About time

Judith Brown and others write about gender issues in this month's journal.[1] Their observations were the result of a survey to new surgical recruits with questions related to a career in surgery. This is a topical issue in most medical and surgical fields. However, the gender issue of medical specialty choices among female physicians is not a new phenomenon; others have discussed it before — even as early as 1969[2] in the peer-reviewed literature. Unsaid in the paper by Brown and colleagues[1] is how to relate the role of female surgeons (or male surgeons who are more domestically oriented) to the more conventional ideas of how surgeons work. It is about time we are better able to delineate the implications of the increasing number of surgeons with different expectations about lifestyle. Women are only 1 group — most graduating physicians desire a different lifestyle than their forebears.

The evaluation by governing bodies for budgeting purposes and defining overall job equivalencies is becoming more difficult. Recruitment by small departments has been a traditional sore point, as older, more established physicians perceive the newcomers as not working the same hours or holding the same responsibilities. However, the glass ceiling seems to have been broken in many places, and that is only appropriate. The University of Western Ontario (UWO) has accomplished raising the numbers of female surgeons with a concerted hiring policy, resulting in an equal number of women and men now being recruited. In my division at McGill University there is no overall gender recruitment plan, but we now have roughly the same overall ratio of men to women as UWO — and this has been accomplished solely by hiring on merit. Hiring on any other basis is undesirable. Affirmative action will not give us the best surgeons. More women will enter surgery; the number of women enrolled in medical school is the highest it has ever been. Today's male-dominated specialties will see a gradual — or perhaps abrupt — drift to a more equal ratio of women to men, much as pediatrics and obstetrics and gynecology has until now. This will happen as much as morning rounds will become afternoon rounds, which are less disruptive to families. I don't see surgeons, especially new surgeons, stopping this drift. We are not the first country or society to see this change and can probably learn from others' experiences.

Another concept yet to be broached is how will societal views and the attitude in the surgical specialties themselves change toward the surgical community as we switch over to the next crop of surgeons. Will the same value be placed on patient care and contact or even on the surgical specialty as we go forward with surgeons who are devoting more time to other things?

It is about time we, as surgeons, take the issue to heart and debate it openly. The topic is old news for governments and for the medical associations who determine pay scales and hiring positions. It just seems to be news for us surgeons.

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