

# When Fairness Feels Unfair: Rethinking ‘Reverse Discrimination’ in Surgery

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## Introduction

**“All animals are equal, but some animals are more equal than others.”**

– George Orwell, *Animal Farm* (1945)

A junior doctor once told me, *“I realised I didn’t belong the moment someone felt the need to tell me I did”*. In that moment, Orwell’s paradox felt alive in the surgical ward: equality spoken aloud can sometimes expose the inequalities that culture quietly preserves.

Diversity, equity, and inclusion (DE&I) aim to ensure opportunity is based on excellence rather than advantage. Yet to some, these reforms are misperceived as a wolf in sheep’s clothing: a virtuous idea perceived as tokenistic or unfair. The belief that supporting underrepresented groups disadvantages others fuels perceptions of ‘reverse discrimination’ (1). This tension does not arise from falling standards but from fears of cultural disruption, reduced opportunity, or perceived loss of status (2,3). Such anxieties turn DE&I into a zero-sum story, recasting inclusion as exclusion and obscuring its purpose. Recognising this is essential if surgery is to redefine who belongs and foster a culture where inclusion strengthens excellence.

## Yesterday: Legacy of Exclusion

Concerns about ‘reverse discrimination’ do not arise in a vacuum. For decades, surgical culture has been centred on a narrow archetype. The 1998 *Brennan Report* described a profession that valorised stoicism and a “macho” ethos, implicitly excluding many capable candidates (4).

Despite almost half of female medical graduates expressing interest in surgery, only 15–16% of surgeons in Australia are women (5). In urology, women represented just 14% of members of the Urological Society of Australia and New Zealand (USANZ) and 28% of trainees in 2021 (6). These disparities persist in cultures where harassment and marginalisation have long been embedded. Women account for 56% of bullying victims in medical settings, and reports found that most Aboriginal and Torres Strait Islander medical students and doctors experienced negative reactions from non-Indigenous colleagues (7,8). Such environments not only disadvantage underrepresented groups but also deter entry and drive many out. Indigenous representation remains low, with Aboriginal and Torres Strait Islander

specialists comprising under 0.3% of the workforce and Māori doctors only 5.1% in Aotearoa (9,10).

These inequities persisted through opaque selection, rigid pathways, and mentorship shaped around those who fit the traditional archetype (11). Against this backdrop, policies that remove invisible advantages can feel, to those who historically benefited from them, like a new form of unfairness.

### **Today: The Hidden Curriculum**

Many structural barriers have been acknowledged, yet a subtler obstacle persists: the 'hidden curriculum' of unspoken norms and expectations (12). These cues shape who is seen as 'naturally suited' to surgery long before formal assessment. Large-scale implicit association testing of clinicians showed a persistent link between men and surgical roles, and women and non-surgical roles (13).

When DE&I challenges these inherited expectations, the shift can feel destabilising for those who benefited from them (14). Opposition often adopts a zero-sum framing: that if opportunities widen for women or Indigenous trainees, others are unfairly excluded. This assumes opportunity is finite and casts inclusion as loss, when broadening who belongs ultimately expands the profession's collective capacity.

Still, scepticism should not be dismissed. One survey showed that around one-fifth of surgeons are concerned that diversity efforts may themselves become exclusive or undermine meritocracy (15). Such views stem from uncertainty about how established notions of merit and belonging will adapt. Having entered medicine as a first-generation student without inherited networks, I saw how assumptions shaped expectations. At times, proving capability was needed to stand on equal footing. Mentorship, for me, was a seat earned rather than reserved, underscoring how belonging depends as much on perception and access as merit. Change, even when fair, can evoke fear. Until these perceptions of belonging and fairness are directly confronted, structural reforms alone cannot achieve inclusion without inadvertently reinforcing perceptions of exclusion.

### **Tomorrow: Redefining Fairness**

Achieving inclusion without exclusion requires making fairness visible and accessible. When transparent selection criteria, scoring systems and expectations are clearly articulated and consistently applied, suspicion diminishes (16). Allowing DE&I to be seen for what it truly is: restoring fairness rather than redistributing opportunity.

Inclusion succeeds when historically advantaged groups act as partners. Research shows that environments flourish when those historically advantaged understand the

purpose of change and actively contribute to it (17). I experienced this firsthand when a surgeon recognised the value of my cultural background and involved me in caring for linguistically diverse patients. Inclusion was not abstract – it strengthened patient safety and the teaching environment.

Cultural transformation depends on reshaping who is perceived as belonging in the surgical field. Representation in leadership, inclusive teaching and visible diversity broaden the image of the ‘typical’ surgeon. Longitudinal mentorship, including same-gender or culturally concordant, remains the strongest predictor of retention (18–20). In urology, initiatives such as Surgical Women in Australia and New Zealand Urology (SWANZU), along with the rise in female chairpersons at USANZ scientific meetings, which increased from 6% to 44% between 2014 and 2022, normalise diversified leadership and show how representation can shift culture (21).

Flexibility in training, historically viewed as deviation from the surgical ideal, is now essential for retaining capable trainees (5). These shifts reflect a broader truth: inclusion strengthens, rather than weakens, excellence. Women now constitute 27% of fellows under 44 – up from 17% a decade ago – with no evidence of declining standards (22–23). Diverse teams produce higher-impact science, stronger organisational performance, and innovative solutions, while cultural concordance improves adherence and preventive engagement (24–27).

## **Conclusion**

Orwell warned that belonging falters when perception eclipses reality. In surgery, DE&I faces the same challenge: reforms can expand the table, but perceptions still decide who feels permitted to take a seat. Entering medicine from a culturally diverse background, I realised how proving capability was necessary to counter entrenched assumptions about who is a suitable fit. These experiences confirm my view that fears of ‘reverse discrimination’ stem from shifting perceptions, not changing standards. Through transparency and broader mentorship, surgery can cultivate a culture where inclusion and excellence reinforce one another, and where merit and opportunity are shared, not inherited.

## References:

1. Reverse discrimination. Boston Medical Center. January 31, 2004. Accessed November 26, 2025. <https://www.bmc.org/glossary-culture-transformation/reverse-discrimination>.
2. Son Hing LS, Bobocel DR, Zanna MP. Meritocracy and opposition to affirmative action: making concessions in the face of discrimination. *J Pers Soc Psychol*. 2002;83(3):493-509. doi:10.1037/0022-3514.83.3.493.
3. Iyer A. Understanding advantaged groups' opposition to diversity, equity, and inclusion (DEI) policies: the role of perceived threat. *Soc Personal Psychol Compass*. 2022;16(5):e12666. doi:10.1111/spc3.12666.
4. Brennan PJ. Trainee selection in Australian medical colleges. Medical Training Review Panel; 1998. Accessed November 27, 2025. [https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/becoming-a-surgeon-trainees/rpt\\_brennan\\_report\\_1998.pdf](https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/becoming-a-surgeon-trainees/rpt_brennan_report_1998.pdf).
5. Royal Australasian College of Surgeons. Breaking barriers: developing drivers for female surgeons: survey report. Royal Australasian College of Surgeons; 2020. Accessed November 27, 2025. [https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/operating-with-respectcomplaints/Break-barriers-report\\_2020.pdf](https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/operating-with-respectcomplaints/Break-barriers-report_2020.pdf).
6. Urological Society of Australia and New Zealand. Urological Society establishes framework to address gender equity issues; 2021. Accessed November 27, 2025. [https://www.usanz.org.au/publicassets/10054dff-b07f-eb11-90fc-0050568796d8/20210308\\_USANZLaunchesGenderEquityInitiative.pdf](https://www.usanz.org.au/publicassets/10054dff-b07f-eb11-90fc-0050568796d8/20210308_USANZLaunchesGenderEquityInitiative.pdf).
7. Australian Indigenous Doctors' Association. Report on AIDA member survey. Australian Indigenous Doctors' Association; 2021. Accessed November 27, 2025. [https://aida.org.au/app/uploads/2021/01/Report-on-AIDA-MemberSurvey\\_Final.pdf](https://aida.org.au/app/uploads/2021/01/Report-on-AIDA-MemberSurvey_Final.pdf).
8. Averbuch T, Eliya Y, Van Spall HC. Systematic review of academic bullying in medical settings: dynamics and consequences. *BMJ Open*. 2021;11(7):e043256. doi:10.1136/bmjopen-2020-043256.
9. Australian Indigenous Doctors' Association. Growing the number of Aboriginal and Torres Strait Islander medical specialists 2023. Australian Indigenous Doctors' Association; 2023. Accessed November 27, 2025.

[https://aida.org.au/app/uploads/2023/09/AIDA-Growing-the-number-of-Aboriginal-and-Torres-Strait-Islander-medical-specialists-2023\\_v3.pdf](https://aida.org.au/app/uploads/2023/09/AIDA-Growing-the-number-of-Aboriginal-and-Torres-Strait-Islander-medical-specialists-2023_v3.pdf).

10. Medical Council of New Zealand. The New Zealand medical workforce in 2024 (workforce survey report). Medical Council of New Zealand; 2024. Accessed November 27, 2025.  
[https://www.mcnz.org.nz/assets/Publications/Workforce-Survey/Workforce\\_Survey\\_Report\\_2024.pdf](https://www.mcnz.org.nz/assets/Publications/Workforce-Survey/Workforce_Survey_Report_2024.pdf).
11. Mwipatayi BP, Armari E, Mwipatayi MT, Wong J, van Dam H, Chetrit S, et al. Gender inequality in surgical training selection: a systematic review. *Clin Surg*. 2020;5:2862. Accessed November 27, 2025.  
<https://www.clinicsinsurgery.com/open-access/gender-inequality-in-surgical-training-selection-a-systematic-review-6866.pdf>.
12. Hafferty FW. Beyond curriculum reform: confronting medicine's hidden curriculum. *Acad Med*. 1998;73(4):403-407. doi:10.1097/00001888-199804000-00013.
13. Salles A, Awad M, Goldin L, Krus K, Lee JV, Schwabe MT, et al. Estimating implicit and explicit gender bias among health care professionals and surgeons. *JAMA Netw Open*. 2019;2(7):e196545. doi:10.1001/jamanetworkopen.2019.6545.
14. Ballinger T, Jiang T, Crocker J. Lay theories of diversity initiatives: theory and measurement of zero-sum and win-win beliefs. *Group Process Intergroup Relat*. 2024;27(4):859-881. doi:10.1177/13684302231193320.
15. Backhus LM, Cooke DT, Bush E, Lui N, Higgins R, Berry MF, et al. An exploration of myths, barriers, and strategies for improving diversity among Society of Thoracic Surgeons members. *Ann Thorac Surg*. 2019;108(5):1454-1460. doi:10.1016/j.athoracsur.2019.09.007.
16. Hagelsteen K, Pedersen H, Bergenfelz A, Mathieu C, Tägil M, Gärtner H, et al. Different approaches to selection of surgical trainees in the European Union. *BMC Med Educ*. 2021;21:363. doi:10.1186/s12909-021-02779-5.
17. Johnson WB, Smith DG. How men can become better allies to women. *Harv Bus Rev*. October 2018. Accessed November 27, 2025.  
<https://hbr.org/2018/10/how-men-can-become-better-allies-to-women>.
18. Hemal K. Diversity and inclusion: a review of effective initiatives in surgery. *Am J Surg*. 2021;221(6):1315-1325. doi:10.1016/j.amjsurg.2020.08.03.

19. Williams JS, Walker RJ, Burgess KM, et al. Mentoring strategies to support diversity in research-focused junior faculty: a scoping review. *J Clin Transl Sci*. 2022;7(1):e21. October 6, 2022. doi:10.1017/cts.2022.474.
20. Georgi M, Morka N, Patel S, et al. Impact of same-gender speed-mentoring on women's perceptions of a career in surgery: a prospective cohort study. *J Surg Educ*. 2022;79(5):1166-1176. doi:10.1016/j.jsurg.2022.05.014.
21. Graham V, Bray G, Lyon K, et al. Gender diversity in urology scientific meetings: an analysis of the last nine years. *ANZ J Surg*. 2023;93(10):2645-2652. doi:10.1111/ans.18497.
22. Royal Australian College of Surgeons. Activities report 2023. Royal Australian College of Surgeons; 2023. Accessed November 27, 2025. [https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/reports-guidelines-publications/workforce-activities-census-reports/2023\\_RACS\\_ActivitiesReport\\_2023\\_V3\\_Final.pdf](https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/reports-guidelines-publications/workforce-activities-census-reports/2023_RACS_ActivitiesReport_2023_V3_Final.pdf).
23. Wallis CJD, Ravi B, Coburn N, Nam RK, Hurria A, Klaassen Z, et al. Comparison of postoperative outcomes among patients treated by male and female surgeons: population-based matched cohort study. *ANZ J Surg*. 2022;92(9):2079-2086. doi:10.1111/ans.18180.
24. Al Shebli BK, Rahwan T, Woon WL. Preeminence of ethnic diversity in scientific collaboration. *Nat Commun*. 2018;9(1):5163. doi:10.1038/s41467-018-07634-8.
25. Gomez LE, Bernet P. Diversity improves performance and outcomes. *J Natl Med Assoc*. 2019;111(4):383-392. doi:10.1016/j.jnma.2019.01.006.
26. Hofstra B, Kulkarni VV, Munoz-Najar Galvez S, He B, Jurafsky D, McFarland DA. Diversity-innovation paradox in science. *Proc Natl Acad Sci U S A*. 2020;117(17):9284-9291. doi:10.1073/pnas.1915378117.
27. Marshall A, Pack AD, Owusu SA, et al. Responding and navigating racialized microaggressions in STEM. *Pathog Dis*. 2021;79(5):ftab027. doi:10.1093/femspd/ftab027.