VOICES OF SURGERY

WOMEN IN GLOBAL SURGERY

A PUBLICATION DEDICATED TO GLOBAL SURGERY
AS OF 2016, IN THE USA, ONLY 19.2% OF SURGEONS ARE WOMEN, IN THE UNITED KINGDOM, ONLY 11.1%. GLOBAL DATA IS NOT AVAILABLE IN LOW AND MIDDLE INCOME COUNTRIES.

*WOMEN IN SURGERY: CHALLENGES AND OPPORTUNITIES - DE COSTA, JOSEPHINE, BA/LLB; CHEN-XU, JOSÉ, BSC, MD; BENTOUNSI, ZINEB, MD; VERVOORT, DOMINIQUE, MD - WHO GLOBAL HEALTH: JULY 2018 - VOLUME 1

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The Emergence Of Gender Equity In Global Surgery
From the Program in Global Surgery and Social Change, a powerful argument is put forward for women in the surgical workforce.

Cambodia’s All Female ENT Unit
Hannah Callas, a Fulbright scholar working in the Children’s Surgical Centre, describes Dr Kim’s story and the remarkable ENT service.

Innovating To Bring The World Closer Together
Dr Nadine Hachach Haram is a surgeon, an entrepreneur, a mother and a global leader. We learn how Proximie, a technology company she founded, is bringing the surgical world within touching distance.

Finding My Surgical Direction In Ghana
Despite the doubters and challenges ahead, Dr Dorcas Osei-Poku still dreams of becoming a neurosurgeon in Ghana

A Woman In Global Surgery
Zineb Bentounsi is a leading voice in the global surgery movement. She describes her contrasting experiences between being an advocate for global surgery and in the operating room itself.

Changing The Landscape Of Tomorrow
Xiya Ma beautifully summarises the current landscape of women in the global surgical landscape and raises hopes for a brighter future.
WOMEN IN GLOBAL SURGERY

April 2019

Dearest Readers,

Women have been a part of surgical practice for over 5500 years, first recognised when the Sumerian queen, Shubad of Ur was discovered entombed with her surgical instruments, ready to continue her surgical practice beyond this world. Throughout the years, as civilization grew and developed, it has been known that female surgeons have struggled for equality with their male counterparts, indeed some needing to hide their gender just to continue their work, dressing up in a masculine fashion. The most renowned being Dr James Barry, a trauma surgeon and pioneer in the field of global surgery, whose sex was not revealed until after her death in the 19th century.

In many parts of the world, it is still considered that a woman’s primary role are domestic duties with limited contributions to the workforce. Those striving beyond this, breaking traditional barriers and obtaining higher learning, often face many challenges, having to prove themselves to their colleagues and peers in a professional capacity as well as to their family and friends in their private life.

Today we have a situation in which we have obtained a gender balance within medical schools, but still many surgical departments lag behind, with a far higher male prevalence. Other medical specialties are often promoted above surgery to female doctors, for their perceived alignment with traditional females roles.

As you read our 6th issue, we at One Surgery hope to raise awareness of the global gender imbalances within the surgical field and embolden the voices of those open enough to share their experiences and thoughts. We want to encourage, to inspire and enable women globally to find their strengths in order to fulfill the ambition of a career in surgery and fill the desperate gap in the worldwide surgical workforce.

With love always,

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THE EMERGENCE OF GENDER EQUITY IN GLOBAL SURGERY

BY JACQUELYN CORLEY, M.D. AND ELIANA KIM, B.A.
You Are Not Alone

Within hours of publishing the first blog post about our new organization, The Gender Equity Initiative in Global Surgery, our email inboxes became flooded with inquiries from women all over the world(1)(2). What is this initiative about? Can I find out more? How do I join? Yes, this was extremely encouraging as we had hoped we could garner interest and recruit other potential members.

However, the most striking discovery was that there was a recurring theme embedded in many of these messages that echoed similar struggles we have had in our own career paths. Many of these women expressed a strong desire to pursue a career in surgery, but had been told by others that this was unlikely, improbable, or even impossible because they were women. Here we thought these attitudes were isolated just to neurosurgery or to the United States, but apparently sexism and gender inequities are universal. The sad truth is that women on every continent face parallel challenges and barriers that create an arduous and sometimes lonely road to becoming a surgeon.

However, we are here to illuminate the other side of this coin. You are not alone. We experience these struggles together, and in this unity we can support one another and generate momentum for change. The fact is simple and plain: Women belong in surgery.

The Argument for a Woman Workforce

We understand from the Lancet Commission on Global Surgery (LCoGS) that 5 billion people around the world lack access to safe and affordable surgical, anesthesia, and obstetric (SAO) care(3). In order to address this large disparity, there needs to be an estimated 143 million additional surgical procedures each year. Thus the shift in global health away from mission trips and surgery camps to surgical system strengthening and prevention of catastrophic expenditure bolstered by universal health coverage is not only appropriate, but essential to meet these demands(4)(5)(6). It is clear that there is a severe shortage of SAO professionals to fill these gaps. In fact, the only way to accomplish these seemingly insurmountable goals is to engage and empower the other half of the population that has traditionally been left out of the surgical field. Women need to start contributing more to the SAO workforce as well as to research and policy endeavors in order to meet these critical LCoGS benchmarks.

Furthermore, the case for racial and ethnic diversity in healthcare workforce has already been solidified and we recognize the virtue in culturally competent care and assuring an awareness of issues unique to minority populations(7). Gender is no different, and women surgeons are poised to be strong and powerful advocates for women patients. Studies have demonstrated that patient outcomes are improved when female physicians and female surgeons are in the picture(8)(9).

Finally, and perhaps most importantly, gender equity in surgery is a human rights issue. In 2015, all member states of the United Nations adopted the Sustainable Development Goals (SDGs). The 5th SDG is to “achieve gender equality and empower all women and girls”(10). We are all bound by this
commitment and must address the profound issues of gender discrimination and unequal opportunities that exist in the world. The field of surgery is by nature intense and unforgiving and has been traditionally male dominated. But if we can achieve gender equality in this domain, there is hope for all others.

A Tower of Blocks

A recent qualitative study by Liang and colleagues compared the various factors for why women leave surgical training to a tower of blocks(11). With this analogy, one can imagine a block representing a distinct difficulty or barrier. Once an individual has accumulated three to four stacked blocks, a threshold effect is reached and the tower might tumble down, representing a departure from the surgical field. Some of these identified obstacles include: long work hours, fatigue and sleep deprivation, unpredictable lifestyle, impact on relationships, lack of learning opportunities, bullying, impact of child rearing duties, insufficient role models, sexism and discrimination, unavailability of leave, a distinction between valid and invalid reasons for leave, poor mental health, absence of interactions with other women in surgery, fear of repercussion, and lack of pathways for independent and specific support. Some of these barriers are common to both men and women; however, many are specific only to women, rendering them vulnerable and cemented within an inequitable institution.

While this study was conducted on those already in surgical training, some of these issues are just as apparent and perhaps more potent for younger women in school who aspire to become surgeons. Not only must we work tirelessly to recruit young women into the surgical field, but we must make systematic and structural changes to our programs and departments in order to retain these valuable members of the workforce.
We Can Be Agents of Change

If these obstacles and limitations are so ingrained in the culture and foundations of health care, how can we possibly create change?

We cannot simply wave a magic wand and instantly eliminate the systemic inequalities deeply rooted in the patriarchal institutions of medicine and surgery. However, what we can do, is start from the grassroots and create a ripple effect. This is precisely what our organization, the Gender Equity Initiative in Global Surgery, aims to accomplish; and we are tackling this challenge through three main strategies: research, mentorship, and advocacy.

Research will give us a way to answer the key questions we have: why are there so few women surgeons and even fewer in positions of power? Why do female medical students feel discouraged from considering a career in surgery? Why do many more women leave surgery than men? We need to illuminate the female narrative in surgery and identify the often subtle and invisible barriers that disproportionately affect women surgeons. Our findings will inform the surgical community and the academic world on the experiences of women surgeons and help generate solutions to remove the obstacles in their career paths.

Messages generated with research can be amplified through advocacy. We all witnessed the power of effective advocacy in 2015, when a single tweet by Dr. Heather Logghe featuring #ILookLikeASurgeon spurred a movement that swept across social media and mobilized women surgeons all over the world to share their stories, uniting them through common experiences and challenges.

Four years later, the movement is ongoing - and ever growing. We must continue this momentum with a loud and persistent voice for gender equity that can be transmitted and amplified through social and mainstream media, and at various meetings and gatherings. Effective advocacy will be far-reaching and disruptive - and that is exactly what we need to make the cultural and systemic changes in surgery.

Last but not least, mentorship will be crucial for the empowerment of women in surgery. Being a surgeon is difficult and demanding; and being a surgeon as a woman is even more challenging due to the additional obstacles built into the system. Through our global mentorship network, senior surgeons who are passionate about global surgery and gender equity can help juniors navigate their early careers and provide support through the similar obstacles that they may have had to overcome earlier in their paths. They can also mentor any young women interested in surgery and serve as role models for them, dismantling any gender-based stereotypes and limiting perceptions early on.
A Feminist Initiative

Through the Gender Equity Initiative in Global Surgery, we want ensure that any woman in the world, regardless of where they live and what resources they have, is fully supported through their aspirations and career paths in surgery. Our model will enable women to lift each other up in solidarity and change their surroundings together. We would also like to engage men - as mentors for female students and trainees in surgery, as supporters for their women colleagues, and fundamentally, as allies to women fighting for equal rights. With a collective voice for gender equity, we can disturb the status quo maintained by centuries-old institution of surgery and elicit systemic change to make it a better environment for all.

About the authors

Eliana E. Kim is a co-founder of the Gender Equity Initiative in Global Surgery, and an advocate for women’s rights and health. Currently at the Program in Global Surgery and Social Change at Harvard Medical School, she is involved in the Global Neurosurgery Initiative and also does research on health and humanitarian aid in North Korea. Follow her on Twitter @eliana_e_kim

Jacquelyn Corley is a neurosurgery resident at Duke University Medical Center and a research fellow at the Harvard Program for Global Surgery and Social Change. She is a co-founder of the Gender Equity Initiative in Global Surgery, an author, and a human rights advocate. Follow her on twitter @JacquelynCorley

REFERENCES

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CAMBODIA’S ALL FEMALE ENT UNIT
Dr. Kim’s path to becoming a surgeon

BY HANNAH CALLAS
In Cambodia’s capital city of Phnom Penh there is no dearth of medical doctors. In hundreds of private and public clinics, providers can charge desperate patients exorbitant fees for services of varying effectiveness, a system which leaves provincial Cambodians struggling to find appropriate, affordable care. Situated two kilometers across the Tonle Sap river at the Children’s Surgical Centre, an all female ENT department is working to break this mold by providing free surgery and education to their patients.

The team’s youngest surgeon, Dr. Kim, pursued medicine in response to her own family’s troubled history accessing healthcare. Kim was born to farmer parents in the Kampong Cham province, about an hour outside Phnom Penh. When she was just two her father became very ill but attempts to seek care were futile. Doctors in Phnom Penh insisted they could not help, and without knowing where else to go, the family returned home where her father soon passed away.

“My family was always afraid if we had a sick relative again, we wouldn’t know how to bring them to the hospital and find a good doctor. It’s very hard because when you’re from the province the education is not enough,” Kim says regarding the support she received from her mother and aunt when she decided to become a doctor after high school.

Since qualifying from the University of Health Science in 2016, Kim has gone on to help hundreds of patients beyond her immediate family. When Kim joined the ENT department, Drs. Sothea and Davy had already undergone 10 months of training with visiting British fellows Drs. Charlie Huins and Mahmood Bhutta. Sothea and Davy were proficient at treating chronic middle ear disease by performing tympanoplasty and mastoidectomy, procedures a recent graduate like Kim had no experience with.

“Before coming here, honestly I didn’t know much about ENT, just the summary we learned in school”, Kim admits. But with an ever crowding waiting room, Davy and Sothea wasted no time in starting Kim’s training. Of her first few months in the operating room Kim says, “I thought ‘oh this is very hard for me’ because I know nothing.
I had never seen something like this before. I thought it’s very interesting that after the surgery the patient had no infection and the hearing was better, sometimes I think it’s like magic.”

Over time she became more confident under department head Davy’s thorough training. Within six months Kim was completing her own simple cases as Davy and Sothea kept a close eye. She is still being trained on mastoidectomy, but Kim has to date independently completed 146 operations, 112 of which were the chronic infection treating tympanoplasty procedure. Kim is grateful she found such a supportive environment to excel as a surgeon, and is still excited every day by the work she gets to do.

While Drs. Sothea and Davy had foreign surgeons leading their training program, remarkably Kim was able to learn from her Cambodian peers. About Davy’s teaching Kim shares, “during the operation, she was really focused on me, she taught me what is safe, what is unsafe. It wasn’t rushed. Davy taught me how to go slowly, go step by step and take good care of the patient.”

Still, Kim admitted to being nervous when Dr. Charlie Huins returned for a week in 2017 and joined her on an operation. “I told him if I make a mistake please tell me, but he was silent the whole operation and at the end asked, ‘who taught you to do tympanoplasty like this?’ He was very surprised when I said Dr. Davy was the one who taught me to become a surgeon.”

It was a compliment to the whole department’s effort that Kim had come so far, and the praise from Charlie made Sothea and Davy especially proud.
Kim went on to tell me about her favorite patient memory, a woman who had traveled to other clinics in the province and city, spending money on medicines that didn’t improve her year long hearing impairment. This woman was in a position not unlike Kim’s growing up, with little access or understanding of care. After a quick examination, Kim noticed hard wax blockage in each ear and carefully removed it. The woman kissed her on the cheek and was so happy to have her hearing back she began crying.

It was a learning opportunity for the patient who had pursued unsuccessful avenues of traditional healers long before seeking out a doctor and ultimately finding Kim. Laughing, Kim recalls the time she was a child and had an ear infection.

“My mom told me ‘put this perfume in your ear’ and I did. After several days I finally went to the doctor and got ear drops and antibiotics but in the province the education about this is still slow.” Kim goes on, “before I became a doctor, when anyone in my family was sick they didn’t know where to go. Right now I can help.”

When I asked if her family still had a tendency to rely on traditional healers in their village she laughs again, “the first thing in their mind is to go to the Khmer traditional doctor, my family in the province believes in this and I said ‘if you trust the Khmer traditional doctors why did you send me to study to become a medical doctor?’ And now my family listens to me.”

As Kim, who is seven months pregnant, began to discuss her most memorable operation her son started kicking signaling it was time for an afternoon snack. “When he feels hungry he starts to kick. He kicks during surgery but its not strong enough to bother me, I just put my hand down and say ‘don’t kick now I do surgery.” Since the remainder of my questions were not as important as surgery, we wrapped up the interview and joined the ENT nurses tucking into pears gifted earlier that day by grateful patients.

About the author

Hannah Callas is a Fulbright scholar researching surgical training at the Children’s Surgical Centre in Phnom Penh, Cambodia. She can be contacted at hannah@csc.org
INNOVATING TO BRING THE WORLD CLOSER TOGETHER

NADINE HACHACH HARAM
My name is Nadine Hachach Haram. I am a surgeon, an entrepreneur and a mother. I have lived in the US, Lebanon and the UK and seen first-hand the disparities and inequalities in healthcare in each of the countries I have lived, regardless of how rich or poor they are. I hear the voice of my grandmother driving me forward, instilling in me that no matter what the obstacles are, you must always give your all for what you believe. I feel that responsibility and a desire to innovate, to change, to simply not accept the status quo.

As a 14-year-old girl living in Lebanon, having recently returned to witness the aftermath of a civil war, I was a typical teenager. I wanted to change the world and I was keen to make a difference. I had experienced a life without war but arriving in a country where the scars of war were both physically and mentally visible, heightened my desire to help others.

When I learnt how powerful reconstructive surgery is, from recreating a child’s smile or enabling someone to use his hand again, I was hooked – I knew plastic surgery was for me and that I wanted to become a surgeon.

My route into surgery brought me to London and it was here that I also became involved with organisations like Facing the World – a charity for children with facial disfigurement - as well as working with non-profits back in Lebanon, like Global Smile Foundation MENA that provides care for children who need cleft lip and palate reconstruction. Surgeons travelling to share their skills for the benefit of the native patients and doctors is nothing new. It has a huge beneficial impact but is constrained by time and resources in the form of ‘parachute missions’. This work helped to focus my passion, but I started to realise that ultimately my dream was to remove barriers to the very best healthcare for every patient, regardless of location.
Which is where technology stepped in. I’d heard about new concepts like remote surgery and telemedicine, and they fascinated me. What really grabbed my attention was the idea that, using the internet and everyday digital communication devices, doctors and medical practitioners could carry out examinations or consultations from afar. More than that, particularly through the example of robotics, there were concrete examples of surgical procedures being carried out under the guidance of a consultant who was in another city or even another country.

This really fired my imagination because, when you look at the underlying reasons why there is limited access to safe surgery all across the world, you realise that the main issue is a shortage of expertise. There just aren’t enough surgeons to go around. Figures from the World Health Organisation show there are just nine surgeons per 100,000 people in the US and one per 600,000 in Sierra Leone. It estimates that there will be a shortage of 100,000 surgeons in the US by 2030.

That means travelling to where a surgeon with the required skills and expertise is based, straining healthcare economies and exacerbating waiting lists, adding to spiraling costs and, ultimately, patients missing out on the surgery they need, when they need it.

I started to see a solution. What if, you could have a consultant or specialist overseeing a procedure from afar - but instead of operating through an expensive robot, they were guiding, coaching and collaborating with a surgical colleague? This was happening in telemedicine - two doctors using a live video link via an iPad to collaborate on a patient consultation, to get an expert opinion in real time and speed up the care process. I believed the same could be done with surgery.

This solution began to become a reality when my co-founder, Talal Ali Ahmad, an experienced telco engineer based in Boston, and I mapped out a concept which could be used by everyone. To do this we needed to ensure it was affordable, accessible and
interactive, so we layered in augmented reality (AR) to aid this two-way collaboration. With AR, it is not simply a case of two surgeons communicating via video link, and one telling the other what to do. It is far more.

AR creates a rich collaborative experience, the ability to overlay digital content onto a live video feed so you can demonstrate, guide, query and instruct in much greater depth. From digitally marking up where an incision should be made, to transporting yourself into the image your colleague sees via your camera to demonstrate a technique, AR replicates the experience of having a senior colleague in theatre offering expert guidance and opinion - not just voice, but visual demonstration.

Together, Talal and I ran with the idea and founded Proximie. In 2015, one of the first procedures was carried out - reconstructive surgery carried out on the hand of a young man in Gaza who had been injured in a bomb blast, under the guidance of a consultant in Beirut.

It was filmed by Al Jazeera and went on to become Foreign Press Association’s Science Story of the Year 2016. It showed us what was possible and led to the fruition of our idea becoming a reality in countries throughout the world.

Since that point I have been on an incredible journey from giving a Ted Talk on the future of surgery to receiving a British Empire Medal in the Queen’s Birthday Honours 2018. Proximie has won numerous awards and we are working hard to bring its true power, of enabling the scaling of surgical expertise, to more and more patients, surgeons and organisations. None of this would be possible without my firm family roots – the voice of my strong, selfless grandmother pushing me forward and the support of my husband, children, parents, and sisters in their never-ending encouragement of that dream of my 14-year-old self.

To find out more about Proximie, including opportunities to join its growing team, visit www.proximie.com
About Nadine Hachach Haram

Nadine is a surgeon, lecturer and NHS Clinical Entrepreneur, who co-founded augmented reality healthtech company, Proximie. She received the British Empire Medal in the 2018 Queen’s Birthday Honours for her innovative work within the field of surgery and medicine.

Nadine started her undergraduate journey at the American University of Beirut and then graduated with a BSc with distinction from University College London (UCL), receiving the Jack Drummond and Jackson Lewis prizes, for top marks in the faculty and department of biochemistry and molecular biology.

She then went on to graduate from Barts and The London School of Medicine with a distinction and earned the Harvey Minasian Prize for top academic excellence. Her surgical journey has seen her work at a number of London hospitals where she chose to specialise as a plastic and reconstructive surgeon.

Nadine also undertakes a number of roles to help advance surgery, including council member of the Royal College of Surgeons Future of Surgery Commission, council member of the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS), Innovation UK and council member of the Royal Society of Medicine plastic surgery section.

She lives in London with her husband and three children. She was born in San Diego, California, to Lebanese parents and moved to Beirut in her teens, where she lived with her parents and three sisters before coming to London to undertake her university education and train as a doctor. Her parents and three sisters still live in Beirut and she travels home to see them regularly.

She was named on Forbes Middle East 100 Most Powerful Arab Businesswomen list in 2017 and was also a speaker at Ted Women 2017, TEDxNHS 2017 and TEDxCWG.
# Upcoming Global Surgery Events

**April**
- **11** International Maternal Health Day 2019
- **13** 14th Global Health and Innovation Conference (GHIC) 2019 - New Haven, CT, USA
- **20** IncisioN Global Surgery Symposium (IGSS) 2019 - Kigali, Rwanda

**May**
- **23** International Day to End Obstetric Fistula
- **25** Global Surgery Day 2019

**June**
- **20** COAGS Symposium, Montreal, Canada
As a 16-year old in Ghana, West Africa, I came across the news of three urologists who passed away in a gory motor accident. The importance with which the news item carried in the media opened my eye to how essential it was to work in the field of medicine and do all that you can to save lives. After reading about their contributions to the field of medical studies and healthcare delivery, I was spurred on to pursue medicine to the highest level. During my biology classes in high school, I was particularly fascinated about neuro-anatomy and this birthed an interest of neurosurgery in me. Furthermore, after some research, I found out that there was no female neurosurgeon in the country. This also psyched me up to give off my very best to attempt to achieve the feat of being the first or amongst the first female neurosurgeons Ghana will produce.

However, the cultural trend towards women aspiring to the highest possible level in their careers has to a large extent not been affirmative in Ghana. The field of surgery and all its subspecialities has not been an exception. Usually, women, due to their roles in domestic settings, are deemed to be inhibited and are not encouraged to reach their potential in the world of business and science. This assertion is faulty on several grounds as women in times past have pioneered or led several groundbreaking and life changing processes and research findings.

I recollect in medical school how a lecturer and some of my medical student colleagues dissuaded me when I declared my intention to specialize in the field of neurosurgery. This was after the lecturer had inquired of the class what our various intentions were when the time came for us to narrow down the focus to a specific field of medicine. This encounter was quite discouraging as I watched my lecturer and colleagues laugh their heads off as I made known to them my resolve to be a neurosurgeon.

My father, in contrast to the disheartening disapproval from my lecturer, encouraged me daily. With the support of my family, I was completely confident that my dream of becoming a female neurosurgeon will come to pass despite any challenge I may face along my career path in future.

I enjoyed my surgical rotation as a house officer at the 37 Military Hospital in the Greater Accra Region and the Presbyterian Hospital at Agogo in the Ashanti Region of Ghana. Over the years throughout my rotation, I have met mentors, both male and female whose contributions have been invaluable towards the ascent to my aspiration. Along the way, tedious but essential surgical skills and habits as well as practices have been ingrained in me and this has gone a long way to bolster my commitment to stay on track. I also had an internship stint in Germany with the Neurochirugie, Universitätsklinikum Dusseldorf where I witnessed at first hand, female neurosurgeons who had successfully raised families and were at the peak of their powers as full-fledged neurosurgeons.
This experience sparked off so much determination in me. As a medical officer in a surgical department, I have found fulfillment in the various roles I have played for the past 15 months. There has been a great deal of challenges as a female medical officer. Some include the lack of respect and presence of doubt in my surgical competencies due to my age and gender by many allied health professionals and at certain times, my work colleagues. There have been instances where I had to spend some minutes convincing allied health workers on duty that I am highly competent enough to perform a surgical procedure unsupervised. However, there have been other positive instances where superiors recognize the essential process of encouraging and guiding a junior colleague through the mill not only in a bid to achieve the present objective but also to impart essential experiential knowledge.

On a daily basis, I am faced with many challenges. While some of them are short-term in nature, many of them border on the issue of having the best possible balance in my career and family life. My current and most pressing conundrum is planning for pregnancy with my spouse and raising a family. I keep getting confused as to when to start my family. However there is hope. Without much knowledge or availability of female neurosurgeons or female surgical residents, I have had to grapple with how it will tie in with my pending residency program. Despite this dilemma, I have had very valuable counsel from colleagues and mentors. These pieces of advice will definitely go a long way to serve as a catalyst for the achievement of my objective.

Despite these challenges, and with the support I receive from family, friends and most work colleagues, I am quite certain of the direction I have chosen to follow and will ensure that all the available avenues and resources will be exhausted to achieve my goal.

About the author

Dr Dorcas Osei-Poku is an aspiring neurosurgeon, training in the Northern Region of Ghana. She can be contacted via Twitter here: @chrisdoc89
A WOMAN IN GLOBAL SURGERY

ZINEB BENTOUNSI, M.D
I am not a surgeon, at least, not yet. Will I ever become a surgeon one day? I am still not sure.

For the last 3 years, I have been active within the global surgery sphere, first as a medical student and since last year, as a medical doctor. When I met the first global surgery advocates and read about the inequity of access to surgical care, I immediately felt in love with the field. It felt right, it put words on situations that I had experienced in Morocco while I was training to be a doctor and it filled me with hope. If there is a movement, if we all join forces, then maybe I will not have to see preventable deaths happening because of a lack of access to surgery anymore. I truly embraced the message and became the most passionate global surgery advocate that I could have possibly been.

I joined forces with other passionate medical students and we founded InciSioN - International Student Surgical Network. We grew with it and it grew with us, almost symbiotically. This part of my life has been a blessing and I hope that it will continue to be. If I am not sure to become a surgeon, I am sure to be a woman in global surgery.

Yes, in the global surgery arena, men and women are equal! Advocating, researching, educating, writing, lobbying, presenting at conferences and all the other activities that global surgery involves are less gender connoted. So as a woman, I felt supported by my seniors, cheered by my peers and admired by my juniors. I thought that I could feel the same in the operating theatre. Isn’t it the same world? Isn’t the sphere of the operating room the same as the global sphere of surgery?

But I never felt the same. When I look back to my medical school years, I see a young inspired version of myself that was keen to learn everything she could so that one day she can operate. I was feeling a moment of grace whenever I was in an operating room.

There is just so much at stake, life is never more fragile than it is in an OR, the need for mixing science, art and precision is never greater and time is never more precious.

I was keen to enter this world, to be part of the chain, but I did not feel welcomed. I was not taken seriously, neither by the patients nor by the surgeons. Almost all of them were male, and I could not relate to the few female examples that I had met. I felt that they were either too tough - I am just like a man, or too overwhelmed - looking unhappy. As the time went by, as the exhaustion accumulated, as the slightly sarcastic remarks about my “silly idea to become a surgeon” became less and less subtle, I started doubting my career goal.

When I opened up to family and friends about my doubts, the general reaction was relief: “Ah you are finally being reasonable now”.

As the only career that I had considered during my training was surgery, suddenly I wasn’t even sure that I wanted to continue in clinical medicine anymore. So here I was, at the end of my training, uncertain about my medical career and yet thriving in the global surgery arena. The more reasonable idea I had at that time was to pursue further my interest for global health and allow myself a one year break from the clinical world by doing an MSc. I am now half way through this year as I am writing, did I find answers?
Well, I can see more clearly what exactly is scaring me about surgery and the surgical training. To name a few, I would say that I am concerned about not being able to balance my personal life with my professional one. I want to have a family (please don’t assume that all women want that) and my fertility years will be exactly the years during which I would be training as a surgeon. Will I be able to take sufficient maternal leave? I am also concerned about my mental health because if I have to fight every day to reaffirm my presence amongst my male colleagues, will it become unbearable? Also, will I have time during my training to pursue my other interests being advocacy and research on global surgery?

I am concerned, maybe lost, but not hopeless!

It warms my heart to see that I am not alone, that hundreds of young female medical students and doctors ask themselves the same questions.

How much potential does the surgical field lose right from the start by treating half of its future generation so badly that they disregard the field?

If there is a certainty I have, it is that it shouldn’t be that way. It is a problem that the surgical system needs to address urgently and not by blaming women and saying that they should be more resilient!

Why does the surgical culture pride itself by being tough? It does not have to be. I am sure that a patient’s outcomes will be better if surgeons - both men and women- are happier, healthier, can spend time with their families and explore other interests! We should fight for that. It is not just a fight that women should carry, it is a fight that all of us should carry for our own benefit, the benefit of the next generations and the benefit of our patients.

About the author

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CHANGING THE LANDSCAPE OF TOMORROW BY NURTURING THE FUTURE FEMALE LEADERS TODAY

XIYA MA
Earlier this year, as I was rotating through various surgical specialties at one of the largest hospitals of my home institution, I couldn't help but notice the evolving gender trends in residents and attendings alike. While in most surgical departments male attendings were more numerous, some, like the plastic surgery department, defied this norm with five female surgeons for three male surgeons. There was also an impressive majority of surgical residents who were women: I was pleasantly surprised to learn that the urology department, traditionally seen as a more “male” profession, was run by a team of three residents, all women. While I am proud to see both genders being well represented at my hospital, I am also fully aware that this situation is an exception to the rule in many parts of the world.

It is not revelatory to note that the medical and surgical worlds have been inaccessible to women until relatively recently. One of the first known female surgeons in the Western world, Dr Miranda Stewart, was only known to be a woman at her autopsy as she had to work under the façade of a man, Dr James Barry, in order to practice medicine (1). Many more like Dr Elizabeth Blackwell and Dr Mary Edwards Walker, two other pioneers in the world of women in surgery, struggled to get their abilities recognized by colleagues and institutions alike (1). To this day, although the Association of American Medical College found in 2018 that 51.6% of newly admitted medical students were female (2), the presence of women in surgical fields remains sparse. For instance, within the field of plastic surgery, Bucknor et al highlight that only 14% to 25.7% of practicing plastics surgeons are female in high-income countries like the United States, Canada, and Western European countries, despite improvements over the years (3). In Japan, female surgeons represent but 7.2% of members of their national surgical society, which makes it difficult for them to voice their opinion (4). In the light of the Tokyo Medical School scandal, where the institution was found to favor male students over female students in entrance exams, eight other medical faculties in the country were found guilty of similar acts (5). In low- and middle-income countries like many in the African continent, research on the situation of women in surgery is limited, though the latest statistics from the Ghana College of Physicians and Surgeons showed that women represented 35.2% of their members, physicians and surgeons combined (6).

For the women who do make it to their surgical training, many other challenges arise. Several studies focusing on American female surgeons in training suggest that female trainees present higher dropout and burnout rates (7). Lack of mentorship and conflicting family duties were often mentioned as factors that would precipitate the former.

Despite the grim facts, attitudes are changing. Many, including us at the International Student Surgical Network (InciSioN), believe that a key factor in achieving better gender representation in surgery and global surgery is providing aspiring female surgeons, at any level of their training, with the opportunities to flourish in the field, and most importantly with the support they need throughout their journey. For example, we believe it’s important for InciSioN to have a gender and geographically representative team to maximize the quality of our work as a team. The InciSioN International Team is composed of 49 students and trainees at various level of training from 36 different high-income and low- and middle-income countries, and 27 of its members are female (55%). We make sure to be sensitive to representation whenever it comes to opportunities within and beyond the organization. As a matter of fact, one of our first papers published as an organization addressed the topic of women in surgery, analyzing the current challenges and suggesting avenues looking forward (8).

On the other hand, we also call for all current surgeons, regardless of gender, to extend their hand in helping the future generation of female surgeons to build their career. The presence of women in medicine and surgery cannot be ignored, and it can only be to everyone’s benefit to nurture half of many medical school classes into achieving the career they desire.
As anyone who once was a beginner knows, it can be intimidating trying to navigate in a world we know little about, and solidarity between the experienced and the newcomers has never been so needed.

FINALLY, TO ALL THE ASPIRING FEMALE SURGEONS AND GLOBAL SURGEONS: DON’T BE AFRAID TO REACH OUT TO PEOPLE YOU ADMIRE, TO TAKE LEADERSHIP ROLES, AND TO CREATE YOUR OWN OPPORTUNITIES TO GROW.

There are a variety of organizations started by supporters of current and future women surgeons that can offer mentorship or networks, such as the Association of Women Surgeons, Women in Thoracic Surgery, Women in Otolaryngology, and the Gender Equity Initiative in Global Surgery, to name a few. The world needs you to help deliver essential surgical care in a safe and affordable manner to five billion people worldwide who do not have access, or nine out of ten people in low- and middle-income countries (9). The paradigm is shifting, and there is no better time than now for women to make their impact in pushing towards surgery for all.

REFERENCES

(6) Ghana College of Physicians and Surgeons. www.gcps.edu.gh

About the author

Xiya is a 3rd year MD-MSc student at the Université de Montreal, Canada. She is Co-Chair of Incision - the International Student Surgical Network - and as the vice-president of external affairs (VPE) of the Canadian Global Surgery Trainee Alliance (CGSTA). An aspiring global plastic surgeon, she is passionate about research, medical innovation and women in medicine.
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