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EDITORIAL

Academic Surgery—the 3 Perils: *Sticky Floor, Glass Ceiling and the Slippery Slope*

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Diversity, equity and **inclusion** (DEI) are the buzzwords of the twenty-first century. Academic Surgery also needs to be conscientious about it. Academic Surgery is a highly competitive field lacking the diversity and inclusiveness in various ethnic groups, gender, and those with lesser socio-economic-academic backgrounds. This has led to lack of equity, because certain groups establish their hegemony and paramountency over others due to their backgrounds especially the privileges they receive in education system. Thus, circulation of elites and non-elites goes on in every society incessantly. Ceader Clarke in a television show in 1969 in America focussed on the evolutionary model of representation in the society in 4 stages. **Recognition** that is for a long time a country or a society does not recognise its minorities. This may be still true for several countries today. **Ridiculing** comes next where the majority make jokes on their own minorities. This is followed by **Regulations** where DEI is ensured by promulgating laws. As the society matures and value judgements of the majority community changes comes the 4th stage of **Respect** towards the equally talented minorities. The impedance to this process of forging DEI can be seen in the 3 perils of academic surgery, viz., ***sticky floor, glass ceiling*** and ***the slippery slope***.

The term 'sticky floor' is a metaphor to describe the systemic barriers faced by minorities, who, despite their abilities and qualifications, get stuck in low-level or entry-level positions, preventing them from breaking free and rise to higher leadership position because of belonging to non-recognised group or individual in spite of their inherent merit and value. These barriers are traditions, denial of access to resources, opportunities and mentorship; exclusion from high-profile research projects or leadership positions; and biased hiring.

'Glass ceiling' is the next hurdle, a term coined in the late 1970s during feminist movement to describe the invisible, but impenetrable barrier that prevented women from rising to high-level positions, regardless of their qualifications and abilities. It has since been used widely to describe barriers faced by all under-represented minorities and women in particular in a variety of fields, including academia and surgery. This barrier is created by individual mindsets and even institutionalised biases including assumptions that they are less competent or committed to their careers. This leads to stereotyping and discrimination that limit their access to opportunities, thus preventing them from achieving their full potential. Historically women were considered unfit for so many jobs which they (the women) are now holding for example fighter pilots. The glass ceiling not only limits individual opportunities but also hinders the field's ability to promote, enthuse and retain diverse talent. Attitudinal change can abolish glass ceiling barriers.

If the minorities manage to break through the glass ceiling, they encounter the 'slippery slope'. This refers to them being subjected to significant negative consequences in response to a small initial action taken by them which is discordant to the organisation's thinking. This results in discouragement. Lack of support and mentorship, exclusion from important research projects, publications and even social gatherings of the academic bosses hinder their career prospects and may even force them to leave the field. Developing respect and change in value system can retard the slippery slope.

It is obvious that ***sticky floor***, ***glass ceiling*** and ***the slippery slope*** are a continuum which acts as barriers against minorities. General lack of overall diversity, inclusiveness and equity is well documented in data from American surgical academic leadership, national associations, editorial

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boards and academic conferences [1–4]. In fact, a new censorious term 'manel' has been coined to describe absence of female panellist from an academic forum [5]. Even elected bodies with equal voters from men and women often elect a male candidate. Moreover, it is important to remember the difference between equality and equity. Equality is the state of being equal, especially in status, rights, or opportunities and means each individual or group of people is given the same resources or opportunities. Equity is the quality of being fair and impartial and recognises that each person has different circumstances and allocates the exact resources and opportunities needed to reach an equal outcome.

Unfortunately, not much data is available from Indian academic surgical world but the narrative is not dissimilar. Another prevailing misconception is that good scientific research and training only take place in large elite metro-based institutes. This resonates with the unfortunate trend from the USA where universities hire most (80%) of their tenure-track faculty members from the same handful (20%) of elite institutions [6]. Such lack of diversity, whether in the USA or in India, deprives many qualified people from contributing. Many small and mid-sized institutions offer good academic curriculum and innovative research atmosphere and invaluable experiences for their trainees along with state-of-the-art surgical management for their patients [7].

The key to reducing such disparities is by making critical and clear judgement in the assessment of diversity amongst the student and surgeon workforce. Other corrective policies which have shown promise in the USA are transparent measures for faculty recruitment, retention and promotion, identifying and removing structural barriers to minority's promotion. Focused mentorship by senior leaders, pilot projects on leadership and advocacy and career development programmes run for the marginalised. These are done in much subtle manner by benevolent leaders without an overt reservation policy [8–11]. The *Indian Journal of Surgery* is very well given to the above principles of exercising DEI. Similar initiatives are being undertaken in Indian surgical system too. In the Indian context, policy of reservations and opening of large number of medical colleges in both public and private sectors has created several opportunities for all and will mitigate the issue of sticky floor to a large extent.

Awareness of DEI has led to many changes, but a lot more remains to be achieved in academic surgery to prove the thesis that all people are equal and deserve equal rights and opportunities. This has prompted calls for all of us to put our own house in order first [12]. The society however evolved and advanced not only through the concept of 'equals' but also on social principles of egalitarianism. In our opinion, arithmetical 'equals' is an Utopian idea—in academic surgery, let us democratically develop advantage points for less represented with even playing grounds, impartial attitudes, unbiased thoughts, justified decisions and equitable solutions. Finally, let us develop innate respect for less privileged by changing value judgements.

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