Commentary

Commentary on: The Leaky Pipeline of Women in Plastic Surgery: Embracing Diversity to Close the Gender Disparity Gap

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The female presence in plastic surgery is growing: the proportion of female plastic surgery residents participating in integrated programs increased from 14% in 1990 to 40% in 2015.[1] In a 2019 survey of plastic surgery residents, the majority of respondents were female (54.3%).[2] Of all surgical residency training programs in 2018, plastic surgery was the closest approaching gender parity with a female-to-male ratio of 38.9% to 61.1%.[3] This trend is reflected by the 10% increase in practicing female plastic surgeons over age 55, indicating not only an increase in residency graduates, but faculty retention as well.[3]

However, female surgeons represent just 5% of full professors in academic institutions as reported by the Association of American Medical Colleges in 2012 (page 6 of the article).[4-6] At a time when women are increasing their presence in surgery and medicine more than ever, their representation at the top is severely lacking. This important article discusses why.

The reason for the attrition of women at each step along the academic ladder, known as the "leaky pipeline," is simple: the cultural and institutional support for women having children during training and junior faculty years has not kept pace with the growing presence of women in academic medicine. Women in medicine, surgery more specifically, as cited in the article, frequently delay childbearing due to rigid residency training requirements, lack of defined program maternity leave policies, lack of breastfeeding allowances, and childcare expenses. The unintended consequence of having to ask for maternity and childcare-related coverage from colleagues without children is another difficult barrier.

As faculty, additional challenges women face may include lack of a prorated compensation package (factoring in time off for maternity leave) resulting in a longer promotion cycle and delayed career advancement, and lack of onsite daycare. Sheryl Sandburg's rallying cry for women to "lean in," to encourage women to "have it all," puts unrealistic pressure on women to concurrently be a productive surgeon scientist, omnipresent mother, attentive spouse, and parental caretaker, all within an institutional structure that already makes any single one of these goals difficult. In reality, most women need to sacrifice playing one of these roles in order to just get by. So yes, you can have it all, just not all at the same time. Those who work and have a family constantly have to balance competing forces on their time and energy, and feelings of guilt that they are not enough of any one of these things: surgeon, scientist, mother, wife, daughter.

Perhaps the leaks in the pipeline should be reconsidered as rest stops on a highway where female surgeons can focus on other roles. For example, taking a few years off or working part-time to raise a child until kindergarten. Then, after five years, get back on the on-ramp and continue as a surgeon. It is the difficulty of getting off and on this highway, toggling between surgeon, scientist, mother, wife,

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and daughter, that contributes to female careers stalling out on the roadside. In some families, women cannot have it all at the same time; something has to give. Men are less likely to make these pit stops in their professional life due to biology (recovering from delivery, nursing), and cultural expectations. Their careers continue to speed along at the same pace. In a recent article, "The Impact of Plastic Surgery Training on Family Planning and Prenatal Health," female residents married to a nonphysician spouse were significantly more likely to wait until after training to have children than male residents married to a nonphysician spouse (64.7% vs 21.1%; $P = 0.007$).[2]

What would really be impactful to increase women in academia are the following accommodations to help women navigate between their roles: longer and paid maternity leave for residents and faculty, onsite daycare with hours that accommodate clinical and surgical service demands, a prorated compensation package, breastfeeding allowances (specifically, time during the clinical schedule to nurse or pump in a room with a sink and refrigerator), and paid clinical associates to cover call, lessening the reliance on colleague coverage. With these resources in place, women may have children during their prime reproductive years without fear of retribution from their residency program or division, fear of lack of childcare, or fear of professional penalty. Perhaps this would decrease the rates of infertility in women pursuing surgical subspecialties because women will no longer have to face the difficult sacrifice of postponing childbearing for their careers.

As a female plastic surgeon who has delayed childbearing until after training, I have encountered these barriers. At a certain point in my career, I made the decision to not become involuntarily childless.[7] During this critical inflection point, all of my roles hung in the balance: surgeon, scientist, wife, daughter. Could I add one more? I have the utmost respect for the incredible women who have scaled the surgical academic rungs, who have deftly navigated their many roles and succeeded. It will be through our advocacy and empowerment that these proposed solutions come to fruition. Perhaps then we can "have it all," and all at the same time.

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