

EDITORIAL COMMENT ON

“Lady urologist and male patients with prostate cancer”

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As a member of the Editorial Board and a pioneering woman in the world of urology, I would like to make some comments on the letter from Prof. Montironi and his team published in the present issue of *Archivio Italiano di Urologia e Andrologia* (1) about *Suzanne Koven's* book published in 2021 (2).

After her internship and medical residency at Johns Hopkins Hospital, Suzanne Koven joined the Harvard Medical School and practiced basic internal medicine at *Massachusetts General Hospital* for more than 30 years. Of particular interest is her “*Letter to a Young Woman Physician*,” an essay describing the challenges faced by women physicians, including her personal struggle with “*imposter syndrome*,” a long-held secret belief that she is not smart or good enough to be a “real” doctor. Consulted by thousands of readers around the world, Koven’s “*Letter*” turned into a heartfelt reflection on her medical career.

Montironi’s letter focused on 4 points, which I commented on separately

1) *Male and female medical students and residents*

In Italy, the admission tests for medicine and especially for graduate school have changed things a lot. If we look at the entrance exams today, we do not find big gender differences; in fact, perhaps it is women who get in more easily. It used to be that before entering resident schools it was almost mandatory to attend the department in which one then wanted to attend resident school for a certain period of time; and in that case female students were discriminated against in that they did not always get in by simple “*choice*” of the committee. In some Urology schools they were known to be asked not to show up. I entered in resident school in 1987 and the opinion of all my colleagues was that I could never become a surgeon, at best I could be an instrumental nurse in the operating room or alternatively I could only do urodynamic examinations or work on prostate biopsy slides.

Today, in fact, the situation has changed, and the real first obstacle for women is to establish themselves in the world of work in the surgical environment, and this is mainly because mentoring is practically exclusively male. Female residents are hardly trained in the operating room, as being often more precise and willing than male residents they are mostly employed in the outpatient setting.

In academia, especially in the surgical branches, there are no women full professors except in negligible numbers. In Urology today, 2024, we have only one female full professor out of more than 40 men. Therefore, in Urology the pyramid is extremely gender biased, with few female researchers and very few female associate professors who are often unfairly denied academic progression even with impeccable curricula. The fact that the Authors state that in their realities “both women and men have the same chances to succeed in their future professional and academic careers and with patients” shows a new and certainly promising opening for a better future for women uropathologists, but I do not see the same situation in the surgical branches.

2) *Women urologists*

It is evident that the percentage of women in urology services, academic and otherwise, has been lower than that of male urologists. Why? The decision to become a urologist today is a difficult and not very popular choice. In general, the number of students enrolled in surgical residence schools is lower than in medical schools, and the reasons may be different. Surgery involves specific and more complex reasons, first and foremost the risks, including medico-legal and well known to all, inherent in the profession that are undoubtedly higher and the training that is often difficult.

The choice to become a surgeon today is often uneconomical, and many students prefer branches that allow for greater profits even in private freelancing. Currently, students in the period of the competition for admission to resident schools, no longer attend the hospital ward and the operating room.

The student goes from being a “*medical student*” to a “*resident*,” without knowing the realities of the department, much less the operating room. Being a resident in a surgical branch means having different goals and expectations. Many come

to resident school without knowing their aptitudes; academia does not always help the resident discover them and understand what their practical skills are. Women residents, for the most part, have little opportunity to experience the operating room and are often referred to super-specialties that involve a more clinical than surgical approach. This makes it increasingly difficult for women urologists to get a grip on and demonstrate surgical skills, if any, once they enter the workforce.

Montironi *et al.* reported Mayer's statement (3), "Relatively few women hold leadership positions in the session, and this reflects an old approach of a fundamentally male profession, an approach that has changed rapidly over time." It is not yet clear to me how it is changing. My experience is similar to that of Suzanne Koven, reported in her book "Letter to a Young Woman Physician, Notes from a Medical Life." We are of the same generation, and I can only agree with at least some of what she says. I too have experienced many of her difficulties, although we probably have different characters, and I never felt like an impostor and always believed in myself. In some ways my situation was even worse because in the urological world, when I started working, I was the "only" woman, unlike in *Internal Medicine or Gynecology* where sometimes women outnumber men. The urological world was, moreover, one of the most difficult for a woman to experience: all the colleagues were men and most of the patients were also men. In addition to this, the real discrimination was the fact that surgery was almost always precluded to women. Surgery was always reserved for men. The reasons? They are unclear.

For a long time, optimistically, I thought the reason was mainly based on the long-standing belief that long and sometimes demanding Open surgery was not suitable for the female physique: surgeries that were too long and tiring. Unfortunately, however, the reality, also based on my personal history, was more discriminatory, and the male belief was that women did not have the surgical ability in their hands. Today, however, many women are proving that this ability is not exclusive to the male gender.

Today, many women urologists are unable to understand some of Suzanne's considerations because they experience a different situation. Two elements are turning the tables on women in Urology and in surgical branches in general. The first is the introduction of new technologies and the robotic surgical approach that are completely changing the scenario. Surgeries are no longer so physically strenuous and the ability to maneuver the robot is proving that the female gender has capabilities equal to those of the male gender, and I don't want to say better because I would discriminate in the opposite sense.

On the other hand, it is true that in both gender surgical skill is related to individual factors. Just as we are not all inclined to play the violin, so we are not all predisposed to surgery, as well as to mathematics, singing, or dancing. The second factor is the increase in jobs where women have somehow managed to emerge, which has prompted many more women to become urologists and follow suit. Almost as if to say that if one did it, so can others. That's why today's new generations do not feel the gender difference significantly, and this is especially true where there is female leadership.

Finally, regarding Wallis's study (4), it is interesting because it shows that empathy, which is considered a predominant female characteristic, can improve outcomes after surgery. This is important because it underscores the importance of shared decision making as part of the physician-patient relationship and how today this approach should be considered a must for any therapeutic approach.

3) Male patients

Both male and female patients can decide which physician to follow. I think it is important that in every field there are specialists of both genders, so that each patient can choose the gender he or she feels comfortable with. I think the patient is sovereign in his or her choice.

In my opinion, the fact that men do not want to be seen by women has been used, in an exaggerated way, as a discriminatory element. Actually, I don't think any particular comments are necessary. We found this news in the newspapers, but no one ever wrote that some women do not want to be visited by men. Yet it happens and it is not news. A few years ago, there were no women urologists. It was normal for the male patient to find it strange to be seen by a woman, just as it was normal for a woman to be seen by a male gynecologist because there was no alternative. Today, patients consciously choose the specialist physician based on their professional considerations and preferences. To find many women in urology clinics today means that the population is adapting, and fortunately this is no longer new.

So today everything is changing for the better and it is nice to have the opportunity to choose freely. I don't see why I should be offended if a man prefers not to be seen by me. The important thing is that in the end the patient finds the right solution to his urological problem. Perhaps I am a bit presumptuous to think that those who choose differently will not necessarily choose the best!

4) Self-respecting man

I agree with Montironi (1) of course patients are treated equally both for regardless of gender and social class. I think this has always been the case, independent of the historical era and the gender of the physician.

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