Women in Surgery
The Same, Yet Different
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In 1993, Claude Organ, MD, wrote an editorial in this journal on the subject of women in surgery. In that editorial, he expressed the hope and expectation that in the near future there would be no need for such editorials. Over a decade later, I am as surprised and disappointed as Dr Organ to find that there remain “women in surgery” issues of sufficient gravity to warrant discussions, committees, lectures, research, and, yes, editorials.

The number of women at all levels of surgery and presurgery is measured, remeasured, and studied from every direction. This has an odd, somewhat isolating effect on those of us under scrutiny. Most women surgeons of my era, and certainly those before, have spent our careers being as sexually invisible as possible while attending to the business of learning and practicing surgery. The goal was to be accepted as a surgeon, not a woman surgeon. Now, to be a surgeon and thrown into the spotlight as women is blinding. Being asked to write this editorial made me both proud and uneasy. Talking about it with my colleagues, friends, and husband (a male surgeon) has been uncomfortable. Are there issues? Is discussing them not just a form of whining? And yet, as I review the literature and ponder my assignment, it is obvious that there are deep and complicated issues that have very real implications for the future of our field. The subject is sensitive, volatile, and difficult to think about or discuss evenly. That has changed little since Dr Organ’s editorial, but our current culture and the sheer number of women in surgery have forced an exploration of the issue.

The bright spotlight has turned up some interesting facts. We know, for example, that although as many women as men now enter medical school, many fewer women go into surgery. We know that the highest levels of academic surgery, the executive committees of societies, the chairmanships, and the full professorships, women are vanishingly rare. We know that women residents are less likely than their male counterparts to be married and even less likely to have children. We know that women surgeons are overwhelmingly more likely to be married to other full-time professionals. We know that women surgeons spend more time on domestic chores than their male counterparts, epitomized by those with children who spend nearly an entire extra workweek (39 hours on average) on child care.

THE CHILDBEARING ISSUES

It is easiest when talking about women in surgery to focus on parenting or, even more narrowly, on pregnancy and maternity leave. These are discrete topics that can be discussed and, to some extent, addressed. For many years, there was an expectation that surgical residents, essentially all men, would not be married. Later, when marriage was deemed acceptable for residents, family was expected to stay out of the way of surgery. Introducing visible family in the form of pregnant surgeons has been interesting, and likely very difficult for women surgeon pioneers. In the 1980s, women on Wall Street wore suits with padded shoulders and little bow ties. Similarly, early women surgeons hid their femaleness from their colleagues by remaining single, or at least child-free, to
work just like the men. The idea of a pregnant surgeon
or surgical resident was shocking, although male sur-
geons and residents commonly had children. Surgery is
without a doubt a macho field. Early on, pregnant sur-
geons took great pride inshouldering their full share of
the work during pregnancy, operating up to delivery, and
returning to work in as little as 2 weeks. This is the ma-
cho version of pregnancy.

Formal maternity leave policies for surgical faculty and
residents are still evolving at many institutions. It is sur-
prising that in 2002 an article on maternity leave policy
was of sufficient merit that it was published in Surgery;
one would have hoped that maternity leave was no longer
newsworthy in this century. And yet published it was,
and it will likely contribute to solving the vexing prob-
lem of what to do with the pregnant surgeon, leaving us
with more amorphous issues to discuss. As surgeons, we
prefer the finite, solvable problem. Softer issues like cul-
tural change, unmeasurable currents of isolation, and in-
explicable attrition are more difficult to cure. Although
women have practiced surgery since ancient times, there
have been long periods when they were formally ex-
cluded or at least marginalized. The first formal sur-
geon’s guild in the Western world specifically excluded
carpenters, smiths, weavers, and women.

THE AMORPHOUS ISSUES

I began my surgical residency at Massachusetts General
Hospital, Boston, in 1987. It did not occur to me that I
was any different from the other residents. I was aware
that it was still a male-dominated field, but I felt the bar-
riers had already been broken by women before me. By
the time I started my training, I felt that if a woman wanted
to be a trailblazer she would need to focus on fire fight-
ing, flying fighter jets, or space exploration. From my per-
spective, surgery was already open to women. I did not
see any issues and did not feel that I encountered any.
In medical school at the Columbia College of Physi-
cians and Surgeons, New York, NY, the clerkship direc-
tor asserted that surgery was a great field for women, es-
pecially those who wanted to have a family. He stated that
a surgeon’s day is, by definition, chaotic. Time to per-
form a case or complete rounds cannot be scripted. We
never know just how long it will take to prepare pa-
tients for a procedure and make sure, in our hearts, that
we feel they understand exactly what they are trusting
us to do. We are called to many locations at once: the of-
cine, the committee meeting, the operating room, pa-
tient phone calls, medical records, the floor. My clerk-
ship director contended that it’s not hard to wedge a little
more chaos into that scenario by throwing in a parent-
teacher meeting or a Halloween parade. That seemed bril-
liant to me. As long as one can tolerate some chaos, it
should all work out. I wanted to be a surgeon, and this
brilliant rationalization made perfect sense. I don’t re-
call registering the fact that there was only 1 categori-
ical woman surgical resident in that residency program. Now,
moved to another surgeon and with 2 sets of twins, I
can state with authority that there is a limit to how much
chaos can be managed in 1 day. Still, I heard what I wanted
to hear and made my choices with my eyes open. I do

think surgery is a special career that attracts special people
who are more likely to have the skills to keep all, or at
least most, of the balls in the air at the same time.

As a resident, I did not feel at all isolated or different.
There were 2 women on the Massachusetts General Hos-
pital faculty at the time: Patricia Donahoe, MD, was chief
of pediatric surgery, and Susan Briggs, MD, did general,
vascular, and trauma surgery. There was 1 other woman
in my intern class, and ahead of me in the residency were
4 women of the approximately 60 residents engaged in
either their research years or their clinical training. True,
at any given time I was often the only woman in the room.
True, I changed in the nurses’ locker room. True, I was
commonly mistaken for a nurse and once for the “TV girl,”
but none of this seemed significant. I was a surgeon.

In my second year of residency, I rotated on the gy-
execology service. My team consisted entirely of women,
which initially seemed a little odd, even inferior in some
way. I was reassured when rounds went smoothly and
the patient care seemed well organized and thorough.
I was more struck by the breakfasts we shared after
rounds. Breakfast was easy, comfortable, relaxing, and
somewhat reenergizing. I could not then, and cannot now,
put my finger on it. I must say, however, that being at
work in the company of women was a little easier than
being at work in the company of men. In some way it
must be that when I was with the men I felt the need to
keep my guard up or, at a minimum, I was expending
energy to fit in. My experience then mirrors those issues
that we now probe so diligently. That subterranean sense
of being different is at the heart of our current discus-
sions about women and surgery.

In one study about women in academic surgery, more
than half of women surgeons responding to a survey felt
that they were excluded from mentoring, informal net-
working, and collaboration in ways that hindered their
advancement. This is a difficult thing to measure or prove,
and yet the perception itself seems important. If women
carry that sense of exclusion with them, why would other
women enter the field? How can we change something
that is so hard to measure or legislate?

ISSUES OF WORK DISTRIBUTION

Women in surgery are highly visible. The sense of ur-
gency to recruit more women into surgery may some-
times lead to premature promotion or assignment of re-
 sponsibilities. Some women fear that their successes are
only due to their being female; likely some of their col-
leagues make the same assumption. Both these lines of
thought are uncomfortable for the woman who sits at any
but the most junior levels. As more emphasis is placed
on the importance of attracting women to the field, the
women already in the field are asked to serve on com-
nittees and in administrative roles. Women are dispro-
portionately burdened by administrative assignments,
something that takes away from the time to be academi-
cally and clinically productive. Several authors have sug-
gested recognizing an administrative track in surgical ca-
erers, of equal weight to research and clinical tracks. At
this time, the administrative roles are often underappre-
ciated in terms of promotion or salary.
HIDDEN FACTS AROUND CLINICAL PRACTICE

Surgeons have long been excused from family and community commitments and were often married to individuals who took full responsibility for overseeing these areas. Surgeons were expected to miss many family affairs and community rituals in the interests of their patients. The prevailing concept was that absolutely nothing could interfere with the care of patients. The most dominant surgeons were those with the biggest practices, often doing the most difficult cases. An unspoken discrepancy in this system is that those same dominant, busy, committed surgeons were the ones invited all over the world to give talks and receive honors. During those trips, someone else took care of their patients. This was an accepted pattern for famous surgeons. It has always led me to wonder, does it really matter whether the reason you can’t see your patient every day after surgery is because you are out of the country giving a keynote address or because you are out of the office at a child’s soccer game? We have a model of shared responsibility for patients already; is it somehow less legitimate if it is invoked to allow for part-time work or involvement in the community than it is for world travel and lectures?

CHANGES IN PROCESS

How has the presence of women in surgery changed the field? If nothing else, it has forced us to examine ourselves, always a healthy practice. We look again at the surgical meritocracy and think anew about what earns merit. Is it research? High clinical volume? Long hours at work? Mentoring and career development? Education? Organizational skills? Administration? Leadership? Willingness to serve at the departmental, hospital, or national level? All these things have value and can be fairly put into the mix. Synchronous with the increase of women in surgery has been a greater emphasis on balance in life, for which women are both blamed and credited. It is not obvious to me that these 2 issues are directly related. Certainly, life balance is a greater preoccupation of today’s young people than it was of their baby-boom and postwar parents. It is not only women and more commonly men as well. In any case, these 2 phenomena have coincided and these, along with new workweek regulations, are altering the way that surgery is practiced. Work is shared. Surgeons sign out to each other on weekends. We answer each other’s phone calls at night. We take care of our patients as a team. The simple fact of increasing numbers of women in surgery makes their presence less of an issue. As events repeat themselves, they become more familiar and less anxiety provoking. The first pregnant surgeon is a crisis; the 10th is routine. The first surgeon to weep instead of yell in frustration sends shock waves; the last presents a familiar if still disconcerting situation. The first woman to work part-time looks like a failure; the fifth to join a successful practice of other part-timers is another part of an elaborate system of health care with room for all willing workers.

WOMEN IN LEADERSHIP

The history of American surgery has been a history of men. Women, for the most part, were a sporadic presence, known mostly to their own communities and patients. Now, at the beginning of the 21st century, we find the field peppered with women, a relatively recent phenomenon. There are many living women surgeons who are firsts: first woman to finish a given residency program, first woman on staff at a particular hospital, first woman president of a society, first woman editor of a journal, first woman chair of a department. Soon we will have our first woman president of the American College of Surgeons. At upper levels more than at junior levels, though, there are still issues. In 2002, Olga Jonasson, MD, a leader among surgeons and among women in surgery, wrote that “[t]he remarkable underrepresentation of women in [leadership organizations in surgery] speaks for itself. Women have not established a meaningful presence in decision-making bodies in surgery.” Women are significant ones. Now there are leaders and role models in surgery who transcend any sex categorization: Julie Freischlag, MD, chair of the Department of Surgery, Johns Hopkins University; Kathryn Anderson, MD, president elect of the American College of Surgeons; and Barbara Bass, MD, chair of the American Board of Surgery. How has the growing number of women in surgery affected our profession? What if any effects will there be in the future? Which of the recent changes in surgery are due to the presence of women and which due to a broader cultural change in which everyone, men and women, seek a different distribution of time between work, family, and leisure? These questions are hard to separate.

THE CONTINUUM OF CHANGE

The changes that I have seen over the years are related to sheer numbers. I no longer feel so highly visible. I am now surprised to find a leadership group composed solely of men. Departments and residencies often have formal maternity policies and even have cause to apply them. At the residency level, there appears to be little concern that any resident will perform less well than others because of sex. Part-time work, flexible-time work, and modified work hours, either temporary or permanent, have been encouraged by such leaders as Andrew Warshaw, MD, at Massachusetts General Hospital, and Larry Kaiser, MD, at University of Pennsylvania Health System. The upper levels are less well blended; Dr Jonasson’s concern is real. And yet I am optimistic. Attaining leadership is a long process. Women only began entering surgery in significant numbers in the late 1980s and the 1990s. Now, 15 years later, those residents from the 1980s are starting to emerge as mature surgeons and leaders. There is a certain mandatory developmental lag while those same women first learn the skills of surgery, develop a body of research, and then learn how to work on a committee, to mediate, negotiate, chair a group, and finally to emerge a leader. Those women are all in the pipeline.
THE FUTURE IS NOW

Shining a bright light on these topics may be uncomfortable, but I am relieved to have them illuminated. I am grateful to have the peculiar issues that make my work day different from a man’s acknowledged, hopefully without whining. There was a time when I would avoid sitting by the only other woman in a room full of surgeons, feeling that putting the 2 of us together somehow created a ghetto. Now there are enough women in the room that it doesn’t matter where I sit. The balance is no longer defined by sex. The most comfortable meeting I have ever sat in as a surgeon was the Archives of Surgery editorial board meeting. Dr Organ has worked to make the hope he expressed in 1993 a reality. The board is a generous mix of surgeons from all types of practices, from multiple ethnic groups, and from both sexes. I do not know how many women are on the board. That is the point. I am blinded to their sex by their number. I can sit anywhere I want because no one person can skew the balance of the table. That is the goal for surgery and for society at large; not whether 12% or 20% or 50% of surgeons are women, but whether good people want to come to the table and feel comfortable enough to stay there.

Dr Organ was wrong about the time frame for women blending seamlessly into the world of surgery, but I am convinced that he is right that it can and will happen. That day is getting ever nearer. It has been my privilege to witness, and be part of, the process.

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