always support women. Revelation #2. There doesn't need to be a generational gap for bullying and harassment to occur. The power differential does need to exist. Revelation #3. Institutional discrimination continues in GS program #1 to this day. Program Director #1 has left and now holds a senior leadership position in a major accreditation

organization despite the program being on probation more than once during his tenure. This cannot continue. Sexism, discrimination (both open and disguised), misogyny, disrespect, and bullying have no role in the training or practice of medicine. *Time is up.*

Aggressive

Anji Wall

"The other faculty members don't think that you are aggressive enough to train with us." This is what my mentor shared with me in confidence when I did not match at my first-choice residency program. I was crushed. I could not understand how aggressive behavior in surgery is considered a positive personality trait. Moreover, as a champion athlete in college *and* medical school, I knew that I could be aggressive in appropriate settings. I had never considered that a hospital or operating room was a place where I should be aggressive. The term aggressive means ready to attack or confront, and it is synonymous with hostile, belligerent, and antagonistic. How, I wondered, could being aggressive be a desirable trait for a surgical resident? Reflecting on my journey so far, I think that the answer to this question lies in the culture that has been created by—as Joan Cassell states in "Doing Gender, Doing Surgery: Women Surgeons in a Man's Profession"—the 'adrenalized vocation' of surgery that values arrogance, courage and decisiveness.

When I rotated at my first-choice hospital, it was everything I'd dreamed of in a surgical training program: intense cases, prestigious research, and teaching rounds with rapid-fire questions that ranged from surgical history to postoperative care. What I didn't notice at the time were the toxicities I'd been conditioned to see as normal. Abrasive, tough surgeons ruled the program. Their hierarchical culture left little room for collegiality. Attending surgeons reigned over the operating rooms, where they had permission to behave how they saw fit: verbally assaulting nurses, scrub technicians, anesthesiologists, and residents. Broken or undesired instruments were thrown to the OR floor for any reason. This behavior was not universal, but far too prevalent and obvious to excuse as one or two bad actors. The operating room culture accepted unprofessional, unkind, and unbelievable behavior as the norm. While my rejection was devastating, not matching at my first-choice program turned out to be the best thing that could have happened to me. The residency program that I did match into valued and promoted attending surgeons and surgical residents who were entirely different. The administrative chief resident's orientation lecture entitled "This is how we roll" outlined the first two rules of surgical residency: Be Nice and Respect Others. We were informed that the annual Emergency Room Consultation Award was a coveted honor for surgical residents. The emergency room residents selected the surgical resident who they determined performed the most timely, respectful, and helpful consultations. Beyond expecting me to become a competent clinical and technical surgeon, my residency taught me that I must also embrace collegiality and kindness. Being confrontational in the OR, ER, and wards was a detriment to patients and not an essential ingredient in excellent care to patients. Such care is best achieved when we work together with respect and lift each other up.

When I left residency for transplant fellowship, I had grown accustomed to the collegial team-centered culture of residency. I thought that I had chosen a place that had a similar culture, and I was so excited to spend two years gathering amazing technical training with staff who would build my surgical career. There were smooth cases, and I made some good relationships, but I can't ignore the fact that parts of the experience were unnecessarily abusive. There was a superficial collegial relationship among the staff and toward the fellows, but in the blink of an eye, attitudes would shift, and normal interactions would turn into confrontations on the wards, in the ER, or in the OR. Artificial or real disasters loomed all around, and an unsuspecting

nurse, circulator, anesthesiologist, or I would become the target of a rampage. If these situations had happened daily, I would have known what to expect. But the whims of any particular surgeon felt random, and, early on, I was entirely unprepared. I had so many positive interactions, but the negative ones were so powerful that I still get chest pain when I think back to my fellowship.

By my second year of fellowship, I was getting more accustomed to the culture and had developed strategies to cope with confrontations. On one particularly busy day, I procured and prepared a liver and left my co-fellow to implant it with the attending. I left to round on our patients. When I returned to see if the liver implant had gone well, the attending surgeon greeted me with a slur of insults to my intelligence and my training. "Have you ever back-tabled a liver before? You clearly don't know what you are doing . . ." And then the attending turned to personal insults. In fact, I had back-tabled about 75 livers in the past year and had never been told that I was incompetent at that procedure. My heart sank, I got a lump in my throat and left the room in tears. I assumed I had irreparably damaged the liver or made the case exceptionally difficult or dangerous for the patient. I asked my co-fellow after the case what I had done wrong. He said that there was some bleeding from a short hepatic vein that they controlled with a single stitch. It was no big deal, took about 15 seconds to fix, and there was minimal bleeding. I absolutely should have been more attentive to this vessel. However, my relatively minor error did not warrant a verbal assault on my competence.

Later that year, my co-fellow was so burned out that he desperately needed a break and asked me to cover primary call on a weekend for him. It was my birthday, and while I was getting burned out myself and would have liked to have stayed home, it was important to me that we stood up and cared for each other. We had a pediatric liver transplant patient for whom the liver was procured elsewhere and shipped to us. I was the point person for communication with the organ procurement organization and was keeping tabs on the timing for organ arrival. This timing is critical for coordinating the flurry of activity in any transplant. We use it to decide when to bring the patient to the OR, ensuring the patient is not under anesthesia any longer than necessary, but also not rushed through any delicate procedures. The coordinator called me frantically because the courier had gone to the wrong airport and there would be a 45-minute delay in the arrival of the liver. I called the attending and asked about what to do. We did the math, calculating the distance from the arrival airport to our hospital, figuring that if we picked it up ourselves, we could save about 20 minutes. The attending was already in the operating room, the patient was stable, and I was told that the delay would not be a huge deal. In an effort to save whatever time we could, I was asked to call my burned out co-fellow to see if he could go pick up the liver. I did not have a car, and I could not pick it up myself. My co-fellow refused because he did not think that he would save much time. Left to tend to an uncomfortable conversation, I proceeded to the OR to talk to the attending in person. I explained that my co-fellow was not going to pick up the liver, and my attending turned on me. The stable patient from a few minutes ago was now inexplicably described as critically unstable. Looking at the monitors and labs, the patient appeared just as stable as he had been 5 minutes before. I was ambushed in front of the entire operating room staff. Everyone just stood there as I was berated for the unacceptable delay. In a sideways effort to stem the tide of anger, our physician assistant immediately volunteered to go pick up the liver, averting the dramatic, manufactured disaster. Attempting to maintain what dignity I had left, I walked out of the operating room, deflated and defeated. The attending anesthesiologist who witnessed the confrontation found me, assuring me that the patient was fine, and told me that no one should be treated like that. Despite being treated like garbage, I had to pull it together and spend the next several hours sharing the intimate space of the patient's abdomen, doing an incredibly intricate procedure with the attending who had railed on me less than an hour before.

The behaviors described above and others that I experienced in fellowship perfectly characterize the aggressive culture of surgery. As a fellow,

I struggled to learn in the environment of toxic surgical personalities. I was constantly on edge. Before long, I was anxious about every part of my job: rounding, communicating with attending surgeons and operating. I questioned my abilities and my desire to be a surgeon. I honestly hated being in the operating room, which had been my absolute favorite place to be during residency.

The unfortunate truth is that my story is not unique. The behaviors are not shocking to anyone who has interacted with a surgical trainee, and my experience is not specific to women trainees. Other surgical trainees, both men and women, have been subjected to worse treatment, longer hours, and more egregious abuse. A residency friend described her fellowship experience as "becoming her worst self."

In the end, I made it through fellowship by putting my head down, ignoring the aggression, operating in silence, and avoiding interactions that were not necessary for patient care. Ultimately, I got outstanding technical training and landed a dream job with phenomenal partners and a team-oriented approach to patient care in all areas of the hospital. But I accomplished that *in spite of* being beaten down for two years, not because of it. I could have left fellowship with exceptional training, a sense of self-worth, and a love of the operating room.

As surgeons, we must create a culture of zero-tolerance for abusive behavior in and outside of the operating room. We cannot continue to value the aggressive, arrogant alpha-male. We cannot treat technical excellence as a hall pass. No one is too good to be kind. The circle of workplace violence needs to stop with us. Accepting a toxic environment because a surgeon or group of surgeons are technically excellent is not acceptable. No one surgeon or surgical group should be considered so valuable to an institution that they are allowed to poison it from the inside.

The best surgeons I have worked with are not only technically competent, but they are also collegial and calm. They recognize the value of every person in the operating room, treat them with respect, and gain respect by instilling confidence rather than fear. They are able to manage emergencies with coordinated teamwork rather than chaos. This story is not as much about how my gender affected my training in surgery, but about my experience in a culture pickled in toxic masculinity. The 'adrenalized' vocation of surgery has allowed some surgeons to become kings and act like toddlers because they are strong, aggressive, dominant leaders.

The increasing number of women in the surgical workforce creates an opportunity to change. I believe that women bring a balance to surgery that encourages communication, holistic care, and teamwork, and our presence as leaders in the operating room, surgical administration, and resident education will force a culture change. Now that I am in the driver's seat as an attending surgeon, I vow to live by my chief resident's rules of surgery: be nice and respect others. My trainees will not only be technically excellent surgeons, they will be kind, respected for the way they treat others, and they will love being in the operating room!

The Other

Sabha Ganai

> *"From Maximus, I learned self-government, and not to be led aside by anything; and cheerfulness in all circumstances, as well as in illness; and a just admixture in the moral character of sweetness and dignity, and to do what was set before me without complaining." —Marcus Aurelius*

Surgery is an act of harm—an injury that is performed with good intentions, counting on expertise, diligence, and faith that the patient will ultimately heal with a better outcome. Critical to informed consent is establishing the doctor-patient relationship—a bond founded on trust, a trust forged through conversation, encouragement, coaching, and connection. I have given a lot of thought about what it means to fight for your patients. However, when I became a surgeon, I

never thought I would be put into a position where I would need to battle members of my own team, individuals who had never developed a relationship with my patient as an awake being. I had assumed that the surgeon had authority within her operating room, but I learned I would have to police myself, keeping a pleasant tone to appease those in the room while not backing down on maintaining standards. I will recount one lesson I learned about how surgeon mistreatment can be the sequelae of a struggle for power. This is a case of a conflict of commitment where a deliberate choice is made to impose disparate values of team members over those held within the fiduciary duty and expertise of the surgeon to honor the patient.

My dispute started with "Bob," a surgical technologist, or "scrub tech," a team member whose duty is to maintain sterility and support the surgeon with instruments, sutures, and supplies needed for the safe performance of a procedure. I was taking care of a patient with a large pelvic tumor that had a gluteal component, a sensitive threat as she literally did not recognize what she was sitting on until the outer portion grew to the size of a cantaloupe. After much discussion, we charted a course for radiation followed by resection, diversion, and reconstruction. In the operating room, I coordinated with the circulating nurses the borders of a fairly wide field to prep and then my resident and I exited the room to scrub. After gowning, I acknowledged Bob and took a few towels to start draping the perimeter of the field.

I turned around to find Bob was blocking my path, arms folded. "That is not how Dr. C drapes," he declared. I took a pause to understand what he meant, as Dr. C was a local private-practice surgeon, and while technically not one of my partners, was someone whom I respected. I replied with whatever humor I could muster, "I would hope not, I don't think he does these cases—and he's not on the consent." Bob did not budge, and I sidestepped his blockade. I mirrored his body language and crossed my arms as well. I gave him the benefit of the doubt and asked him to tell me his way of draping, which involved cutting through a paper drape, and I tried to reason, "Unfortunately, this is a sarcoma, not rectal cancer. We prepped much wider than an APR, and I do not want to contaminate the field." I held out my hand, yet Bob continued with a silent attempt at intimidation.

I thought about grabbing the drapes from a scrub tech who was hijacking my case and attempting to practice medicine, but backed down knowing I would get reported for being a belligerent 'nit-picky' female, or in gender-neutral terms, 'detail-oriented.' Instead, I sighed, "Look, this is a long case that hasn't even gotten started . . . Plastics will be operating till tomorrow if we don't . . ."

Before I had even finished my sentence, my chief resident, a man, took the drapes from Bob, and immediately handed them to me in deference. We draped, proceeded with our time-out, and started our dissection. Several scrub techs changed hands during the course of that case, but as I was in a state of flow, I let Bob go.

A few sarcomas later, I took care of a man with a 15 cm tumor near his groin, a large mass overlying his femoral vessels. We had a similar plan for radiotherapy, followed by resection and reconstruction. In advance of the procedure, I asked my plastic surgery colleague if she would be available earlier in case I needed help with nerve monitoring. I also requested a vascular tray, a set of specialized instruments, to be available. At another hospital at which I worked, I had team consistency and the vascular tray was laid open before me with every instrument displayed on a separate table. At this hospital, I was by now used to a constant battle to have the tray open and ready when I needed it because it required more time and effort for the scrub tech to count the instruments.

When I walked into the operating room, I saw Bob and spoke with him about needing the tray opened. Bob replied that it was taken care of and pointed at the tray in the corner of the room. It was there, sterile, closed, and not counted. He was not much of a conversationalist, and he implied that he was busy and would get to it. He went on to organizing other instruments, so I went on to positioning and, after readdressing the need for these instruments in our time out, proceeded with starting the operation.

The resident and I spent time tediously dissecting a margin from the tumor and slowly rolled it over, exposing branches of the femoral vessels that we meticulously tied. When I asked for a Satinsky clamp from the tray to be ready, recognizing a larger venous branch, Bob then made an unexpected excuse that the tray was intended for the Plastics portion of the case and that I couldn't have it. I sternly reiterated that I needed it and he did not respond. Around that time, Dr. P, the plastic surgeon, walked into the room to check on the timing of her portion. Unfortunately, her presence did not change the power dynamic in the room, which included me, Bob, a female resident, a female circulating nurse, and a female nurse anesthetist. As I continued dissecting, I got into a little bleeding from the vessel I meant to clamp, so I held pressure and proceeded to ask for the clamp again. Bob and I made eye contact, then he pointed to my left shoulder, which had a stray curl of hair coming from under my bouffant hat. Bob demanded that I put on a sleeve as my shoulder was contaminated. I explained to Bob that my left hand was sealing the levee, and I could not move it. Bob and I were at an unfortunate impasse.

I then turned to look straight at the nurse anesthetist who was standing behind the drapes at the head of the bed. Raising my voice, I stated, "We have a choice here between dealing with massive bleeding from this tumor versus redosing antibiotics—I want you to call your attending in—*now*!" In a moment of realization of the implications of what was going on, the clamp was immediately given to me, my finger was removed, and torrential bleeding did not happen. I immediately looked back at Bob, and without emotion said, "I'll take a sleeve for my left arm." The sleeve, of course, did not reach my left shoulder, but I diligently complied with his concern for patient safety. Bob left, flustered, for his break, and my concentration remained focused on getting that tumor out rather than getting distracted by trivial power struggles.

My resident, the female one who was assisting me, wrote a memorable faculty evaluation critiquing my conduct with Bob, suggesting that I should become more like a few of my male trauma colleagues and learn to ask for things without raising my voice. I read this in all seriousness, but then smiled at her naïveté, then laughed, because I absolutely hate raising my voice, but recognize very well that I am often not heard unless I vocalize louder, slower, and with a lower pitch. I reminded myself that at this particular hospital if I were one of my white male trauma colleagues, there would be no uncertainty that I would have a functioning team. There would be no insubordination. If they needed an instrument, they would be given it without hesitation. I have been criticized by staff for asking the residents too many questions while teaching ('she must not have known what to do'), for doing cytoreductions that last into the night ('she takes too long'), for aborting cases with unresectable tumors ('she wastes our time'), for not asking for help ('she's too stoic'), and for asking for help ('she is too needy'). Yet, for all this, I wish I simply had my orders followed without a request to do things another way.

Within the medical environment, over half of nurses have been subject to "lateral violence," a phenomenon where health care workers transform the workplace into an environment of bullying and deliberate victimization of individuals, often through subtle and repeated acts of aggression. The Institute of Medicine has taken workplace violence seriously as it has a direct link with patient safety, and the Joint Commission recognizes that in addition to newly-trained or unmarried female nurses, female physicians are often targeted in hospital settings. The bizarre notion that female surgeons could be subject to a skewed form of hierarchy in the operating room does not feel right, but is supported by data where female attending surgeons perceive less psychological safety than female surgical residents, the opposite of the finding for male surgeons who continue to grow in confidence when they become attendings.

When it came down to discussions with administration about inappropriate words and behaviors I was soon facing from numerous individuals, male and female, I was not surprised when it was dismissed as an issue with interpersonal communication. They told me I was called a "bitch," and this was condoned as acceptable within a professional

environment since I unknowingly insulted a circulating nurse by spelling out the name of an instrument I requested but they couldn't locate. The word, "bitch" of course, is a term reserved for women surgeons—we must recognize that we will be perceived as hostile when we use agentic communication, when we ask for things and give orders with the pressure of time—something surgeons are required to do in order to take care of their patients.

During my surgical residency, I did not recognize a problem with gender and surgery. I had become one of the boys, and I was proud and emboldened as I perceived myself as an equal and competitor amongst a hierarchy of brothers. It was a time when I was unable to connect with women surgeons because I did not see them, and like my resident, I judged them harshly when they were not treated with respect. Unfortunately, as we train more women and minorities to become surgeons, we still have not worked with the establishment to change a culture and system that otherwise supports discriminatory treatment directed at them and their patients. I now hold the banner high that women and minorities who become surgeons are full of grit and compassion and an ethos of excellence, and I want to hear more about their struggles and celebrate their triumphs.

Institutional culture is determined by implicit norms that drive team behavior. It is hard for any one person to dictate culture, but through influencing the process and design of teams to value diversity, inclusion, and open discussion of our vulnerabilities, we may be able to reset our collective priority back to helping patients and limit healthcare worker burnout and attrition. With great optimism, I see men and women in medicine, those individuals who honor a fiduciary duty to serve their patients, as the best-equipped professionals to regain control of institutional culture in healthcare settings, which is moving away from caring for people and closer to commanding, controlling, and profiteering. Our patients deserve better, and we deserve better.

Making the Most of Opportunity

Elizabeth H. Stephens

In part I'm named after my paternal grandmother, Helen Elizabeth Stephens, and in many ways, the name was very apt. If I had one word to describe her, she was determined—fiercely determined. She grew up in St. Louis, and while the boys in the family were allowed to go to college, that was not an option for her. Not deterred, she paid her way through art school, and in the midst of the Depression was a working woman selling furniture and then running her own gift shop in a time and place where it was very difficult for anyone to earn money let alone a single female in a society where she "should" have been married and at home producing children.

She traveled to New York City and San Francisco on buying trips, and purchased her own car; she must have been quite the sight driving around St. Louis.

She eventually married a physicist and life took them to Philadelphia, where my grandfather became a prominent leader in the field and Dean of the University of Pennsylvania. My grandmother, when not painting or selling her art, was an organizer, heading the local library board, a founding member of the University of Pennsylvania Women's Club. Her dogged independence and perseverance continued as she aged and her husband passed away. She kept on with her hobbies, ice dancing every week until 95 when her ability no longer met her standards, climbing up on ladders to prune her pear tree when she was nearing 100, and continuing to travel to exotic places to explore and paint.

My grandma "Stevie" and I frequently chatted, and as I became interested in medicine and ultimately congenital heart surgery, she would always say, "Isn't it wonderful you love what you do." I may have been complaining about how sleep deprived I was, or how everyone thought I was a nurse, but her comment redirected my thinking: I was so lucky to have the opportunities I had. Just two generations ago, she didn't have the opportunity to pursue her academic dreams, but,

undeterred, she had forged another road for herself. I not only had an opportunity to go to college, but also to get a PhD, become a physician, and even become a cardiac surgeon. My grandmother passed away before I started residency and the real rubber hit the road. I had no idea the types of challenges I would face and need to overcome, but I am forever thankful for her perspective. I would draw on her example as I faced the travails of being a minority in my field and institution.

The various episodes of discrimination and bias I experienced are not unlike other females pursuing cardiac surgery as the lone female in their department. It was a daily feeling of having to swim upstream against a strong current in an open ocean while others swam in an indoor pool with no current at all. While the manifestation of the bias varied from day to day, it was fundamentally my life's path disrupting people's notion of who a cardiac surgeon was.

The point is not the specifics of what I have experienced and continue to experience, but learning how to respond. I had a decision to make: either become bitter about how what I was experiencing was unfair and made my road so much tougher than those around me, or make a conscious decision each time I experienced one of these situations to let it roll off my back. I could bemoan my plight, drown in self-pity, or eat-away at myself with bitterness toward those around me, or choose to rise above it—just like my grandmother had. Interestingly, I only heard about how my grandmother wasn't allowed to go to college through my father, she never spoke about the opportunities she didn't have, but instead would speak of the opportunities she had created for herself. I am not condoning how I have been treated, but my experience changed when I made a conscious decision to not let others hold me down. Most of what I experienced I did not have control over, but I did have control over how I responded. As I thought more about it, the 80-year old patient who had just had a CABG and was recovering in the ICU didn't intend to insult me by asking me for water and assuming I was the nurse as opposed to the surgical fellow, despite "MD, Ph.D." clearly embroidered on my long white coat. He grew up in a different world, a world in which he never had seen a female physician, let alone a cardiac surgeon.

But here was the opportunity to be the change I sought. If I was the first female cardiac surgical fellow a nurse or patient or attending had ever met, I wanted to be a great one. I wanted to be excellent at my job, a team player, pleasant to interact with, and not dragged down or bitter because of what I was experiencing as a minority. I had an opportunity to inspire change by the way I acted and carried myself. Not that I was the perfect resident—far from it. I got crabby when exhausted, just like those around me. One time, after I had emergently opened the chest in the unit during a code, the bedside nurse asked me for my cell number. As I remember, I had been up all night, was exhausted, and assumed it was just in case there were further issues with the patient. I quickly agreed and she jotted down my number. But as she talked more, she said she had a daughter in high school who was considering medicine, and she would love if I could talk to her. My bleary eyes brightened and I, of course, said I would be happy to meet her for coffee or whatever could be helpful. That's who I wanted to be more often. Someone who could show others that it was possible for a female to be a successful cardiac surgeon despite the added baggage. And this is how I end up at coffee shops talking to females of all ages about what it's like to be a minority in cardiac surgery. Many of them may never pursue surgery or medicine, but I hope they see that they too can pursue their dreams despite their gender or minority status.

One insight that helped me along my journey was to realize and accept that I was different than those around me not just in my gender and appearance, but the way I may react to aspects of training. I may process a difficult case or an attending's words differently. This is not just my personality in the setting of the often macho, male-dominated world of cardiac surgery—such gender differences have been scientifically demonstrated across fields. To be successful in the field, I didn't have to conform to those around me. Acceptance of such differences then allowed me freedom to

find ways to cope with stress in a manner most helpful for me.

Over time, viewing how others have reacted to the #MeToo movement and even discussing with those around me my training path, I have realized that if you are not a minority and walking in my Danskos daily, it is virtually impossible to grasp what we go through. Even the males I train with, though they may occasionally notice the comments or actions of others related to my gender, don't have a concept of what it's like. This is not at all intentional, not a conscious decision to ignore what they see happening around them, but it can feel as if others don't believe our experience or the weight of it. And honestly, when one is perpetually sleep deprived and pressed by the immediate needs of pagers going off, emergencies we need to respond to, the endless checklist of being a good resident, it can be even harder for us as minorities to grasp or accept this added burden to our journey. In many ways, it is easier to try to just ignore it or push it aside, but reflecting on how our experience is different also validates our daily struggle and better enables us to process it and move beyond it.

With the advent of the #MeToo movement, I have noticed how attendings' attitudes have changed towards me. While many of the comments are in jest, I am concerned that the publicity and impact of the #MeToo movement may hinder males from investing in and mentoring females. I was the only female at my institution and all my attendings were male. The only way I was going to receive mentorship at my institution was from a male attending. If they are afraid that any comment or interest that they showed in my training may be misperceived and lead to some report to human resources, my training would have been detrimentally impacted. I was very lucky to have several attendings take an interest in my development as a surgeon, but I could tell after the publicity of the #MeToo movement, there was a hesitancy on the part of certain attendings that wasn't there before.

Our journeys as minorities in our respective fields are not all the same, and how each minority reacts to and copes with the resistance they experience is also unique. This is simply my story. I share it in hopes that it will help and inspire others. To sum up what I've learned—be the change you want to see and make the most of each opportunity!

Becoming a Role Model

Erica M. Carlisle

As a general surgery resident on an off-site vascular rotation, I rounded early to assure all dressing changes were complete prior to going to the OR. One morning, I entered the room of an 80-year-old patient status post debridement of a leg wound. The physical therapist had also arrived early that day, and he was working with the patient when I entered the room. MSNBC news was blaring on the television—reporters were highlighting the upcoming presidential election. "Oh honey," uttered the physical therapist to me and the two female medical students rounding with me. "We can change the channel to something more suitable for you girls—maybe a make-up infomercial?" Up to my elbows in topical antibiotic cream and gauze bandage rolls, I paused, stared at the therapist, and remained speechless. I was shocked that he had so blatantly disrespected my team and me. But sadly, the encounter wasn't unique. I said nothing and resumed the dressing change with little more than a roll of my eyes. I then packed up my supplies and left the room ashamed—ashamed that I hadn't come up with a snarky comment to teach this person that what he said was offensive, and even more ashamed that, in my silence, I had taught the students that tolerance of such remarks and attitudes was acceptable.

Years have passed. I am now a pediatric surgeon. Throughout my professional life, I have made a calculated, specific effort to select both training programs and faculty positions in departments of surgery that truly support egalitarian principles, and I consider myself to have been successful in

this endeavor. I have been markedly impressed by the chairs of surgery and division chiefs' efforts to promote the success of women in their departments. Despite these efforts from the top, I have been disappointed to find that this egalitarian spirit rarely permeates all layers of these great institutions. Sadly, I have been reminded of this early morning dressing change numerous times along my journey when I have encountered similar exchanges. I am grateful that my criticisms pale in comparison to those of many of my female colleagues or many women who underwent surgical training in the decades preceding mine. However, while the individual examples may seem trite, I think many can agree that the repetitive nature of these micro-aggressions is simply exhausting.

Throughout my training and career as a pediatric surgeon, I have been required to respond to all critical pediatric traumas when on-call. Parking near most institutions is at a premium, so the trauma surgeons are often asked to park their vehicles in locations typically used for other purposes. Late one night, prior to my arrival in the trauma bay, my resident called to notify me that the ED physicians were having difficulty securing the airway of a child who had recently been in a motor vehicle crash. Just arriving in the ED parking lot, I promptly parked my car and walked quickly through the ED—ID badge in place. While I heard someone shouting "ma'am" meters behind me, my attention was focused on rapidly arriving at the patient's bedside. It was not until a paramedic walking in front of me suggested that the shouting security guard was shouting at me that I paused. I turned around and was met with gruff requests to account for my parking spot utilization and extreme surprise when I explained that I was the trauma surgeon on call. After assisting the guard in lifting his jaw from the floor, I wondered whether a male surgeon would have been shouted after and forced to explain himself in such a manner. Perhaps so—parking can be difficult at large academic institutions—but while I have had many conversations with female colleagues about the need to explain themselves when they enter a room, my male colleagues have never expressed such a concern. The episode continued. After assuring the patient's airway had been secured, I helped transfer the patient to the CT scanner only to be asked to move aside by a radiology tech as I was deemed "too little" to help move the patient. I uttered my standard response to this statement, "I'm bigger than I look," and continued to help move my patient. Walking back to my car after the patient had been safely transferred to the ICU, I wondered why such statements are thought to be acceptable. Likely, the radiology tech would not have told someone that he or she was "too old" or "too overweight" to complete a task. Given the frequency with which I have been told I am "too little" to participate, I am fascinated with why this is different.

The operating room is often a more controlled place to work than the trauma bay, although, despite the tremendous progress that has been made in OR culture over the past several decades, I am often surprised at the struggle to maintain gender neutrality in the OR. For instance, I have no male colleagues that have had attending providers stand closely behind them with a hand resting on the small of their backs to whisper the anesthetic plan in their ears, although many of my female colleagues have experienced similar efforts at multidisciplinary communication. Although less overtly offensive, I can recount multiple other instances that impact efforts toward gender inclusion and neutrality in the OR. For example, my pediatric patients are often mandated to receive gender-based pink or blue cling wraps for their IVs. An occasional anesthesiologist persistently seems shocked when I refer to my husband (also an anesthesiologist) as my "partner" rather than my "husband," and I was once told by a particular male staff member that I am a better doctor because my husband is a physician. While I credit my partner for making me a better person in a multitude of ways, I think my successes and failures in surgery are much more related to my thirteen years of training and dedicated study than to my partners' professional status.

I am also quite frequently frustrated when I enter clinic or pre-operative rooms only to find surprised faces from parents when I introduce myself as the surgeon. I've developed charming responses to the question of when they will see the "doctor" and

entertaining approaches to regain control of the room when they turn to my male chief residents to summon clarity or confirmation. I have bitten my tongue numerous times rather than expressing my sincere hope that 25 years from now when their daughter enters the room as a surgeon, CEO, senator, or some other professional that has in the past been typically held by a male, she is not met with such apprehension.

In each of these encounters, what worries me most is not the impact of these acts on my own psyche, but rather the impact that my responses have on the trainees that are in the room with me. Much like my encounter with the physical therapist during that early morning dressing change a decade ago, I worry that even an occasional failure on my part to clearly and confidently address these issues serves to promote tolerance of such attitudes. Yet I struggle with which battles to pick, recognizing that failing to acknowledge teaches tolerance but "overreacting" may minimize the message. Sadly, evidence of this tolerance is readily apparent. I see it when the medical student on my service responds to congratulations from faculty for an excellent presentation with statements that her husband, a chief resident, came up with the idea, or when my chief resident credits her successful fellowship match to luck rather than her own hard work and record of excellent performance.

Such interactions prompt me to reflect upon my position as a role model and how I often feel rather underprepared to excel in this role. I attribute much of my professional success to the excellent mentoring I have received throughout my training—from my undergraduate senior thesis advisor to the pediatric surgeon who inspired me to pursue training in the field to my research advisor as a surgical resident, to my current surgical partners—my career has been shaped by the outstanding people with whom I have had the opportunity to work. But the majority of these people have been men. While they could demonstrate many of the leadership skills I needed to develop, they were simply unable to model how to respond to some of the issues I have mentioned because, quite frankly, they have never been faced with such concerns. When I entered residency, there were relatively few female faculty on staff in my department. This changed remarkably over time, given persistent efforts on the part of surgical leaders, and during my fellowship I was excited to work for a strong female division chief. I have since appreciated the ever-increasing opportunities to engage in directed, purposeful mentorship through both local and national societies. I have no doubt that this targeted approach to mentoring will help me develop into the role model that I hope to become. I just hope this happens before too many other female medical students credit their partners with their success, too many female residents are told they can't help because they are "too little," or too many little girls in my operating room can't be taken to the recovery room without pink cling wrap around their IVs.

They Can't Stop the Clock

Amy Stewart

Starting surgical residency was a dream come true. I had a vision of residency where we would work as a team and learn from engaged senior residents and faculty. I would work hard but be rewarded with increasing responsibility, knowledge, and respect. My residency class was three women; 100% women! We met before orientation and became fast friends. Then reality hit for all of us. Day 1: '1 in 3 women drop out of surgery. Which one of you will drop out?' was the welcome we received from a male senior resident, 'You aren't women here, you are surgeons,' and 'I better not see any pink around here,' said others. I thought it was an initiation and laughed it off. This could not be real, but it was.

From the very first week, most of the senior residents treated us like unwanted stepchildren who could do nothing right. Mistakes were not tolerated. I was on my own as soon as orientation was over. There was no constructive criticism or education,

just berating and public embarrassment. One senior resident would anonymously textpage with a list of missing orders or other perceived missteps from call. Others would wait until rounds with the attending to ask about missing information, as to embarrass us directly in front of the faculty. This was counter to what I had seen in my medical school rotations, where senior residents would shield junior residents and give support should the intern falter. We were expected to know everything without instruction. Information only moved uphill, so as interns we were the last to know but the first to be blamed. It would have been more helpful to discuss why an order was needed or why a different decision would have been better. I quite clearly remember, as an intern, caring for a traumatic subdural patient on a blood thinning medication who needed rapid medication reversal. I was alone in the emergency room caring for this patient when the nurse said she could not run the blood product needed to reverse the medication as fast as I requested. In my inexperience, I believed her. When the patient decompensated a short time later, I called my senior for help. They were furious that I had not managed the patient properly. With some mentoring or a more welcoming environment, I may have had the knowledge needed to push the nurse for faster administration, or would have been able to reach out sooner to my senior for advice. Instead the patient died.

"Call me if you need me, but you better need me if you call," was a common refrain. The chief residents were only seen if there was an operative case or if their favorite faculty were rounding. The mid-levels were only available if you needed to be supervised, which was accompanied with comments such as 'I can't believe you're not signed off on this yet.' Otherwise, you were on your own to cover; consults, floor patients, notes, orders, call faculty or consultants, and overnight coverage of four general surgical services, cardiothoracic surgery, trauma, vascular, and neurosurgery. Additionally, we were responsible for a full lineup of cases every day, even post call.

Never mention duty hours—it made you look weak. We would regularly be called into the office to "correct" our duty hour sheet to get the numbers under the required 80 hours per week. This bothered me because, even though I only logged my hours from the public schedule and not what I actually worked, I was scheduled for more than 80 hours a week. I was already bending the rules by not logging my actual hours worked, now they wanted me to go even further and log less than I was scheduled. We stayed until the work was done, usually late, despite our duty-hour logs that said we left promptly on time. These heavy schedules and late nights caused issues for our home life. During our five years of training, there was one new baby, three weddings, and two divorces between the three of us. I had a school-aged child. There was no room for motherhood in our program. I left a little early to take my daughter to an event once and the senior called and made me come back to sign out in person.

The behavior from the senior residents was learned from the top, faculty were just more subtle. I was not spoken to unless absolutely necessary. There was no friendly banter on rounds or in the operating room like they did with the guys. I just received judgment and criticism, or worse, silence with no feedback at all. As an intern, I had an attending that refused to talk to me on the phone. If I called to staff a consult, he would yell at me, 'find me someone who knows what they are talking about' and hang up. Another one said that he does not learn intern names, and only learns their names if they made it to second year. Even socially, my classmates and I were excluded. Faculty would invite the guys for drinks, golf, and boy's nights. I never saw the inside of a faculty member's home, except for department events where everyone was invited.

As time went on, it became clear the male residents were given leeway in their behavior and progressive responsibility in the operating room. The women were chastised for being too aggressive and were not trusted with even the most basic of cases. The male senior residents would waltz into a trauma, set up shop in a corner chair and bark out commands at everyone, then disappear. They would walk away after a bedside procedure, leaving a mess of sharps and supplies; they would rarely get calls from staff because they would regularly scold

the caller for calling; they would take the entire team on circuitous routes on rounds to units we did not even have patients, to ogle the best-looking nurses. These behaviors seem to have no adverse effect, and they were even praised for their leadership and control of the situation. No misbehavior was tolerated from the female residents as we were continually called to the program director's office for seemingly benign interactions and incidents. When the female residents oversaw traumas, we were scolded for being too bossy and aggressive.

I once upgraded a trauma consult to a trauma activation when the patient began decompensating. The senior was furious. I should have handled the decompensating patient myself. After bedside procedures, we would be written up by nursing if we did not leave the room clean and perfect. In the operating room, the male residents would earn progressive responsibility. They would position the patient, start the operation, and perform as the primary surgeon. Operating room responsibility was stagnant for us. Faculty would position and re-position the patient, even if what we had already done was perfect, and rarely let us take the role of primary surgeon. Even on small cases, the attending would lead, not giving us a chance to prove our skill. During a senior level thoracic surgery rotation, I was told not to position the patient, the attending would do it himself. He then proceeded to do the entire case while I held camera, despite the fact I was a senior resident who had done many of these cases during my five previous months of thoracic surgery, and a few days prior, I saw him let a male junior resident position the patient and perform the case as the primary surgeon. This lack of autonomy was not restricted to me. After my classmate had her baby, she was relegated to retractor holder for the remaining time in residency, and she was given little autonomy from our mostly male faculty.

I thought as we became more senior, things would improve. The opposite was true. We became targets of a few faculty who actively tried to have some of us removed from the program. Mid-residency we had a new attending who decided I could do nothing right. I was the first resident to have a rotation with him. His trauma rounds could take more than six hours, frequently until late afternoon. Staff members who rounded with us—social work, chaplains, etc.—put a time limit on their participation in rounds so they could leave and complete their daily work. He would not let me leave. Critical patients and urgent procedures had to wait until rounds were complete. I kept his evaluations of me because of the contradictions in his requirements. I needed to use a computer on rounds to provide the level of detail he wanted, so he wrote, "Insufficient knowledge of discrete patient are issues." Apparently, I should be able to recite all information from memory for the Intensive Care Unit (ICU) patients. "ICU resident should see 6 patients in 90 minutes," "Preparation should be complete for rounds at 7:30 am," and there should be "2 ICU and 2 floor residents." However, this made no sense. This was July, so the trauma ICU could have 15–20 severely injured patients. I had to have all patients ready for 7:30AM rounds, not just six. There was only one ICU resident: me, and 1 floor resident: a brand new orthopedic intern, scheduled that month, not two ICU and two floor. I was not responsible for assigning the number of residents on the service. The requirements he had were impossible, and the math did not work. If I came in early to get work started, or stayed late to complete my tasks, he wrote "deficiency in compliance with duty hour regulations." Even voicing my concerns to him and others were documented in my evaluation as "deconstructive discussions" and "criticizing or complaining." I had never seen patient care done this way, and I thought he was dangerous and a threat to the patients' well-being. (I still do.)

I was not the only one with this feeling, as half of the trauma ICU nurses quit because of him over the first year. I spoke with the director of education and human resources outlining my concerns early in his tenure. Initially, they were supportive of my concerns, but he would openly criticize us at faculty meetings and over time the original support from the education director turned to comments such as "maybe you are a bad resident." This level of disrespect and degradation of your reputation wears on you. It was an institutional form of gaslighting. They made me feel crazy and destroyed my reputation, despite my valid concerns.

Please do not misunderstand—it was not all bad. When you are in the thick of it, you do not realize

how bad it is. This narrative is a 20/20 hindsight realization. My classmates and I stuck together and helped each other through, and women are resilient. When my classmate had a baby, we covered for her without hesitation. I made many friends at the hospital who were very supportive; always there for a reality check confirming what was happening was crazy and we were justified in our outrage. I was assigned a mentor (our program did not regularly have mentoring) because of my perceived failings as a resident, which turned out great. He would listen and helped me navigate the complexities of our program. There were several very supportive faculty—one even told me, "You will be fine once you are out of here." We pushed through. All three of us graduated from this residency program, battered and bruised, but with the training we needed to have successful careers. We have all gone on to become great surgeons, respected by our patients and colleagues. Our refrain when things got bad was, "They can't stop the clock." Residency one day will end, and we will get through this, and no one can stop us. Despite the failings of my residency, I succeeded, but imagine what I could have accomplished in a supportive program that worked for women instead of against us.

The Gold Watch Game

Jan B. Newman

I was looking forward to resuming surgical rotations after spending a year in the research lab. We still had to take call and cover service while in the lab. Despite my protestations, I had been relegated to the SICU for every third night and every third weekend for the year. Other research residents had gotten the choice assignments of covering junior resident surgical call. They got to operate while I got to put in central lines, a-lines, replace tracheostomies, and take care of post-op hearts. My operating was restricted to research animals. I suspected that it was because I got on the wrong side of Pricilla*. Pricilla was the only female surgery attending, and she was in charge of resident assignments. I discovered Pricilla didn't like me, and no one would override her.

My suspicion was this had to do with a problem that had occurred my internship year. I was on the neurosurgery rotation when a medical student on her clerkship, Juanita*, came to me appearing frantic. The chief resident, Joe*, had demanded she accompany him to radiology to check CAT scans on patients. It was the weekend and radiology was a ghost town. With no one around, the chief resident proceeded to grab Juanita and began assaulting her. She escaped but was clearly traumatized. I told her to stay with me and not accompany Joe no matter what he requested. She should make sure there were people around wherever she went. I would report the situation to Pricilla the following day.

The next day I went to Pricilla and told her what had happened. She responded, "I have forgiven Joe a lot because I thought he was a good surgeon."

After recovering from stunned disbelief, thoughts whirled through my head. "Joe, a good surgeon?" "Forgiven Joe a lot?" Had he done this before? It was okay to assault a student. Joe had done two wrong level laminectomies in the last 2 weeks, so no, he wasn't a good surgeon. He was a jack ass.

"Don't go there," I told myself, it is irrelevant.

"This is a significant problem. Something needs to be done. His assault is criminal behavior. I have a med student who is terrorized." I said.

I watched Pricilla's expression. "Thanks for letting me know." She said. It was clear the conversation was over.

I left Pricilla's office, disillusioned. I was going to have to tell Juanita that I was unable to get a suitable response from Pricilla. I didn't know if she would take any action. If Juanita had any other channels, she had better use them. After that interaction, Pricilla and I interacted as little as possible. It was clear our value systems were significantly different. It was always rocky when our paths crossed. We had vastly different views on patient management. I turned out to be right in a couple of dicey situations, which infuriated her all the more.

Fourth year was comprised of four three-month rotations in which we served as chief resident on the service except for the 3-month stretch on general surgery where we were the senior resident. They were Pediatric, Transplant, Cardiothoracic, and General Surgery. General Surgery was last for me. Case volume on these services was unpredictable. As a surgery resident, I wanted to operate.

My year began on a service advertised as having a new hotshot attending. The service began well. We were busy, and I was getting along well with the new attending. It was almost as if I could do no wrong. He was letting me do most of the cases, and there were lots of anastomoses to sew and other delicate procedures. He was to be the attending for my entire 3-month stretch. There were a few cases that I was allowed to do independently, which was generally a signal of the attending's confidence in one's performance. He was full of praise, and our patients were doing well.

That lasted a month. The change was subtle at first. He showed up in the OR as I was closing and came behind me ostensibly to look over my shoulder and discuss post-op care. There was physical closeness, but that wasn't all that unusual—one surgeon peaking over another's shoulder. We sat together at Grand Rounds and M&M (morbidity and mortality) conferences as was the custom. Over time the physical closeness started to extend to these settings . . . an unnecessary leg contact, a hand not on the shoulder. I knew he was married and had several children. I wasn't happy with this turn of events. He suggested he come over to my apartment to discuss some cases. I suggested that wasn't a very good idea. "My apartment is a disaster area," I said. There was a shift in the energy coming from him. It took on a decidedly sexual tone.

What was I going to do about this? Was there anyone I could talk to about it? No, not really. Pricilla had clearly shown her stance. I decided to ignore it. Perhaps he would stop if he felt I wasn't interested. The service was busy, and I was getting little sleep. The last thing I needed was an affair with this guy. Stopping was the last thing he had in mind. The colder I got, the hotter he got. I decided I had to confront him.

I went to his office when I knew he would be there. "Hi Dr. H, I wondered if we could talk for a moment."

"Sure, come on in," he replied.

I walked in, partially closing the door behind me. "I may be reading this all wrong, so forgive me if that is the case," I began. "I don't want to be misinterpreting things, but I am a bit concerned about the nature of your physical gestures. I think it is important that we keep our relationship entirely professional."

"Of, course," he replied. "Where I was before, one of the fellows and the chairman were having an affair. It was uncomfortable for all of us."

"Thanks," I replied.

"What time do you want to round?" he asked.

"How about 4?" He nodded his affirmation.

"Wow, that went well," I thought to myself.

The following day in the OR, I had prepped and draped the patient as I always had. The same way he had wanted it for the last six weeks. That day was different. "That isn't how I drape my patients," he declared, tearing away the drapes. "Start over and do it right."

The nurses gave me astonished looks. We began over. It was exactly as it had been before.

Then we began the case. I made the incision as we had done before. "What are you doing?" he asked. "That isn't how I showed you to do it."

Then came the anastomosis, "That stitch is too far from the other one, the bite is too deep, it is too superficial, it is too close, do you know what you are doing?"

The scrub nurse gave me a knowing nod. First, I was confused, then I realized what was happening. Hell had no fury like a predator scorned. It was to be a long six weeks. I realized he was going to blackball me. My evaluation for that rotation was going to be garbage. His harassment was non-stop. I helplessly watched as he went after one of the nurses just as he had with me. I had no doubt that he was a predator. I had to talk to someone, but whom?

Pricilla was clearly out. As time had passed, our relationship had gotten icier. The guys attributed it to the fact that Pricilla had "grown a pair" as they put it. She would side with the GOB (Good Old Boys). It was not a club I belonged to. I was the

wrong gender and from north of the Mason Dixon line. Here they liked soft-spoken Southern Bells. It wasn't a mold I fit.

I decided to speak to the assistant chairman. I had gotten along with him my research year.

I made an appointment and went to see him. I sat down, and we exchanged amenities.

Then I got down to business and explained what had happened, and how I felt it would affect my evaluation.

"Do not mention this to anyone else. You hear me? If you do, you will never become a surgeon. I'm telling you this for your own good. Do you understand?"

I nodded and got up and left. He left no doubt that my complaints would never see the light of day.

The rotation ended, and I began a new service. While I didn't have to deal with more sexual predation, it became patently obvious that there was a double standard. It seemed the boys could proverbially step in shit and come out smelling like a rose, but every minor breach or error I committed was magnified, even though there were very few and none of significance. It also became obvious that not only did no one have my back, but the attendings were more than happy to throw me to the wolves. The climate made learning nearly impossible, and there was no time for academic review of surgery that was needed for the upcoming in-service exams. My performance was mediocre.

I was informed that due to my spending a year in the lab and not having enough operative experience, the powers that be wanted me to spend an additional year before my chief year. Another year, more of Dr. H, more harassment, more horrible working and studying environment. By that time, I had made friends with a new young attending and his wife. After the news, I sat in their living room mulling over my options.

Spend another year with no guarantee of results? Have to put up with the abuse and harassment for another year? Or resign and take my chances on whether I could find another upper-level position? In the end, I decided that to agree to participate in that atmosphere was to condone it. That was not something I was prepared to do.

I turned in my resignation stating that my remaining in the program would not be beneficial to me or the program. Both the Department Chairman and his assistant were quite upset. The Chief said, "You realize if you leave here, you may never be a surgeon?"

"That is a chance I will have to take," I replied. Clearly, they had not counted on my reaction.

Two other residents followed my example. "If they can do that to you, none of us are safe," one of them told me.

In a casual conversation with one of the anesthesiologists, I was to find that Dr. H had a storied past. He had been gold watched at least twice previously for sexual misconduct. He was passed on from one institution to another.

No legal actions had been pursued. He was free to troll the halls of academia until he would be gold watched again.

My last rotation was on General Surgery with Pricilla. She had been dubbed the Typhoid Mary of MRSA. She went from her ICU full of MRSA to clean patient's wounds and ER abrasions without washing her hands. She was the reason Semmelweis went insane. My resignation had given me a freedom I didn't feel before. When I rounded with Pricilla, I pulled non-sterile gloves out of my pocket and handed them to her in front of the patient as if it was routine. She had no choice but to use them.

**All third-party names in this story have been changed.*

Death by a Thousand Cutting Remarks

Hillary Newsome

In medical school we learn that the approximate blood volume of a human being is somewhere around 5L. If in order to be in danger of bleeding to death, a person needs to lose over half their blood volume, then I am approaching the path of no return. I'm tachycardic and pale. My mentation

has slowed and I'm drifting in and out of consciousness. If someone doesn't intervene soon, I'll be gone. Figuratively, anyway.

I haven't suffered a horrible accident. There has been no procedure gone wrong with significant injury to an aberrant artery. Instead, this has been a slow transition. A drop escapes here and there as a papercut I didn't even know I had. A small stream of red trickles from my finger and gets wiped away. The only evidence of the cut I have is the stinging from the Purell I use in and out of every patient's room on morning rounds.

A random nick shouldn't be too surprising. After all, I deal with sharps by nature of the job: a 15 blade for a skin incision, an 11-blade for a neck abscess, 30-g for an infraorbital nerve block. I am navigating a surgical world. My attendings, the majority of them white males, have hands that are thick and calloused from their own versions of needle sticks and paper cuts. After all, we see the same patients, do the same procedures, though I perform them much less adeptly at this earlier stage (which may be a contributing reason for my lower hematocrit). I seem to suffer from a different barrage of miniscule trauma leaching my precious red blood cells. Is it because I am a woman? Or is it because I am black? Because I am a black woman?

I'm bleeding, and it's because I've been noticed.

"Do you have a self-confidence problem? Because you write like someone who does." That was the observation made after reviewing my life story on a piece of paper. That was how the interview at my state medical school opened. What had I written in my personal statement that had tipped this middle-aged white man off? A story about a young and black woman traversing the unfamiliar terrain of academia as the first person in her whole entire family pursuing a doctorate degree, despite having been told she should consider a different career? Or was it just because I was a 21-year-old and black woman, which then, and now, is enough to make one second-guess herself. My hemoglobin dropped 1 unit. Needless to say, I did not matriculate into medical school there.

"Cystic duct?" I knew that was the answer I read in my textbook while preparing for my general surgery rotation. But the way I said it came off more as a question than an answer. Uptalk.

"Don't talk like that." She demands.

My facial expression turns to puzzled.

"Like that? You know?" Her sentence ending with an inflection that mimicked mine.

"Women surgeons should not speak like that," she concluded.

Blood splatters on the floor and our eyes dart at the crimson fluid. We both know it's mine, probably 150cc or so escaping from the stab wound she had created while reminding me there is no room for a young, millennial woman like me in surgery.

A surgeon must become intimately aware of her patient's body. This patient may have a left level three node, which you must be sure to include in the neck dissection, while the next patient may have some anatomic variant you've never seen.

Unfortunately, something about the way I look—the apparent youth of my dimpled cheeks, the hooding of my eyes, or the texture of my hair—gives each patient just enough courage to forego the social niceties taught to them by their mothers. My patients have seen my full lips, my freckles, my tawny skin, my height and have become so familiar with me in a single meeting that they must tell me their observations of my body. They notice me, while I am trying my hardest to elicit the exam finding that has brought him to our clinic today.

Somedays, I swear if I never owned a mirror, I would still know precisely the way I look—my patients would tell me. Maybe they are thinking their remarks are positive comments and would make me feel good. Maybe they aren't thinking anything at all. But each remark, declaration, and observation cuts me. As routine as the four-year-old with the tonsil bleed, my post-operative day 7 granulation tissue oozes and I swallow every bit with a smile—until my stomach is upset, the hematemesis scares my mother and I'm rushed to the emergency department. My hemoglobin is now down 2 points—all that oozing adds up.

"You have *two* dimples."

"Your hair is so curly and beautiful."

"When I came back from Africa, my skin was almost as dark as yours."

"Your face looks so young."

"You are so tall."

"Your smile is wonderful."

"You look like Shaq's daughter."

"With your figure, it wouldn't matter if you gained weight."

"You have such a nice smile."

"You are such a pretty girl."

"You are a rare breed."

And then there are the comments that remind me of where the world thinks a young woman's place should be.

"I would marry you."

"You would be my girlfriend."

"You are lucky I'm not 30 years younger, I would stalk you."

"Where's your husband?"

"You shouldn't be here alone."

I do anything to keep from choking on the blood clots I'm coughing up from my posterior nose bleed. On my stat H/H I'm 3 points down. I need an intervention soon, or I'll be too weak to carry on.

The intervention for me never comes though, as I realize I'm really just suffering from an anemia of chronic disease. But the disease is not modifiable in any way—I *am* a young, black, woman doctor. The intervention I'm waiting for is *me*. The only way forward is to carry on and be noticed. And so I do, but not without a type and screen and tourniquet.

Salary Inequity and Me: A Personal Reflection

Preeti R. John

I stumbled upon the fact that I was the lowest paid surgeon in the department. I am triple board certified in general surgery, critical care, and hospice & palliative medicine. Nine years into my job as an attending surgeon, after some coaxing from a colleague, I decided to compare my salary to that of general surgery colleagues working at the same facility (all of whom, at the time, were men with children). During the years that I worked as an attending surgeon, I assumed I earned an appropriate and comparable salary for my work, and never gave my income much thought.

This same (male) colleague informed me about a website that allows one to search salaries of government employees by name. When I first looked at this website in 2017, I was practicing general surgery and critical care. I discovered that my colleagues who were practicing only general surgery, who were board certified in only one specialty, and who joined the facility after I did, all earned significantly more than me—by a *wide* margin. There was a $20,000 salary gap between me and the lowest paid surgeon in our group of five general surgeons, and a $125,000 salary gap between me and the highest paid surgeon in our group, who also had a leadership role. When I asked my surgeon colleague if the salary listed for him on that website was correct, he noted that the information was two years old and that it did not reflect his recent pay raise!

The salary discrepancy took me by surprise. Ultimately, feelings of disbelief gave way to anger. A $20K gap is significant, especially considering the loss in retirement earnings alone. The sheer unfairness angered me. I worked hard as an intensivist and functioned as director of the surgical ICU. I led an array of quality improvement initiatives over the years and worked with different clinical departments and divisions to make significant system-based improvements. I launched surgery morbidity and mortality conferences. I published a surgery handbook/guide for residents and faculty. I helped create electronic order-sets and protocols. I strove to improve the care provided for patients in the ICU and obtained approval from hospital leadership to hire more ICU personnel (nurse practitioners) to provide night-time coverage and dedicated care for the sickest patients. So why was I toiling under a wide pay gap?

This was the first job I had accepted after completion of fellowship training. At the time, I knew nothing about salary negotiation. This topic never once

came up during residency or fellowship training, despite the fact that it has the potential to greatly impact a person's life.

Though I had read about salary inequity issues affecting women in various fields, it never occurred to me that I would be among those afflicted with unfair payment practices. Like many women, I was grateful for my job and the security it brought. For nine years, blissfully unaware of being paid less than my colleagues, I went to work each day, bringing my best self to the task at hand—providing care for patients.

Some physician colleagues might roll their eyes and say "put on your big girl pants," or "men who negotiate deserve to be paid more," or "women should not whine—if you work less, you will be paid less." But women who work equal hours and who are equally or more productive than their male colleagues ought to be rewarded by salary parity. However, there is much evidence in the published literature to the contrary—women often get paid *less* for doing the same jobs as male colleagues.

My book 'Being a Woman Surgeon—Sixty Women Share Their Stories' published in 2015, comprises personal stories and revelations by women in surgery. Leaders in the field wrote that they were shocked to find inexcusable salary discrepancies between men and women when they became department chairs. One even described how men in her department regularly asked for salary increases, whereas the women in her department never raised the issue.

Despite knowing this, however, it never occurred to me to compare my salary to those of my colleagues. When my salary discrepancy first came to light, I spoke up about it and was asked by friends if I would leave, or look for another job elsewhere. The thought of leaving never occurred to me. Why would or should I leave a job I had come to love, in an institution I had come to love? Why not work on fixing the salary discrepancy? Yet, routinely, women tender resignations and leave, because it is often easier to do this rather than to tackle the difficulties that arise with challenging decisions about salary determination.

Although this is a generalization, women tend not to negotiate their salaries, tend to be poor self-promoters, and lack the same sense of self-worth that men embrace. Men speak up for themselves, and when they do not, their colleagues who are 'buddies' and are in leadership positions, will look out for them and ensure that they get salary raises. Women are often described as nurturers. However, when it comes to aiding each other in the workplace, sometimes the opposite is true. In fact, the men around me are the ones who have supported and enlightened me about pertinent issues. Had it not been for my *male* colleague who encouraged me to look at my salary and compare it to others, I would not have discovered this issue for myself and would have continued to be underpaid.

I resolved to turn my experience into something positive that would enlighten other women and help them realize that naivety does not pay. (Pun intended).

What Are the Reasons for the Salary Gap?

Upon investigating the 'salary inequity' issue in my field—surgery—I found that being-female is only one of several 'risk factors' for earning a lower salary. Being unmarried and childless ranks as another disadvantage, relegating single, childless women to the 'non bread-winner' category. Being an ethnic minority is another. Research publications from the United Kingdom reveal that ethnic minority physicians working within the National Health System are often paid far less than their Caucasian counterparts. Thus, as a South Asian unmarried woman, all the odds were stacked against me.

In general, when determining a surgeon's salary, several factors are taken into consideration: surgical specialty, qualifications, number of years of experience, fellowship training, board certification. Pay tables exist within the federal government system, but the categories offer salary ranges for different medical specialties. The American Association of Medical Colleges (AAMC) website also provides salary data for various medical and surgical specialties.

Salary transparency is vital to ensure equity. Working within the federal government system affords a certain degree of salary transparency

(salary data is publicly available for federal government employees), but transparency alone is not enough to rectify the problem. Awareness and education about salary inequity and willingness to have open discussions are key. Cooperation from our male colleagues can be encouraged only if there is acknowledgment that a problem exists.

Accountability—holding leaders accountable when salary discrepancies are discovered—is also vital to ensuring pay equity. Do I believe that department chairs and leaders in surgery are evil and scheme to pay women less than men? No. However, I do believe that biases—both conscious and unconscious—play a big role in perpetuating salary inequity. Hospital administrators should be educated about the issue. People who believe that men with families ('bread-winners') deserve higher salaries than single women, regardless of the amount of work being done, must not have the platform to exercise their biases.

I believe it would be beneficial for leadership positions in health care to rotate rather than remain indefinite, allowing leaders to develop a sense of infallibility and complacency and the belief that their actions or inaction will be excused. Women in leadership positions should use their platform to address pay parity. The topic should be discussed at conferences. Workshops and training courses about work-place biases and salary negotiation should be conducted. Creating awareness and encouraging productive conversations is the goal, rather than accepting the status quo or embracing and condoning a victim mentality.

Research into salary inequity issues within medical fields, conducted by objective third-party players, and with adequate time frames to be completed, would provide more clarity into the issues at play at medical centers across the nation.

What would I advise women who discover an issue with their salary compared to that of colleagues? Be prepared to provide concrete evidence of your worth, your qualifications, and your productivity. Know salary-related data and be prepared to justify reasons for why you should earn the same as your colleagues. Discuss your salary with your supervisors and human resources. State requests and summarize meeting discussions in writing. If you decide to file a formal complaint, be as objective as possible. State facts. Be clear about your goals: are you requesting an immediate increase in salary and what is this request based on? Are you entitled to back pay for the years when you earned a lower salary than colleagues who did a comparable amount of work? Keep emotions at bay and keep your eyes on the goal: pay parity.

The existence of the 'Equal Pay Act' does not guarantee that we will get equal pay for equal work. Salary inequities persist, and institutions often fail to pay women the same as men for equal work. Being naïve to the issue is no longer excusable. We alone are our best advocates.

We need to convey to leaders in the field of surgery that salary inequity is as prevalent in 21st century United States surgery as it was in years past, and thus warrants further investigation and explanation. Unless this gap is eliminated, women considering a career in surgery will have yet another issue to take into consideration when making a career choice.

According to a recent report by the AAMC, "Even in 2019, women at academic medical institutions across the country are still receiving less pay than their male counterparts." In this report, Harvard medical school professor of Surgery, Dr. Sareh Parangi, president of the Association of Women Surgeons, says: "Unequal pay for women often begins with their first job and persists for the duration of their careers." I know this to be true because this is what happened to me.

Pema Chodron said in *When Things Fall Apart*: "Everything that occurs is not only usable and workable but actually the path itself. We can use everything that happens to us as the means of waking up."

In closing, I say it's time to wake up, fellow women surgeons! Salary inequities exist. It is up to us to identify, discuss, investigate, and rectify it.

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But I Love My Big Hair! An Essay on the Discouragement and Difficulty of Becoming a Woman Surgeon

Katherine Bakke

Ever since I was a girl, I have had long, curly blonde hair. It is my most prominent feature. In grade school, mothers would exclaim "look at those curls!" while little children would coo, "it feels like straw." Not being striking in any other way, my hair was a way for people to identify me, describe me, and differentiate me from others. By the time I reached adulthood, my hair was a manifestation of my personality—a bit big, a tad unruly, and utterly authentic. I loved my long curls and what they said to the world about me.

However, long hair is, in many ways, impractical for a doctor. I learned this lesson in anatomy lab during medical school. I hated anatomy lab. Our first dissection involved taking a hammer and chisel to my cadaver's spinal column in order to break it open and expose the spinal cord. The clang of metal against bone was barbaric, and I didn't find disemboweling my cadaver or giving him a craniotomy to be any more palatable. Twice a week for a year, I struggled to dissect desiccated tissue and memorize the sinews that composed the human body. After each session, I returned home starving and would let my hair down as I cooked dinner, the scent of the lab wafting out from my tumbling strands, forcing me to decide which need to prioritize—hygiene or hunger. Hunger won every time. This was perfect preparation for my life as a general surgery resident: the adage, "eat when you can, sleep when you can . . ." doesn't mention anything about showering.

Given how much I loathed anatomy lab, I never expected to be a surgeon. However, my trauma surgery rotation was a singular experience. The first time my pager alarmed, I hustled down to the trauma bay with my heart racing. My job was simple—stand behind a yellow line until summoned by the trauma chief, then shear off the patient's clothes and throw warm blankets over his body. I performed these tasks nervously but satisfactorily and then stepped back to watch the resuscitation.

The patient was a young man in a motorcycle crash. The scene was frenzied, with shouts for vitals, fluids, and a chest tube. Amidst the chaos, I watched as a surgery resident calmly lined up the instruments he needed for the chest tube. The last thing he did before effortlessly placing the tube into the patient's chest and evacuating a flood of blood onto the floor was load a 0–0 silk suture in a needle driver and flick his wrist, draping the suture's tail onto the sterile field. I was captivated by the commanding grace with which he approached his task. If life's decisions can be pinpointed to moments—moments pointed to in order to explain one's decisions—then that moment was mine. The flick of a wrist sparked my mind and heart simultaneously, and I thought, "That! That is the kind of doctor I want to be."

Yet, I resisted the idea of becoming a surgeon. Medical students are advised to "find their people" and enter a specialty in which they feel they belong. While my brain lent itself easily to surgical problem solving, and years of childhood sewing projects had given me "good hands," there was little if anything about my personality that was surgical. My attitude was upbeat, not stern; I was detail oriented but not anal retentive; I was self-deprecating, not arrogant; and, honestly, I enjoyed talking with patients more than most psychiatrists. I was also a woman.

While there were a number of women surgeons at my medical school, I struggled to relate to them just as much as I struggled to relate to the male surgeons. Some were demanding perfectionists who were respected for their operative skills but disliked for their terse behavior. Others were quiet and reserved, which is to say their demeanor was measured and restrained. None of them enjoyed the liberty of their male counterparts, who cracked jokes at work, talked about patients passionately, and expressed their frustration readily. During my sub-internships, rotations designed to garner letters of recommendation to accompany one's residency application, I was encouraged to act like the surgeons I heard about in stories or saw on television; "be tough," "be more confident," "know everything." Throughout the rotations, I grew

increasingly insecure as I failed to fit the mold of a "typical surgeon," so incongruous was she with the person whom I knew myself to be. By the end of my time on service, the department didn't know what to do with me—the odd woman with curly hair who just didn't fit in—and I went without mentors as I prepared to apply to residency.

Daily, I fielded commentary about my choice to become a surgeon from peers and professors alike—the majority of which was discouraging. Doctors in non-surgical disciplines asked me if I hated myself, if I wanted to have a life, if I wanted to get married, or if I wanted to have kids—as if all these things were incompatible with being a surgeon. I was advised to have "an exit strategy" for when I burned out. I was told that "surgery would be wasted on me." Surgeons added their own thoughts on the matter, which were equally corrosive to my confidence. One surgeon told me, "You exude compassion, but you have to show us you're tough." Another said, "You should try to match in a big city, so you have dating options. Men are intimidated by ambitious women." One expressed his doubt that I would finish residency when I admitted to him one day at the scrub sink, that I felt tired. When I told a surgeon that I loved to sew, and that those skills easily translated to the operating room, he dismissed the idea, saying, "I don't see the connection at all."

The culminating remark, though, came from the chairman of surgery. In our meeting, which was compulsory for anyone applying to a general surgery residency, we had a conversation about why I wanted to be a surgeon and what made me a unique applicant. I was wearing a white lace blouse, with short sleeves and a crew neck collar, and black slacks. My hair was down, as it usually was when I wasn't scrubbed. At the end of the meeting, the chairman made a cautionary comment, which prompted me to ask, "Do you have concerns about my application?"

"No, I think you'll make a fine surgeon," he said in a tone that sounded more obligatory than sincere. I sensed that he wasn't finished, so I waited for him to continue.

"I would, though, try to look a little more professional on your interviews."

My mind searched for the meaning in his comment—my outfit couldn't be any less offensive, I could walk in high heels, I was probably the last person in her twenties to own and actually wear pantyhose. Then, it dawned on me.

I leaned forward and whispered, "Do you mean my hair?"

Almost imperceptibly, he shook his head in the affirmative.

Shocked and without thinking, I grabbed my hair in both hands and exclaimed, "But I love my big hair!" He nodded his head and offered no further defense for his comment. I left his office, enraged and dismayed. I had grown used to people telling me I was "too nice" to be a surgeon, but my hair? The one thing that said everything about me without saying anything? Did that, too, not belong in surgery?

I entered the residency interview season with a desperate desire to belong. When asked during interviews what made me most nervous about starting residency, I admitted my greatest fear was not the hard work, long hours, or fear of making mistakes but that I would match at a program where I didn't fit in. The surgeons interviewing me always seemed confused by my answer, and I didn't have the energy to elaborate, exhausted as I was by the prior months' onslaught of critique about my personality and appearance.

However, during interviews, I began to see that the culture of surgery was more nuanced than I had previously thought. Not infrequently, I would shake a surgeon's hand after a twenty-minute conversation and notice that they seemed both thoughtful and pleased with our conversation. Sometimes I even heard, "surgery needs people like you." I wasn't the typical surgeon, and it turned out that to some, this was an asset and not a liability. These moments gave me the mettle to continue to be myself during an otherwise rattling time. Come March, I was fortunate to match at a general surgery residency program led by a woman and with near-equal proportion of men and women in each year of training. I felt validated. Someone considered me a surgeon when so many others had not, simply because I embodied qualities that were

antithetical to how they believed a surgeon should look and behave.

Two years into my residency, I find that there are still times when I struggle to fit in. In performance reviews, I am praised for my bedside manner and work ethic, and criticized for questioning authority within the surgical hierarchy. I have been ignored by scrub techs in the operating room, with one refusing to hand me instruments until the attending surgeon reiterated my request. I am frequently confused for a nurse after introducing myself as a doctor. I was called a "little girl" by an ICU nurse after I failed to pass an NG tube in a patient with a tortuous esophagus. I listen to my male colleagues boast about "getting to do the whole case" and feel my confidence slip each time, even though I know they didn't do anymore during the last lap chole than I did. I am only now, slowly, finding mentors.

Even as we inch toward parity in the number of women entering surgical disciplines, the field continues to reward traditionally masculine behaviors while feminine characteristics are under-appreciated at best, and derided at worst. This paradigm applies to both men and women in surgery. Male colleagues have told me that they also were told they were "too nice" to be surgeons. Yet, men can be masculine to the point of toxicity and nevertheless they will be tolerated; they can also be quiet and patient and win accolades. Women who lean too far in either direction are criticized and resented. Mine is not a new observation about the double standards applied to women in this profession, but it is an observation that remains true. I am not the only woman who has received pervasive discouragement in her journey to becoming a surgeon, and I am certain that many women have abandoned the field because of it. Surgery has suffered for its tribalism, for the absence of the women it did not embrace. Parity, let alone equity, for women in surgery will not be possible as long as this paradigm continues.

As much as surgery's arbitrary expectations have caused me pain, authenticity has served as my shield. I am only able to retain my determination and optimism by remaining true to myself. I find it abhorrent to bend to the baseless beliefs of what a surgeon is and is not; doing so is like holding part of me underwater and never allowing her to come up for air. The times I stifle myself, I become depressed, disengaged, and disconnected from the purpose of my work. Being asked, under the guise of feedback or advice, to be disingenuous has been, at times, too much to bear. In fact, earlier in my residency, such advice nearly led me to quit training and abandon surgery altogether. But when I feel I may break, I heed Bernice Johnson Reagon's words: "If, in moving through your life, you find yourself lost, go back to the last place where you knew who you were, and what you were doing, and start from there." For me, that place is the bedside, where I assure each patient that I am here, and that I will take good care of them. Because, when it comes to what matters in a surgeon, that's all there is, has been, and ever should be.

Commentary

Cutting for Equity—Reconstructing the Culture of Surgery that is Still Toxic for Women Surgeons

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Acknowledgments. The courageous women who have become surgeons, particularly those opening the door by sharing their experiences.

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Abstract. Women surgeons face sexism, hostile workplace environments, gender discrimination, sexual harassment and isolation in their training and practice settings, sometimes at significant personal cost. The stakes for telling these stories have been very high for female surgeons who fear exposure, lack of support, and retaliation. Times are changing and with more voices being raised, women are feeling more empowered to speak up. With the advent of #MeToo and #TimesUpHealthcare, communities are developing that create spaces for women to tell their stories. These narratives document the experiences of women surgeons and the resilience they demonstrate in overcoming the gender-related obstacles they face. While each experience is unique, there is considerable overlap in the themes revealed by these narratives. Despite the variations in their stories, these surgeons are in agreement that the culture of surgery needs to change and that the contributions that women can bring—empathy, collaboration, compassion, kindness, wisdom, empowerment, and zero tolerance for abusive behavior, to name a few—will enrich the culture of surgery and improve patient care.

Keywords. Women Surgeons. Gender Discrimination. Sexism. Sexual Harassment. Gender Bias. Gender Disparity.

Introduction

Stories and data matter. Data provides us with evidence and facts. Stories make them personal and memorable. In the stories we can see ourselves reflected. We can see our sisters, daughters, mothers and friends. Data tells us that gender discrimination and sexism are rampant in medicine, as they are everywhere in our society. These issues have tended to fall under the radar in medicine because the stakes for women who expose abuses have been so high.

Women's experiences are often dismissed as hyperbole or as outright lies. We are often disbelieved or questioned. "She must have done something to deserve it. What was she wearing?" What if everything written in these narratives is true?

When you hear one story it can be dismissed as it being the woman's problem. Two stories gets you wondering if women are just difficult. Three, four, five stories and you realize that there is a surgical culture that is deeply dysfunctional. The data is now conclusive and continues to accumulate.

The stories offered here are those of women who worked hard to become surgeons and to practice their specialties. They were motivated by wanting to use their intellect, knowledge, compassion, and technical skills to help people improve the quality of their lives and restore their health. I finished my surgical residency program in 1982 and had no gender or racial role models. I didn't meet another black woman general surgeon until well into my career. Sharing our stories was life changing for me. "It was also a catalyst for healing" (Dawson, 1999). I suspect that sharing these narratives has also been life changing and hopefully healing, for these courageous women. There is healing in being heard. These narratives contain overlapping examples of sexism, harassment, gaslighting, isolation and hostile work environments. Although the details are different, together they paint a painful picture of what many women surgeons experience.

Hostile Work Environments

In 1998, Frances Conley, a respected neurosurgeon at Stanford, documented her experiences with sexual harassment and gender discrimination in her book *Walking Out On the Boys*. She writes about how long it took her to understand just how hostile her Stanford University work environment was. "With sudden crisp clarity, I realized I had been, and still was, a target of "sexual harassment" (a most inadequate label) and that my work-world was one of blatant gender discrimination." (p. 104). The experiences that she writes about in the 1990s are echoed in these narratives, now almost 30 years later. While we have seen some changes, there is still much room for improvement.

In her 1998 book, *The Woman in the Surgeon's Body*, Joan Cassell documents the experience of a female surgery resident that was sent as a query to a column in the Newsletter of the Association of Women Surgeons. "I'm running into problems with the nursing staff. They seem to take the other (male) residents' orders without complaint and follow them to a T. But they almost seem to deliberately try to undermine me, going to the attending or chief resident behind my back and asking if what I have ordered should be done for the patient, and so on. What should I do?" (pp. 90–91).

These types of experiences are documented in many of the narratives. Dr. Temkin writes, "Teamwork remained a large part of why I enjoyed being a surgeon. But in my new Institution a different circulator and scrub tech showed up for each case." Dr. Verran writes of experiences as a resident saying "During one rotation, the nurses in the operating room were all charming and attentive when my male boss was present. However, the minute he left, they reverted to being barely civil with me." Dr. Wall writes "As a fellow, I struggled to learn in the environment of toxic surgical personalities. I was constantly on edge . . . I questioned my abilities and my desire to be a surgeon." The tip of the iceberg, these experiences were frequently coupled with outright sexual harassment.

Sexual Harassment

Laura Bates documents women's experiences of sexual harassment and gender discrimination in her 2016 book *Everyday Sexism*. Women recount their experiences of being catcalled, groped, demeaned, discriminated against, and retaliated against for calling out these behaviors. Bates adds statistics about gender pay gaps and the fact that 1 in 4 US women report experiencing workplace sexual harassment. In her narrative, Anonymous 1 recounts her experience after being sexually assaulted by an anesthesiologist. "I was sexually assaulted by a senior anesthesiologist in the preoperative holding area at the start of a long OR day in the presence of staff, learners, my patient, and her family. I had no intention of reporting the assault. I know how the world works: nobody would ever believe me." With the encouragement of a close friend, she did report the assault. The report was followed by a disrespectful and

painful investigation, followed by retaliation. Only after other information about the perpetrator's misconduct was unearthed did he receive any consequences, and even then he was simply reassigned to another hospital. This demonstrates the commonly seen privilege that abusive men have to enjoy other career opportunities virtually unscathed, while women who have done nothing but report the assault may have their careers harmed or even ended. Dr. Burgess recounts "I had learned, over the years, how to manage the petty sexual harassment by male surgeons, such as arms errantly rubbing against my breasts. . . . but one case was different; as a cardiothoracic surgery resident, I experienced an aggressive sexual assault."

Dr. Temkin experienced a female tech leering and commenting on her body and clothing while changing in the locker room, in the presence of a supervisor. "I spoke to this supervisor the next day about my discomfort with being catcalled while changing but was unaware of subsequent disciplinary action. Noticeable behavior change did not follow." Narrative author Anonymous 2 writes, "During residency, fellow (male) residents would talk loudly and openly about the various nurses' tits and asses. One fellow resident, during our weekly teaching session, thought it was funny to show me a picture of his genitalia; the other residents thought that was hilarious." She also describes how "during residency, an attending physician stalked and harassed me for *years*. He would hide around the corners of hospital hallways, waiting to accost me . . . He would show up at my house at 3 am, wanting to talk." Dr. Barnett writes "I think it is telling that of the three training programs I went through, the only one in which I did not face or note any kind of sexual harassment was the one run by a person who identified as transsexual."

Discrimination

There are multiple studies that document the lived experiences of women physicians. Elmore, Jeffe et al. document that married women physicians experience significantly more emotional exhaustion than do men, both with and without children. Two studies, one by Jagsi in 2012 and the other by Jena in 2016 showed that when controlling for specialty choice, academic rank, and other factors, 37% of the gender disparity in academic salaries remains unexplained. In a 2011 report in the Annals of Surgery, Zhuge, Kaufman, and Simeone note that despite about equal numbers of men and women graduating from medical school, the numbers of women achieving tenured professorships and becoming department heads and deans declines steadily while the number of men rises steadily. The challenges of advancing into leadership positions are evident in the narrative of Dr. Verran. "I put my hand up for formal leadership positions on several occasions and was afforded an acting role at times but nil else." Dr. Barnett writes, "I was being passed over for promotions, awards, and assignments in favor of men who were not as qualified."

Based on the gender schemas we have internalized in our culture, women are expected to be nurturant, expressive, sensitive, warm, and communal. Surgeons are expected to be impassionate, assertive, decisive, and self-confident. When women display those same behaviors that are lauded in male surgeons, women surgeons are punished. This is evident when Temkin writes, "I was judged on a perception of likeability amongst the physicians I was reporting to." Burgess recounts that when she was introduced to a busy cardiac surgeon at her training program " . . . he immediately announced that he had no intention of training a woman, and he wished me 'good luck.'" While he ultimately became an important teacher to her, she had to prove herself worthy in ways not likely required of her male colleagues. Dr. Ganai recounts an experience with a disrespectful and obstructive male surgical tech. "I reminded myself that at this particular hospital if I were one of my white male trauma colleagues, there would be no uncertainty that I would have a functioning team. There would be no insubordination. If they needed an instrument, they would be given it without hesitation." For Dr. Emami, it became clear to her that " . . . expectations of behavior from my gender did not match the way I was behaving. That made it hard for men, such as Dr. X, to respond and relate to me

in a neutral way, as he would to a male resident. Especially since he didn't believe that women had a role in the world of surgery."

When measuring success and failure; for men success is attributed to ability and failure to the difficulty of the task. For women the measures are different. Success is attributed to luck, hard work, or an easier task—implying less ability. Failure is also attributed to lack of ability. This makes it difficult for women to learn from success and failures since so little is attributed to ability. Much of this may be related to unconscious bias, and it has an insidious impact on women's confidence. It has been well documented that women will apply for a job only if they meet 100% of the qualifications, while men will apply if they meet only 60% of the qualifications. One consequence is that women may feel, as Dr. Butler that " . . . there was the constant feeling of being under the magnifying glass of always being 'watched,' probably being critiqued, and clearly always standing out."

Isolation

Women, even Supreme Court justices, are interrupted while speaking more often than men. A study by Moss-Racusin et al. in PNAS in 2012 had faculty evaluate identical resumes that were identified as either male or female students. Consistently the "male" student was rated higher in competence, hire-ability, worthiness of mentoring, and was felt to deserve a significantly higher salary. A study done at the Mayo Clinic noted that during Grand Rounds introductions, if the speaker was male and the introducer was male, 72% of the time the speaker was introduced as Doctor. If the introducer was female and the speaker was male, Doctor was used in 96% of introductions. But if the speaker was female, male introducers used Doctor only 49% of the time, while female introducers did so 98% of the time. Despite the fact that there is no benefit for a woman to make a false allegation of sexual misconduct, men are now fearful of mentoring women in the #MeToo Era as discussed by Soklaridis in a 2018 NEJM piece. The isolation and lack of mentoring are evident in the experiences of Dr. Wandel. She was advised by the assistant dean of her medical school that "women did not go into surgery." When she was in her surgical residency, she notes that "It was a lonely five years for me. . . . I learned it was safer to keep quiet and speak only spoken to. In retrospect, this behavior isolated me even more from my fellow residents."

Intersectionality

These experiences are magnified by the intersectional impact of discrimination when the surgeon is a woman of color. This is demonstrated in the narratives of Drs. Chopra and others. Dr. Chopra recounts a situation in which she met with the Chairman of a hospital surgery department: "I was told that I needed remediation after my last rotation where the surgeons felt 'they weren't sure if I was meant for general surgery.' I wondered if that translated to the fact that I was a woman of colour and didn't fit with their stereotypes."

Conclusion

What are we to make of all this? The negative experiences of women surgeons are well documented. The Lancet dedicated its entire February 9, 2019 issue to women in medicine, science and global health. As Dr. Greenberg so clearly stated in her Michigan Surgery Grand Rounds, we need to "Stop Fixing Women" and address the systemic issues and inequities that result in women surgeons continuing to have these experiences. For too long women have been told that they need to toughen up, be more like the men, ignore the harassment, and be assertive (but not aggressive). This has resulted in personal harm and has kept the profession of surgery from benefiting from improvements that women can bring. Fixing women normalizes the masculine behavior and systems that can be so toxic and renders women deficient. As Dr. Butler notes, "We have to change the definitions of power and strength from the traditional masculine traits of aggressiveness, confidence, and assertiveness to include wisdom, kindness, compassion, and empowerment." When we fix women, that places

the onus for change on women, and the solution is skill-building. When we fix the system, we have to acknowledge that our current system is deficient and that diversity, equity, and inclusion are normal and beneficial. The onus for change rests on the shoulders of leaders and society through education, equitable policy development, and culture change.

As Dr. Wall writes, "As surgeons, we must create a culture of zero-tolerance for abusive behavior in and outside of the operating room. We cannot continue to value the aggressive, arrogant alpha-male. We cannot treat technical excellence as a hall pass. No one is too good to be kind. The circle of workplace violence needs to stop with us."

In reading these narratives we bear witness to the pain that has been shared with us, honor the writers, and open the possibility for moving forward to a more equitable profession. In the words of Dr. Chopra, "This cannot continue. Sexism, discrimination (both open and disguised), misogyny, disrespect, and bullying have no role in the training or practice of medicine. *Time is up*."

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Commentary

Double-Edged Scalpels: The Trials and Triumphs of Women Surgeons

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Abstract. The narratives presented in this symposium describe the many ways in which women are harassed from medical school to residency to fellowship and throughout their careers as surgeons. A clear double-edged pattern in the tactics these women used to cope, the challenges they faced, and the responses they encountered emerge, with each being protective or helpful while simultaneously holding them back. Addressing the systemic cultural issues described throughout will be no easy challenge, but the authors of these narratives provide hope that it *can* be different for future generations of women pursuing surgical careers.

Keywords. #Metoo, Bias, Discrimination, Women Surgeons, Narratives, Social Responsibility

A recent report by the National Academies of Science, Engineering, and Medicine (NASEM) noted that an increasing number of women are entering these fields—a finding which marks progress and should undoubtedly be celebrated (National Academies of Sciences & Medicine, 2018). However, as highlighted by the narratives in this symposium, as well as the NASEM report, when women enter these fields, they face a number of barriers and biases, including sexual harassment, that impact their performance and advancement. The two-sided nature of the NASEM report findings brings to the fore an overarching theme which also emerged in these narratives—the experiences of women in surgery are double-edged. Broadly, for example, these fierce women fight for their right to be in the operating room, but in doing so, face a deluge of backlash that may systematically keep them out. They play by the rules of the game in order to fit in, but the rules are inherently intended to keep them out. They report the harassment of others only to be labeled as troublemakers themselves. Thus, as Barnett so succinctly stated, "to be a woman is a rich and dangerous job."

The following thematic summary was approached through a lens of organizational science

to identify the systemic beliefs and behaviors described in these narratives from multiple angles. It is our hope that these themes shine a light on the challenges women face in surgery as they relate to gender-based and sexual harassment both within and outside of the operating room. It is critical to note that the authors are not alone. More attention has been brought to these issues of late, and the experiences of these authors are, unfortunately, not uncommon (e.g., Stamp, 2019). Further, these authors should be commended for their bravery, leadership, and fierce pursuit of equality. Without their actions and without their stories, surgery could not have made the progress it has today. Despite this progress, much work remains me to be accomplished. As we hope this summary and the narratives communicate, it is both possible and imperative that the culture of surgery change.

The Mirage of Meritocracy

"I had always believed that I would be accepted in this 'man's world' by keeping my head down and working hard . . .", states Wandel in her career-spanning narrative. As a surgeon, she is not alone in this sentiment; many of the women repeatedly expressed hope that the future would be better with less misogyny and fewer instances of harassment. This natural inclination for optimism is not surprising, especially among such a talented and tenacious group of women. After all, meritocracy, in the modern convention, professes to reward those who work hard. But women are at a disadvantage in this regard. Working hard means something paradoxical for women, especially in male-dominated fields. Plainly, women must work twice as hard to be recognized for their performance (Wennerås & Wold, 1997). This, as Wandel points out, might come in the day-to-day life of a female resident assigned "more ER calls and . . . scut work" but also manifests as "being passed over for promotions, awards, and assignments in favor of men who [are] not as qualified", as in Barnett's experience. But it is not just in Barnett's experience. Recent research suggests that past performance is the key criteria used for evaluating leadership and promotability for women while the yet unproven potential is considered more important when evaluating men (Chamorro-Premuzic, 2019; Player, Randsley de Moura, Leite, Abrams, & Tresh, 2019).

On the other hand, women in surgery would do well to remember that this work should be difficult *for them*. As Emami recounts, "during my intern year evaluation, Dr. X., one of my senior attendings, asked me to try and pretend that I was having a harder time at work" after "[worrying] that I was too confident and too quick and efficient." Women who succeed at what are considered male tasks are often penalized unless they behave in a way or take on an identity that aligns with womanhood (Heilman & Okimoto, 2007). This may be, perhaps, why so many talented women interested in surgery were instead encouraged to pursue, or placed into, roles that typically serve a support function or focus on women and children. For instance, after being hired into an adult cardiac surgery program, "one of the senior partners promptly told [Burgess that she] was hired so he could defer care of his ICU patients to [her]." Wandel also received this message loud and clear from her assistant dean during rotations in medical school. "Look at pediatrics or OB/Gyn," he said, "women [do] not go into surgery." Verran experienced a similar push toward specific specialities, "If you said that you wanted to become a family practitioner or a paediatric specialist, then everyone was supportive." Chopra faced more subtle, but still glaring, pressure when the Chairman of the Department of Surgery relayed that surgeons who had worked with her expressed skepticism that she was "meant for general surgery." Further, women who went against this pointed advice potentially faced backlash that could affect their ability to advance in their careers. Verran, for instance, shared that a senior male surgeon in a position of authority "stated I was not cut out to do surgery (and ensured that this happened by blocking my career progression within one major hospital)."

All of these women, at one point or another, "kept [their] heads down, kept quiet, and just tried to do [their] jobs," an anonymous author succinctly summarizes. They all simply wanted to succeed as surgeons. But they were set up to fail. Wandel

described the agony and determination that so many women in surgery experience in their careers of hoping that the next job, workplace culture, and chief resident will be better. In the end, she proclaims, "I was wrong." As Emami also concludes, "I know full well now that gender bias is real and implicit bias permeates our work environments. I also know full well that as women, we are held to different standards".

Being "Just Right"

In many facets of life, women are expected to be interpersonally astute and warm (Eagly, Nater, Miller, Kaufmann, & Sczesny, 2019), and surgery is no exception. As Emami highlights, "'feminine traits' turned out to be more effective in pursuit of [her] goals," helped to "soften [her] deliveries," and protected her, if temporarily, from harassment and bullying. Despite "kindness . . . not [being] highly valued in cardiac surgery," as Burgess notes, women who fail to meet gendered expectations may, nonetheless, result in reprimand. In the face of reporting sexual misconduct among the staff she worked alongside, Temkin was asked if she was "hard to work with","encouraged to smile more", and "[provide] assurances that [she] would work on using more ' please' and 'thank you' in [her] communication with others."

This, of course, does not stop evaluators from making judgments that contradict gendered expectations *before* women are on the job. For instance, Wall recounts the "crushing" rejection from her first-choice program for residency; she was not aggressive enough. However, standards quickly shift when women engage in what Emami deems "norm shattering" behavior *on* the job. "We will be perceived as hostile when we use agentic communication," reflected Ganai after sharing a high-stakes circumstance in which she had to raise her voice and demand action due to insubordination—a response, she knows, that would not even be given a second thought were she a man. Armed with self-awareness of the Goldilocks-like expectations for them, women in surgery are careful to avoid being perceived as overly emotional. Temkin carried this lesson with her in meeting with her superiors, noting that she "presented objective data" in advocating for her success as a director of a surgical service, only to be "judged on a perception of likeability amongst the physicians [she] was reporting to . . .".

While women attempted to juggle others' expectations of them, the constant calibration in search of the "right" femininity, it seems, was never truly meant to end. Rather, it was meant to silence women. Emami recalls, "I was supposed to stick around . . . tolerate the treatment for at least a year . . . and play along with the rules." Across these narratives, many women recounted conversations where they were told they needed to be more likable, lest they be labeled as difficult to work with, while others were criticized for being too feminine, which, they were told, put them at risk for attacks and harassment. There was little clarity on how to reconcile these expectations aside from sticking to the way things have always been in the past, which, as many authors noted, often did not include women at all.

Reigns of Terror

"The way he pointed out the mistake was by yelling, hitting, cauterizing, or head-butting the operating surgeon . . . I left that rotation with only one or two cautery burns on my hands, and I felt very fortunate to have learned so much from him." Chopra's description of an abusive work environment is, sadly, a common thread throughout these narratives. From hazing to name-calling reminiscent of the 2004 film Mean Girls, these narratives depict an image more closely aligned with the bullying behavior of high school days past than of a modern institution advancing scientific medicine and saving lives.

The toxic environment described by nearly all of the authors depicts "testosterone-driven" cultures where there was nothing subtle or covert about the abusive behaviors these women faced. When it came to name-calling, the authors were called "the whore" (Burgess), "dyke" (Barnett), and "bitchy" (Emami). Among other overt hazing stories, Barnett recounts a story of when she introduced herself as

an alumnus during a specific year to a professor from her medical school, "he frowned and said, '1979! X was Dean then. We alumni hated him; he let everyone in; blacks, women, minorities!'" Abuse also extended beyond verbal tactics to physical violence as well. As Wandel describes, "She told me that a staff surgeon has just thrown a chair at the female resident . . ." Importantly, Wall describes a culture in which the powerful lack accountability, "Attending surgeons reigned over the operating room, where they had permission to behave how they saw fit: verbally assaulting nurses, scrub technicians, anesthesiologists, and residents."

Indeed, the lack of accountability in these institutions likely drives much of this behavior. When institutions allow the abusive behavior of those in power to continue unfettered, the signal is clear—this behavior is acceptable here. Institutions must recognize this culture and not be afraid to stand up to senior, respected surgeons in the field. Status, be it power, fame, or success, may sometimes result in overlooking inappropriate behavior, or the granting of what has been deemed idiosyncrasy credits (Hollander, 1958). Verran recounts the impact of idiosyncrasy credits regarding an abusive phone call from a senior academic professor. "I informed several people at work about this particular incident, but no one was prepared to act due to the individual concerned holding a leadership position."

The high-pressure nature of surgery undoubtedly creates a challenging environment. The addition of name-calling, hazing, and physical and psychological abuse by senior surgeons, however, creates an equally life-threatening situation for many of the women in the field. Considering the negative effects of stress and abuse (Ganster & Schaubroeck, 1991; Tepper, 2007), a toxic workplace culture could not only be damaging women's careers, but could also be damaging their physical and mental health. To survive, women must find ways to cope. As Barnett recalls, tongue-in-cheek, "I think full-blown PTSD was an excellent way to go through surgical training of that day." This is clearly not a sustainable method for coping with the culture. Institutions must identify mechanisms for culture change, such as role modeling, training, symbol reform, and reward system changes, (e.g., Schien, 1990) that will successfully create a system and field-wide change in culture to create an environment that is both healthy and productive for surgeons as well as patients.

Dealing with Troublemakers

The narratives presented in this symposium tell the stories of two different types of troublemakers—those who make trouble by sexually harassing others and those who make trouble by reporting sexual harassment. Although the perpetrators themselves are the real troublemakers in these scenarios, those reporting sexual harassment and asking for appropriate consequences to be borne out, are disrupting a long-standing status quo in a strongly hierarchical industry. And as clearly highlighted by these stories, the repercussions for this type of troublemaking can be personally and professionally damaging.

In the case of the individual harassing others in the operating room, it was common for their behavior to be known to others in the organization. They were known troublemakers but there were no consequences for their type of trouble. For example, Emami notes, " . . . He had a history of disruptive behavior and anger management issues." While many of the victims in these stories faced debilitating personal and career consequences, perpetrators were simply moved from one department or even more simply, one room, to another. As one anonymous author recalls, "The head of anesthesia decided to allow him to continue working at the hospital. He would be assigned to different operating rooms than the ones where I was typically assigned and instructed not to interact with me."

While many of the perpetrators brazenly made trouble, several women reported avoiding being labeled a "troublemaker" by not calling out the harasser and not reporting the issue up the chain of command. As Wandel recalled after a colleague confided in her about a sexual assault, "She begged me not to report the incident. She did not want to be labeled a troublemaker. I finally agreed to this, but my decision haunted me the rest of my career." In some instances, when the issue was reported,

the troublemaker label arose in questions and comments suggesting that the victim allowed this trouble to fester. For instance, as an anonymous storyteller recalled her interaction with the Medical Staff Office, HR, and department chair after reporting an assault by the anesthesiologist in her OR, "Why did I allow the case to move forward to the OR, knowing I would be trapped in my room with him all day? . . . This was a near-miss, a disaster waiting to happen, under my watch and for which I had full responsibility."

These narratives highlight two important implications regarding trouble. First, there are implicit rules about what trouble is acceptable and unacceptable. Trouble that sticks to the hierarchical, male-dominated, status quo is permitted. Conversely, behavior that challenges the norm by calling out perpetrators who are often known as such to the organization, is the kind of trouble that is simply not allowed. Second, the surgeons know the rules, and they play by them. For women, this means considering how one's actions, from the way she behaves, speaks, and dresses, may draw attention and make her a target for trouble. This, Butler recalled, was her plan to stay out of trouble—"I was careful, I wore pastels, never let my long hair down, never wore dangly earrings, never wore skirts or heels . . . never."

Hearing Through the Grapevine

For many, the workplace grapevine is likely a familiar concept. The grapevine, commonly characterized as gossip or rumors, represents the informal spread of information throughout an organization (Zaremba, 1988) when formal communication channels fail to provide sufficient information to satisfy organizational members (Houmanfar & Johnson, 2004). Information spread through the grapevine can be both positive and negative (Grosser, Lopez-Kidwell, Labianca, & Ellwardt, 2012). In a sexual harassment context, the workplace grapevine operates similarly. When organizations ignore or silence claims of sexual harassment, they fail to communicate necessary information to organizational members, which, in turn, soaks the seeds of the grapevine that will produce both a protective and vicious fruit.

In the case of protection, the grapevine acts as a type of whisper network which informally facilitates the transfer of knowledge about who may be dangerous. As she recalls her career trajectory as a surgeon, Butler characterizes the role of the grapevine as "a relay" in which women pass critical information from one another, "Stay away from him. He tries it with all the women. Don't meet with him alone." When a hierarchical culture of fear prevents victims of harassment from formally speaking up, and when institutionalized harassment goes unpunished, those who have experienced harassment find other methods for helping others avoid unwarranted advances and inappropriate actions.

The same mechanism that these women viewed as critical to their protection and survival within this system, also served as a mechanism for harm. Many reported the damaging effects that the spread of rumors had on them throughout their career. As Emami notes about being "difficult to work with" for her "big mouth" early in her career, "After a decade later . . . The gossip has lived on and has cost me some opportunities . . ." In many instances, the grapevine flourished when women violated gender or organizational expectations. If women dared to challenge the socially accepted behavior of a predatory surgeon, they became a primary target of gossip. An anonymous author recalls, "Do you know what happened to Dr. so-and-so?" "I heard he was being himself and it upset a sensitive surgeon." This type of gossip serves as a mechanism for bullying, which can have debilitating effects. As Temkin recalls, "I felt as though I could hear and feel her and her buddies gossiping and spreading rumors. When women bully other women, there is no shouting or screaming or physical threats. The volume of everyone's voices actually goes down."

When institutions fail to communicate about sexual harassment events, they fail their surgeons in two critical ways. First, they implicitly endorse the harassing behavior, which further perpetuates a cycle of harassment. Second, they activate the lines of the organizational grapevine, thereby fueling the

spread of information entirely out of the institution's control. As noted here, this information can result in bullying through gossip and rumors about those who have reported harassment. But perhaps equally as damaging, is the message it sends to surgeons—this is *your* responsibility to manage. While the organizational grapevine is a long-standing method of communication for women to learn who is safe and who is dangerous, under no circumstances should it be their responsibility alone to protect themselves at work.

Being Our Own Saviors

A common thread in many of the narratives was the role that female colleagues and mentors played in helping the authors navigate the world of surgery. In some cases, the women around them helped them to thrive, but in others, they actively undermined and belittled them. In one instance, Verran reported that "the nurses in the operating room were all charming and attentive when my male boss was present. However, the minute he left, they reverted to being barely civil with me." However, reluctance to offer support was not limited to one group. Burgess draws attention to the" . . . aloofness of the other two women in the program . . . [who] carefully kept a distance from each other as well." In these isolating circumstances, some of the women learned to become their own advocate. For instance, Burgess recounts how she learned to respond to "petty sexual harassment by male surgeons, such as arms errantly rubbing against my breasts—in these cases, [she] usually stepped on the owner's toes, making everybody move."

Despite these challenging interactions, the authors also celebrated the women in leadership roles who helped them succeed. For example, Wandel stated that she was "very fortunate to work with the one and only female surgeon, a cardiothoracic surgeon [who] taught [her] how to communicate effectively with [her] male colleagues and how to survive in a tough, very male-dominated field." By giving their time and attention, these mentors contribute to what has been deemed the "power of the pack," or the important impact that a close, inner circle of female contacts has on women's career success (Uzzi, 2019).

In fact, many of the women are optimistic that, with more women in positions of authority in hospitals and medical schools, bias, harassment, and assault will decline and workplace environments will improve. According to the NASEM report (2018), this may very well end up as an important stepping stone. However, there is a potential downside to the framing of women as in control of this change. Kim, Fitzsimons, and Kay (2018) found that when women were presented as capable of surmounting gender inequality barriers on their own rather than needing crucial structural changes, others perceived that inequality was both caused by and needed to be solved by women. Put simply, women can't and shouldn't be expected to make this monumental change alone. In fact, several of the authors included in this symposium were in leadership roles and still expressed frustration with their organization's culture and expectations of women. Burgess, for instance, worked hard to improve the environment and shift expectations as best she could as chief resident, but she still faced challenges to her status and, in one instance experienced "aggressive sexual assault" from a man "older in age to [her] but junior in the hierarchy." Additionally, as Verran notes, "I have numerous stories I can recount from a surgical career that has spanned just over 30 years, spread across 4 countries." These incidents are not isolated in nature—combating them will take allyship across levels of organizations for years to come. In short, to borrow a phrase from Wandel that closes her narrative, "there is still work to be done."

Conclusion

As each of these themes highlight, surgery is steeped in crisis. For years, women have worked within the system to fight harassment throughout their careers by being better, playing by the rules of someone else's game, and staying in their place. Their efforts are not for naught. While the focus of this commentary has been on the persistent negative

experiences of women in surgery, signs of progress have emerged. For example, the overtly sexist questions which Burgess was asked in interviews (e.g., "whether my husband supported me, was I planning on getting pregnant?") are now illegal. Further, women are not alone in their fight. Burgess, Wall, and Chopra's narratives all recognized the importance of male allies who helped open doors for them to gain critical experiences. Further, most of the authors changed jobs at some point in their careers. In addition to the horrific environments depicted throughout, there are also sprinklings of positive and supportive environments. This last note is especially pertinent as it suggests that the abusive cultures described here are not mandatory staples of surgery.

On the subject of change, the authors of these narratives present several suggestions. Verran and Butler argue for increased women in leadership roles. Wall and Verran highlight the importance of educating young doctors. Similarly, Wandel discusses her experiences as a mentor. And, Ganai emphasizes the need for system-wide change. All of these suggestions have been explored in the broader literature on culture change and have been found to play an important role in enacting changes that stick. To see true change, however, there must be a sweeping, system-wide overhaul that promotes the development, advancement, and retention of women in the surgical field. As Butler so elegantly states, "We owe it to the next generation of surgeons, of patients, of families, and to the daughters and sons of surgeons to change the narrative." We wholeheartedly agree.

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Commentary
The Value of Speaking up

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Abstract. The authors of the contributions to this symposium #MeToo in Surgery: Narratives by Women Surgeons have courageously told often difficult stories that are important for all surgeons to reflect upon. The stories of discrimination and harassment are terrible to read but in no way surprising for anyone involved in surgical training over the last 30 years. Unfortunately, these experiences are not of historical interest only. They continue to occur and point to the need to change the culture of surgery.

Keywords. Gender Discrimination, Bullying, Harassment, Surgical Culture, Role Models, Female, Surgeons, Medicine, Narratives

The experience of surgical training and surgical practice can be a grueling process in the very best of circumstances. The authors of these 12 manuscripts have all reflected on the topic, "#MeToo in Surgery: Narratives by Women Surgeons." As a man, it is both an honor and a daunting task for me to be asked to comment on these sometimes painful and very personal narratives.

Each of the authors has told a story that at the same time stimulates two simultaneous responses: I cringe that the events described could have happened while fully acknowledging that such events happen more commonly than we ever want to believe. The stories told in this symposium bear strong witness to the tremendous challenges faced by my surgical colleagues who are women. Each of the surgeons who have contributed to this symposium has overcome the natural tendency to keep quiet and forget about difficult experiences. Each of the authors should be commended for having the courage to tell their stories in the hopes that others—men and women—will benefit from the discussion of these issues.

Several themes were reflected in more than one of the stories, and these overlapping themes warrant additional attention. Several of the authors described their experiences while looking back on their paths through medical school, residency, and practice. Although there is an acknowledgment that much has changed over the last few decades, the problems identified continue to be present. As Anonymous Two writes, "Gender discrimination and sexual harassment are both alive and well in medicine . . . I truly believe that we have to first understand the scope of the problem." All the authors argued strongly for the need for more

changes in the culture of surgery to create an environment where prejudice and harassment are not tolerated.

Although role models of successful female surgeons are much more prevalent today than two or three decades ago, surgery continues to be largely dominated by male surgical leaders. Karyn Butler emphasized the importance of role models when she wrote, "I have come to appreciate how imperative it is for trainees to see someone who looks like them so that they too can achieve their goals." More than one of the authors emphasized that being one of few women in surgery during their training meant that they were often in the spotlight whether they wanted this attention or not.

Although surgery has been a male-dominated specialty in medicine, several authors pointed out that harassment and bullying did not uniformly arise among male surgeons, but were often at the hands of women in health care. The negative impact of female nurses discriminating against female surgeons was noted by more than one author. What is clearly evident is that bullying and harassment, regardless of gender, are destructive and should not be tolerated in surgical culture.

Several authors utilized the images of warfare to describe their experiences in training and practice as surgeons. The fact that the imagery of war can so easily be used when describing the experiences of these women surgeons is strong evidence of the tremendously destructive effects that such experiences can have on a person. Just as the survivors of war bear the effects of their experiences for years to come, so we must consider the negative impact that so many of these experiences have on surgeons who have repeatedly been, as Claudia Emami writes, "caught in the crosshairs . . ." We must acknowledge the challenge that these experiences provided and seek to alter the way that women are treated in surgery.

The dramatic variability in experiences between different programs that the authors noted is evidence of the impact that a chair or program director can have on the culture of a surgical program. Although it may not be comforting for someone who is currently experiencing a toxic work environment, there is value in knowing that not all surgical programs treat women the same way. If someone reading these stories is demoralized by their experiences in a surgical program, remember that several authors found that by changing programs, they were able to identify supportive environments to pursue their goals.

It is also clear from these stories that it is not only those in leadership positions that can have an impact on the culture of a surgical department or program. As Anonymous Two has written, "What continues to surprise me is that much of the discrimination and harassment I've experienced has come from my peers, not from the old guard." By failing to object when we see such behavior occurring at any level, we miss the opportunity to try to change a culture.

All of the authors reflect the common belief that one can best overcome prejudice by performance. While this is often true, and in several instances in the narratives, the authors were able to use their talents to overcome great obstacles, we must not forget that there ought not to be different standards of performance for women and men. Women should not be expected to work harder to "prove" that they are worthy of the trust of their faculty or colleagues. The imperative to take excellent care of patients should be applied uniformly regardless of the gender of the surgeon.

This problem of different standards of performance also reflects a related theme noted by several contributors. Women are often judged by different criteria than their counterparts who are men. Nora L. Burgess writes that she was expected to be "sufficiently 'likable' in a way totally different than what was expected of male surgeons." Similarly, Sarah M. Temkin writes, "I was encouraged to smile more." These different standards for female surgeon behavior and male surgeon behavior are deeply disturbing and yet pervasive. A difficult male surgeon is often described as "cranky" or "a curmudgeon," but a difficult female surgeon will more commonly be referred to as "a bitch," as Sabha Ganai has pointed out. Such double standards need to be recognized so that they can be systematically eliminated.

One of the more disturbing aspects of several of the stories in this symposium was the desire by some authors to keep their heads down and remain silent. The challenge of speaking up was that it often seemed to make problems worse. As several authors noted, by speaking up about harassment or discrimination, they were often subjected to further isolation at their jobs, which exacerbated the problems. Nevertheless, the importance of speaking up was emphasized by several authors and is exemplified by the lasting value that a symposium such as this can have. By telling their stories, these authors can give comfort to some who may be experiencing similar challenges and empower others to speak up to further change the culture of surgery.

Several contributors noted the value to an organization of having more surgeons who are women and approach challenges differently. As Karyn Butler writes, "What women and men in surgery must see is that vulnerability makes us better surgeons; it allows us to connect with our patients, to empathize with families, to stand in the center and admit that we were wrong, that we are sad for an outcome, that we care about our patient's pain." The gender diversity of surgery will give students, residents, fellows, and faculty the chance to have diverse role models illustrate the multiple ways of handling the daily challenges of being a surgeon.

One of the striking themes that several of the authors touched upon was the aggressive and often hostile culture of surgery that has continued to allow bullying of surgical residents and fellows. Such egregious behavior is not specific to women in surgery but has been routinely experienced by men and women. Why is it acceptable to behave this way in surgery? Without question, being on the receiving end of verbal abuse and angry tirades can take the joy out of surgical training, and there is certainly no evidence that it results in better surgeons. Anji Wall writes, "As surgeons, we must create a culture of zero-tolerance for abusive behavior in and outside of the operating room. We cannot continue to value the aggressive, arrogant alpha-male. We cannot treat technical excellence as a hall pass. No one is too good to be kind." How much better would the life of so many who work with and are treated by surgeons be if we took this sentiment to heart and changed what is acceptable surgical culture?

As a middle-aged, white male surgeon, I clearly fit the demographic of those in power in surgery who have often not done enough to combat the prejudice and harassment that women in surgery have faced. Nevertheless, it is gratifying to realize that several contributors to this symposium identified the positive impact that one or two people can have on an individual's education and career. Lest we become discouraged about how hard it is to change "the system," we must remember that our greatest impact is on how we treat each of the individuals around us whether they be colleagues, learners, or patients.

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