

Perception of Gender Bias in Otolaryngology and Head & Neck Surgery - A Comparative Study

Daniela Lucidi¹, Marella Reale¹, Eleonora Maria Consiglia Trecca^{2,3}, Sara Parini⁴, Daunia Verdi⁵, Gaya Spolverato⁶, Giulia Molinari^{7,8}

¹Department of Otolaryngology-Head and Neck Surgery, University Hospital of Modena, Modena, ²Department of Maxillofacial Surgery and Otolaryngology, IRCCS Research Hospital Casa Sollievo della Sofferenza, San Giovanni Rotondo, ³Department of Otolaryngology, University Hospital of Foggia, Foggia, ⁴Department of Thoracic Surgery, Ospedale Maggiore della Carità di Novara, Novara, ⁵Department of Surgery, Mirano Hospital, Mirano, ⁶Department of Surgical Oncological and Gastrointestinal Sciences, University of Padova, Padua, ⁷Department of Otorhinolaryngology and Audiology, IRCCS Azienda Ospedaliero-Universitaria di Bologna, Policlinico di Sant'Orsola, ⁸Department of Medical and Surgical Sciences, Alma Mater Studiorum University, Bologna, Italy

Abstract

Introduction: To investigate the differences in the professional and personal life and the perception of gender-bias, among Italian female surgeons working in Otolaryngology–Head and Neck Surgery (OHNS), as compared to those involved in other surgical fields (overall group [OG]). **Materials and Methods:** An online survey was administered to female medical doctors working in all surgical fields in Italian hospitals. **Results:** Of the 1963 responders included, 153 (7.8%) were part of the OHNS group and 1810 (92.3%) of the OG. In both cohorts, female represented approximately one-third of the surgical staff. At least one female in the staff did not regularly attend the operating room (OR), especially in the OHNS group. OHNS responders had to abandon the surgical activities in favour of outpatient services more than OG. A higher proportion of OHNS surgeons encountered gender-related difficulties in the OR. **Discussion:** Several gender-related issues emerged among OHNS responders, the most relevant being involvement in surgical activities and number/complexity of surgical cases.

Keywords: Female surgeon, gender bias, head and neck surgery, otolaryngology, women in surgery

INTRODUCTION

Although the presence of women has been increasing both in general surgery and surgical subspecialties in the last few years, the advancement of women surgeons in leadership roles and in apical academic positions is still limited. This is a multifactorial phenomenon influenced by educational and psychosocial factors that involves traditional gender roles and discrimination trends.^[1-3]

Only recently, some papers concerning the specialty of otolaryngology–head and neck surgery (OHNS) have been conducted but, to the authors' knowledge, none of these analysed an Italian sample.^[4-14]

The field of OHNS has undergone enormous changes in the last decades. Once limited to minor ear, nose and throat (ENT) procedures, it has now evolved into a complex surgical specialty including several subspecialties requiring additional fellowship training. However, a contextual gender-based evolution does not seem to have occurred, with studies in the current literature

demonstrating a particularly low rate of women involved in OHNS with leadership positions in American and European series.^[15,16]

Herein, we describe the results of a multidisciplinary large scale national cohort study promoted by Women in Surgery Italia (WIS Italia), an association dedicated to encouraging women in their surgical career.^[17] The aim of this study was to investigate possible differences in the professional and personal life and the perception of gender bias, among Italian women surgeons, comparing those working into the field of OHNS to an overall group (OG) of surgeons.

Address for correspondence: Dr. Marella Reale, Department of Otolaryngology - Head and Neck Surgery, University Hospital of Modena, Largo Del Pozzo, 71, Modena 41125, Italy. E-mail: realemarella@gmail.com

Received: 04-10-2022

Last Revised: 27-12-2022

Accepted: 07-02-2023

Published: 31-03-2023

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How to cite this article: Lucidi D, Reale M, Trecca EM, Parini S, Verdi D, Spolverato G, *et al.* Perception of gender bias in otolaryngology and head & neck surgery - A comparative study. *Ann Maxillofac Surg* 2023;13:57-63.

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DOI:
10.4103/ams.ams_181_22

MATERIALS AND METHODS

Survey

Between November and December 2020, an online survey investigating several aspects of the professional career and personal life was proposed to Italian women surgeons with various backgrounds (such as OHNS, General Surgery, Thoracic Surgery, Gynaecology and Obstetrics, Ophthalmology, Maxillofacial Surgery, Neurosurgery, Plastic Surgery and Orthopaedics) by WIS Italia.^[17,18] The survey was administered through the RedCap platform and data were collected by 18 women surgeons from several Italian Hospitals, among which two were Otolaryngologists (D.L., E.M.C.T.). The research was compliant with the Checklist for Reporting Results of Internet E-Surveys.^[19]

The items included in the survey derived from pre-test interviews conducted among the authors of the study. Feedbacks regarding the survey coherence and clarity were acquired, allowing an iterative revision and re-test process. The participants were reached by two methods: (1) through e-mail, using a contacts' database previously created for the purposes of WIS Italia and constituted only by female surgeons; (2) invitation through the WIS Italia social media pages (Instagram, Facebook, Twitter and LinkedIn). Since the WIS Italia database was used, it was not possible to extend the survey to male responders, to obtain a male control cohort. Included participants were female medical doctors working in all the surgical fields mentioned above, as residents, attendings and faculty members in Italian academic and non-academic hospitals. Medical students, men and retired surgeons were excluded. Only responders who entered at least 70% of the answers were included in the analysis. All participants gave their informed consent prior to answering the survey, through a dedicated informative page.

Although the original survey was composed of 83 multiple choice questions, in the present study we preferred to focus on 27 items exploring work setting, education, family status, practice pattern and surgical activity, presence of professional role models and gender bias [see: Survey on Female surgeons, as Supplementary Table 1]. Surgical activities were classified by complexity in high, moderate and low complexity cases and according to the role of the interviewer in leading surgeon versus assistant surgeon.

The analysis of results was conducted on the entire cohort, which was classified in two categories: otolaryngologists and non-otolaryngologists, including all the women surgeons working in other surgical fields different from ENT.

The ethics committees of the participating institutions waived the need for ethics approval and the need to obtain consent for the collection, analysis and publication of the anonymised data for this study. All procedures performed in the study were conducted in accordance with the ethics standards given in 1964 Declaration of Helsinki, as revised in 2013.

Statistical analysis

The statistical analysis was performed using SPSS for Windows (IBM SPSS Statistics, Chicago, IL, USA). Continuous variables were expressed as mean \pm standard deviation. Student's *t*-test was used for continuous variables with normal distribution, while Mann-Whitney *U*-test was adopted for continuous variables without a normal distribution. Comparisons between groups were performed by Pearson's Chi-square or Fischer exact test for discrete variables, as appropriate. The results were considered as significant for $P < 0.05$ with a confidence interval of 95%. The statistical model was analogous to that used in the two previous papers describing the overall results of the survey^[17,18] and performed by the statistics department.

RESULTS

Overall, 3225 participants responded to the survey and 1963 (60.8%) were included in the final analysis, while the remaining 1262 were excluded because they entered <70% of the answers. Of the responders, 153 (7.8%) were otolaryngologists and included in the OHNG group (OHNSG), whereas the remaining 1810 (92.3%) were intended as the OG and included all non-otolaryngologists. Table 1 summarises data based on specific responses, number of evaluable responders and statistical comparisons between OG and OHNSG. The OG was mainly made up of general surgeons (1810, 92.2%).

As shown in Table 2, there were no statistically significant differences between the two groups according to age (38.1 years \pm 9.5 in OG vs. 38 years \pm 12.7 in OHNS; $P > 0.05$) and number of trainees (33.5% in OG vs. 23.6% in OHNS; $P > 0.05$). In both cohorts, female surgeons represented approximately one-third (31%) of the staff at their institutions. Also, homogeneous results were found when comparing years of experience (11.8 years \pm 9.7 in OG vs. 11.9 years \pm 12.7 in OHNS; $P > 0.05$) and number of surgeons who completed training experiences abroad (25.8% of OG vs. 25.6% of OHNS; $P > 0.05$). Although the difference was not statistically significant ($P > 0.05$), a lower percentage of women surgeons in the OG (34.9%) compared to the OHNS (40.5%) presented additional qualifications such as PhD and masters degree. Conversely, a statistically significant difference ($P < 0.05$) regarding the number of working hours per week emerged between the two groups (OHNS: 44.9 \pm 2.12 h vs. OG: 48.8 \pm 11 h).

Regarding the family status, about 60% of women surgeons were married/had a cohabiting partner and 36% had at least one child ($P > 0.05$ for both comparisons).

Interestingly, concerning the surgical activities, our results evidenced that at least one female surgeon in the staff does not regularly attend the operating room (OR), especially in the OHNSG (45.7% of OHNSG vs. 36.5% of OG; $P < 0.05$). A further analysis was performed by dividing the results on percentage of women in the staff and access to the OR,

Table 1: Detailed survey responses including statistical comparisons between the overall group and the otolaryngology-head and neck surgery group

	OG	OHNSG	P	Number of evaluable participants (OG)	Number of evaluable participants (OHNSG)
Age (years), mean±SD (range)	38.1±9.5 (26-75)	38±12.7 (27-65)	0.899	1797	153
Practice (years), mean±SD (range)	11.8±9.7 (1-50)	11.9±12.7 (1-40)	0.995	1810	153
Setting (%)					
Non-university hospital	911-50.3	84-54.9	0.095	1810	153
University hospital	622-34.3	41-26.8			
Private practice	258-14.2	27-17.6			
Other	19-1.2	1-0.7			
Academic role (%)					
Resident	605-86	36-80	0.737	703	45
PhD	38-5.4	4-8.9			
Research fellow	39-5.5	4-8.9			
Associate professor	17-2.5	1-2.2			
Full professor	4-0.6	0-0			
Training abroad (%)					
Yes	464-25.8	39-25.6	0.986	1796	152
No	1332-74.2	113-73.4			
Additional qualification (i.e., master degree of 1 st , 2 nd level, PhD, master class) (%)					
No	1178-65.1	91-59.5	0.164	1810	153
Yes	728-34.9	62-40.5			
Family status (%)					
Single/non-cohabitant partner	638-35.3	51-33.3	0.853	1804	153
Cohabitant partner/married	1082-59.9	95-62.1			
Divorced/separated/widow	90-4.8	7-4.6			
Children (%)					
1	322-17.9	26-17.1	0.741	1793	152
>1	324-18	30-19.7			
I would like to	765-42.6	64-42.1			
I am not sure	201-11.2	13-8.6			
I would not like to	181-10.3	19-12.5			
FS percentage in the staff, mean±SD	31.2±19.4 (2-100)	31±11.8 (0-100)	0.994	1798	150
FS in the staff not attending OR (%)					
Yes	653-36.5	69-45.7	0.016*	1789	151
No	1136-63.5	82-54.3			
Being a woman led you to give up dedicating yourself to surgical activities to dedicate yourself to outpatient activities? (%)					
No	1054-58.3	74-48.7	0.015*	1806	152
A little bit	26-1.4	25-16.4			
Enough	338-18.7	32-21.1			
A lot	260-14.4	19-12.5			
I don't care	128-7	2-1.3			
Weekly working hours, mean±SD (range) (%)	48.8±11 (5-100)	44.9±2.12 (10-70)	0.000*	1805	153
Percentage hours in non-surgical activities					
<20	160-8.9	4-2.6	0.000*	1791	152
20-50	705-39.3	46-30.3			
>50	926-51.8	102-67.1			
How many hours of your work would you like to spend in non-surgical activities?					
I like this as it is	692-39	56-37.3	0.106	1776	150
I would like to do more	47-2.6	0-0			

Contd...

Table 1: Contd...

	OG	OHNSG	P	Number of evaluable participants (OG)	Number of evaluable participants (OHNSG)
I would like to do less	1037-58.4	94-62.7			
Percentage hours in surgical activities					
<5	357-19.8	45-29.4	0.036*	1796	153
5-20	637-35.5	52-34			
20-50	609-33.9	44-28.8			
>50	193-10.8	12-7.8			
How many hours do you like to spend in surgical activities (%)					
I like this as it is	438-24.5	33-21.7	0.565	1788	152
I would like to do more	1300-72.7	113-74.4			
I would like to do less	50-2.8	6-3.9			
Percentage of monthly PS as TS, mean±SD (range)	26.1±22.5 (0-100)	22.7±16.4 (0-100)	0.088	1743	143
Percentage of monthly HC cases as LS, mean±SD (range)	8.4±20.1 (0-100)	8.2±11.7 (0-100)	0.352	1657	146
Percentage of monthly HC cases as AS, mean±SD (range)	28.5±26.9 (0-100)	25.6±27 (0-100)	0.995	1658	147
Percentage of monthly MC cases as LS, mean±SD (range)	10.7±15.3 (0-100)	10.9±1.4 (0-100)	0.250	1679	146
Percentage of monthly MC as AS, mean±SD (range)	22.7±22.4 (0-100)	17.4±29.4 (0-100)	0.008*	1679	143
Percentage of monthly LC as LS, mean±SD (range)	17.0±19 (0-100)	15.1±10 (0-83)	0.665	1504	144
Reported critical issues in OR (%)					
I do not find any difficulties	534-43.6	18-20.9	0.048*	1223	86
OR staff often ignores me	265-20.9	16-18.6	0.248		
Expert surgeons do not teach me enough	821-67.1	57-66.3	0.785		
Physical disproportion with colleagues	112-9.1	3-3.5	0.014*		
Poor physical strength	149-12.1	7-8.1	0.340		
Other	253-20.6	13-15.1	0.165		
Role models (%)					
Yes	1465-88.6	127-90.7	0.745	1654	140
No	189-11.4	13-9.3			
Role model's gender (%)					
Female	321-22.3	16-12.7	0.006*	1442	126
Male	1121-77.7	110-87.3			
Gender-biased different treatment (%)					
Yes	1033-62	94-66.7	0.299	1665	141
No	429-25.7	28-19.8			
I don't know	203-12.3	19-13.5			
Manners of different treatment (%)					
More training/advice/support	54-5.1	6-6.4	0.324	1042	94
Less training/advice/support	460-44.1	54-57.4	0.006*		
More unrewarding tasks	453-43.4	46-48.9	0.202		
Fewer unrewarding tasks	45-4.3	6-6.4	0.443		
More acknowledged	17-1.6	2-2.1	0.057		
Less acknowledged	522-50.1	54-57.4	0.375		
Teased or harassed	249-23.9	19-20.2	0.308		
More is expected from me	307-29.5	23-24.5	0.187		
Less is expected from me	178-17	19-20.2	0.478		
Better assignments	7-0.7	1-1.1	0.259		
Worse assignments	277-26.5	27-28.7	0.461		
Positive reviews	28-2.7	3-1.2	0.215		
Negative reviews	96-9.2	11-11.7	0.277		
Better chances of being promoted	3-0.3	1-1.1	0.995		
Worse chances of being promoted	492-47.2	52-55.3	0.512		
Other	90-8.6	7-7.4	0.452		

*P-value significant if < 0.05. OG: Overall group, OHNSG: Otolaryngology-head and neck surgery group, SD: Standard deviation, FS: Female surgeons, OR: Operating room, PS: Performed surgeries, TS: Team surgeon, HC: High complexity, LS: Leading surgeon, AS: Assistant surgeon, MC: Moderate complexity, LC: Low complexity

according to the different fields. The results are displayed in Figure 1.

Fifty percent of OHNS responders versus 35% of the OG reported that they had to abandon the surgical activities to some extent in favour of outpatient services ($P < 0.05$). Even though $>70\%$ in both groups are willing to spend more time in surgical activities, most responders (51.8% in OG vs. 67.1% in OHNS, $P < 0.05$) usually spend more than 50% of working hours in non-surgical activities. Conversely, OHNS responders spent significantly less hours in surgical activities compared to the OG ($P > 0.05$).

Responders in both groups were involved as team surgeons in approximately less than one-third of the monthly planned surgeries (26.1% in OG vs. 22.7% in OHNSG; $P > 0.05$). Surgeons in both groups were involved as leading surgeons in about 8% of high complexity cases, 11% of moderate complexity cases and $<20\%$ of low complexity cases. All comparisons among groups did not evidence statistically significant differences ($P > 0.05$). However, the percentage of surgeries of moderate complexity performed monthly as assistant surgeons by the OHNS responders (17.4%) was significantly lower ($P < 0.05$) than those of the OG (22.7%).

A significantly higher proportion of OHNSG surgeons encountered critical difficulties in the OR versus OG (79.1% vs. 56.4%; $P < 0.05$), as detailed in Table 1.

Most responders had role models in their career, mainly males in both groups; however, the percentage of female role models

in the OHNSG (12.7%) was significantly lower ($P < 0.05$) compared to the OG (22.3%).

When asked about the most common patterns of gender-based different treatment, OHNS responders (57.4%) reported “less training, advice and support compared to their male counterpart” in a significantly higher percentage ($P < 0.05$) compared to the OG (44.1%). Both groups reported that the most critical issues were “more unrewarding tasks,” “less acknowledgement” and “worse chance of being promoted,” and no statistical difference was detected in the comparison between groups ($P > 0.05$).

DISCUSSION

The survey investigated the professional and personal life of Italian women surgeons, comparing global results from all surgical specialties with the OHNS field. Some interesting disparities emerged: first, OHNS responders reported more qualifications (i.e., masters, PhD, masterclasses) than OG. The greater proportion of research-related qualifications could be explained by the existence of many clinical sub-fields in otolaryngology (such as audiology, vestibulology and rhino-allergology), more often associated with basic research. However, this finding is in contrast with the low number of responders entitled with academic roles: only 2.2% of the OHNS responders are associate professors (AP) versus the 2.5% in OG. This data reflects the national scenario of OHNS in Italy, where only 12% of AP are women according to the Italian Ministry of University, Education and Research.^[20] Moreover, neither full professors (FP), nor department chairs in

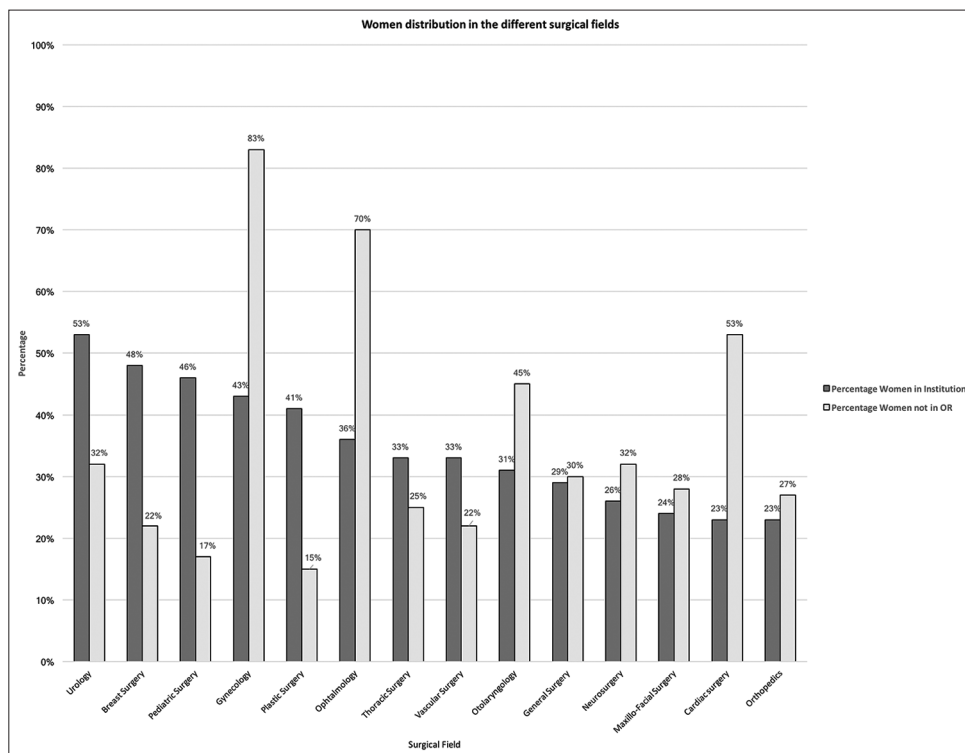


Figure 1: Women distribution of the responders in different surgical fields

Table 2: Multivariate analysis on the role of the different variables associated with overall monthly performed surgeries

Variables	Non-standardised coefficient		Standardised coefficient (beta)	t	P	CI 95% for B	
	B	SE				Inferior limit	Superior limit
Years of experience	0.574	0.231	0.249	2.491	0.014*	0.118	1.030
Academic: 1=yes, 0=no	-4.805	4.561	-0.099	-1.053	0.294	-13.836	4.225
Abroad: 1=yes, 0=no	6.339	4.256	0.126	1.489	0.139	-2.087	14.765
Title: 1=yes, 0=no	0.345	4.083	0.008	0.085	0.933	-7.737	8.428
Children: 1=yes, 0=no	0.662	4.295	0.014	0.154	0.878	-7.841	9.165
Hours for clinical activities (%)	-9.472	3.456	-0.235	-2.740	0.007*	-16.315	-2.629
Hours per week	0.454	0.222	0.175	2.041	0.043*	0.014	0.894

*Statistically significant P value. CI: Confidence interval, SE: Standard error

OHNS in the whole country are women. Garstka *et al.* reported that in the American Head and Neck Society, 60.2% of FP and AP were men, while at the junior level the proportion of female researchers was much higher (54.1% female vs. 36.3% male).^[15] Recent studies showed that the number of female AP is overcoming the male counterpart.^[21] These data suggest that female involvement in academic positions is slowly increasing in the USA and in the future a higher number of women will be covering leadership academic positions.

Despite both groups having an average of 31% female staff, suggesting a progressive “mathematical” equity, a significant disparity in the work tasks between men and women emerged. This has largely been reported in the literature since residency and across many surgical fields.^[22-27] In our study, OHNS responders spent significantly less hours in surgical activities and more in outpatient services, ward and administrative activities, compared to the OG. This trend is supported by the fact that 50% of the responders declared that they abandoned the OR to some extent in favour of clinical activities, and similarly, that almost half of the OHNS participants reported having a female colleague in the staff who does not attend the OR regularly. This may be due to some women being more involved in exclusively clinical subspecialties. However, the necessity to abandon surgical activity in favour of the clinical one seems more a “forced” choice than a personal one, since most women (74.4%) in the OHNSG would like to spend more time in the OR and would prefer to reduce their non-surgical activity (62.7%). Concerning case volume and management of complex cases, no statistical differences were detected between groups, but a substantial surgical “underemployment” was appreciated in the overall responses. On the one hand, the interviewed declared to participate to a high percentage of surgeries (22.7% in OHNS vs. 26.1% in OG). On the other hand, case volume as team leader in high complexity cases corresponded to only 8% of the overall commitment in both groups. The most frequent surgical activity was described as assistant surgeon in high-moderate complexity cases or leading surgeon in low complexity cases. These results led us to reflect on the women’s practice trajectories. On one hand, female surgeons are allowed to participate in surgical procedures as the same percentage as their male colleagues. On the other hand, they seemed

less allowed to develop autonomy in the more complex, experience-building cases.

The third difference is the prevalence of male role models among Italian Otolaryngologists compared to the OG (87.3% vs. 77.7%). The paucity of senior female examples could have a negative impact on the appeal of a surgical career on female medical students and it is a direct effect of the underrepresentation of women.^[28] Finally, it was shown that a significantly higher percentage of responders in the OG did not encounter any difficulties in the OR, compared to the OHNSG and poor training was significantly more reported by the OHNSG than the OG. The mechanisms underlying this scenario of dissatisfaction are complex and could be partially due to psychosocial attitudes on traditional gender roles and discrimination in the medical field.^[29] Finally, although the surgical career does not seem to impede with the creation of a family in both groups, an impact on female reproduction was found, with more than 40% of responders willing to have a child and only <20% having more than one child. Unfortunately, this finding does not seem to receive much attention by the Italian institutions, who have not provided yet sufficient economic and social resources for working women during pregnancy and maternity leave.

This paper has limitations. The most important is the absence of a male control cohort, which impedes a full comparison between genders. As it is conceived, this study focuses on the point of view from women in surgery only, comparing those involved in the field of otorhinolaryngology to those in other surgical fields, and showing that the former perceives a worse professional situation than the latter in many areas. The main implication of this comparison is that work task distribution, involvement in surgical activities, perception of training quality and presence of female mentorship all deserve further attention for the future generations of female Italian otolaryngologists-head and neck surgeons.

The definitive presence of gender bias in the working environment could not be assessed according to the feedback from female responders only. However, it should be emphasised that the structure of several questions from the survey, together with the investigation of specific gender-related issues, allowed to explore the perception of possible gender disparities among

the participants. The questions were designed to investigate the surgical case volume among female surgeons in relation to the entire surgical team and an objective approach with measuring the operative involvement was provided.

Specifically in the Italian scenario, it could be hypothesised that the level of dissatisfaction regarding involvement in surgical activities and academic career is equally high also in the male counterpart, mostly due to the maintaining of age-related habits in the Italian environment, that may contribute to prevent young surgeons to easily pursue their career, independently from gender. Indeed, when interpreting the results, one must consider that they are from an exclusive Italian cohort and thus could be variably influenced by the national psychosocial conditions. A prospective study on populations from different nations could help in clarifying the possible differences.

Eventually, the disparity in the number of OHNS responders significantly lower to OG responders, should be acknowledged.

CONCLUSION

According to the first survey addressed to Italian female surgeons, the otolaryngologists showed several disparities as compared to the overall surgeons group, regarding work tasks, involvement in surgical activities, perception of training quality and gender-based inequalities and female mentorship. All those aspects need deep reflection, as they may be linked to many critical issues, starting from the choice of a surgical career, to the paucity of female leaders in the otolaryngology field.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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Supplementary Table 1: Survey on female surgeons

How old are you?
 How long have you started your surgical career (including resident's career)?
 Where do you work the most of the time (>80%)?
 Non-university hospital
 University hospital
 Private practice
 Other
 If you are in an university department, point your role
 Academic (including resident)
 Hospital doctor
 Which type of academic role?
 Resident
 PhD
 Research fellow
 Associate professor
 Full professor
 Did you spend any training or working period abroad (almost 3 months)?
 Yes
 No
 Have you got any additional title, apart from specialisation's degree?
 No
 I-II level master degree
 PhD
 Master class
 What's your family situation?
 Single/non-cohabitant partner
 Cohabitant partner/married
 Divorced/separated/widowed
 Have you got any children or would you like any?
 I have got a child
 I have got more than a child
 I haven't got any, but I would like to have one
 I haven't got any and I am not sure about being a mother in the future
 I haven't got any and I wouldn't like to have any in the future
 How many women are there in your staff?
 In your department, are there any women who do not attend the operating theatre?
 No
 Yes
 Being a woman led you to give up dedicating yourself to surgical activities to dedicate yourself to outpatient activities?
 No, I decided to give up with surgery
 A little bit
 Enough
 A lot
 I do not care about operating theatre
 How many hours do you work per week on average?
 How many hours (%) of your work do you spend in non-surgical activities (outpatient clinic, examinations, follow-up, ward)?
 <20
 Between 20 and 50
 >50
 How many hours (%) of your work would you like to spend in non-surgical activities (outpatients, examinations, follow-up, ward)?
 I like as it is
 I would like to do more
 I would like to do less
 How many hours (%) of your work do you spend in surgical activities?
 <5

Supplementary Table 1: Contd...

Between 5 and 20
 Between 20 and 50
 >50
 How many hours (%) of your work would you like to spend in surgical activities?
 I like as it is
 I would like to do more
 I would like to do less
 How many surgical procedures are assigned to you as team surgeon per month on average?
 How many high complexity surgical procedures do you perform as leading surgeon per month?
 How many high complexity surgical procedures do you perform as assistant surgeon per month?
 How many medium complexity surgical procedures do you perform as leading surgeon per month?
 How many medium complexity surgical procedures do you perform as assistant surgeon per month?
 How many low complexity surgical procedures do you perform as first surgeon per month?
 Among these problems, which do you think are the most responsible of your difficulties in operating theatre?
 I do not find any difficulties in the operating theatre
 The team of the operating theatre doesn't often consider me
 More expert surgeons do not teach me enough
 The physical difference between me and other team members at the operating table
 The dimensions/proportions of surgical instruments
 The poor physical strength
 Other
 I prefer not to answer
 Multiple answers available
 Did you meet any role models during your training/career?
 Yes
 No
 If so, men or women?
 Men
 Women
 Do you think you are treated differently from your colleagues/superiors for being a woman?
 No
 Yes
 I don't know
 If so, in what ways do you think you are treated differently from your male colleagues?
 I received more training/suggestions/support
 I received less training/suggestions/support
 I received more unrewarding tasks
 I received fewer unrewarding tasks
 I am more often considered
 I am less often considered
 I get teased or harassed about being a woman
 More is expected of me than of a man
 Less is expected of me than of a man
 I tend to get better assignments
 I tend to get worse assignments
 I tend to get overly positive reviews on my work
 I tend to get overly negative reviews on my work
 I have better chance of being selected for a promotion
 I have worse chance of being selected for a promotion
 Other

Contd...