

Why are we ignoring gender equity in surgery?

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Recently, there have been several excellent Canadian studies looking at gender bias in surgery. They have examined bias at many levels. More specifically, they explored physician referrals, outcomes for similar surgeries in male compared with female patients, and reimbursement at both the physician level and patient disease level.

Wallis and colleagues¹ reported on an Ontario database-driven study in *JAMA Surgery*. For a cohort of 1 million patients, patients of female surgeons had fewer complications (e.g., death, hospital readmission, or major medical complications) at 90 days or 1 year after surgery than those of male surgeons. This association was observed across nearly all subgroups defined by patient, surgeon, hospital and procedure characteristics. Despite these findings another cross-sectional, population-based study in Ontario² reported that male physicians appeared to have referral preferences for male surgeons, with more complex surgeries being referred to males. The authors suggested that this disparity is not narrowing over time or as more women enter surgical disciplines and that such preferences lead to fewer referrals to and lower volumes for female surgeons.

Chaikoff and colleagues³ stated in a recent *CJS* article that in 8 of 11 Canadian medical systems surgeons were reimbursed at significantly lower rates for procedures performed on female patients than for similar procedures performed on male patients. The authors considered this to represent a double discrimination against both female physicians and their female patients.

The findings of these studies are shocking, as the Canada of 2023 prides itself on being an equal society. Taken as a collective, what do these findings truly mean for both Canadian surgeons and their patients? How do we address these findings in our practices and systems in quality-improvement initiatives? Gender equity has yet to be achieved even in the highly educated medical profession. What is the response to follow? Certainly, economic equality for procedures should be easy to solve. Referral patterns for operative versus nonoperative cases

will be slower to correct, but will require active management and granular data at a local level. It is now clear that increasing the number of females in medicine and their now scientifically proven competency has not made a difference. The problem is deeply rooted in our society and transcends medicine. It is up to us all to make this a priority. As always, change will come through education and awareness campaigns — but campaigns that have effect. The time is now to deeply examine these issues and offer active and hopefully more appropriate solutions.

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Competing interests: E.J. Harvey is the cofounder and head of medical innovation of NXTSens Inc.; the cofounder and chief medical officer of MY01 Inc. and Sensia Diagnostics Inc.; and the cofounder and director of Strathera Inc. He receives institutional support from J & J DePuy Synthes, Stryker, MY01 and Zimmer. No other competing interests were declared.

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Cite as: *Can J Surg* 2023 October 24;66(5). doi: 10.1503/cjs.013423

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