



**SUBMISSION
TO THE EXPERT ADVISORY GROUP ON
DISCRIMINATION, BULLYING AND SEXUAL
HARASSMENT ADVISING THE ROYAL
AUSTRALASIAN COLLEGE OF SURGEONS**

There is no place for discrimination, bullying or sexual harassment in the practice of surgery or in any modern workplace.

June 2015

Issues Paper

The EAG Issues Paper aims to trigger debate and find solutions that will prevent and address discrimination, bullying and sexual harassment in the practice of surgery.

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Please indicate your preference for publication:

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1. Organisational Culture

Discrimination, bullying and sexual harassment persist in the health sector, including in the practice of surgery, despite clear evidence that these behaviours jeopardise patient safety and negatively impact on victims.

a. Problems persist despite the legal, policy and standards Framework

- *Do surgeons know where the line is, and still cross it?*
- *Are surgeons aware of the relevant professional and educational standards? If so, why do some ignore them?*
- *What more needs to be done to increase awareness of the law and standards? What needs to be done to ensure compliance with them?*

Discrimination, bullying and sexual harassment are not issues limited to the medical profession. However, the AMA believes that doctors need to play a leadership role in addressing these issues.

Despite medical schools, colleges and employers all having relevant policies in place, there is evidence that these are not well understood or well known. While the AMA has not surveyed consultants, we do know from our 2014 survey of specialist trainees that general awareness of bullying and harassment policies across all colleges is low, with only 30 per cent of trainees reporting that they were aware of these.

The AMA has not undertaken any research as to why some surgeons may cross professional boundaries. However, there would appear to be several possible explanations including:

- The hierarchical nature of the medical profession;
- The high stakes environment in which surgeons work, including long working hours;
- The working environment in public hospitals, with a culture of bullying and harassment that can 'normalise' such behaviour; and
- Long-standing culture within the profession, acknowledging the general reluctance of victims to make complaints about bullying and harassment for fear of retribution and the lack of a 'safe place' where they can take a complaint.

In relation to compliance, there appears to be a disconnect between the roles of colleges and employers in handling bullying and harassment complaints. There is also little co-operation between employers and colleges with respect to the development and implementation of bullying and harassment policies and in relation to complaints handling. This environment discourages effective compliance both with respect to the development of well understood and effective policies, as well as in relation to having accessible and trusted complaints mechanisms.

b. *Are we teaching the right skills?*

- *Are Surgical Trainees well enough informed about appropriate behaviour in the workplace and given the skills to deal with the inappropriate behaviour of others? If not, what other training do they need? Why isn't training changing the behaviour in the workplace?*
- *How can the link between patient safety and appropriate behaviour be made clearer? How helpful is this link in preventing discrimination, bullying and sexual harassment?*

It is the AMA's position that education is critical to changing culture, and this needs to commence early - from medical school onwards.

The recent AMA Roundtable on sexual harassment in the medical profession highlighted the need for all medical practitioners at all stages of their career to be up-skilled in performance management, communication techniques, providing assessment and feedback and remediation in order to better handle these issues when they arise and prevent issues escalating where possible.

This stems from the fact that while a medical practitioner or supervisor may be clinically excellent, they do not always have the skills to communicate effectively when giving feedback, having difficult conversations or managing a complaint. Where this is handled poorly, this can have a direct impact on trainee health and wellbeing and career progression.

All doctors require these skills and they should be included in the curriculum for trainees and offered as continuing professional development courses for fellows. This is part of developing the qualities of professionalism and leadership in doctors, and is consistent with the attributes outlined in Good Medical Practice: A Code of Conduct for Doctors in Australia. Consideration should also be given to making this a mandatory requirement for all supervisors.

Doctors at all stages in their career also require further and ongoing education about what bullying and sexual harassment looks like and how to make a complaint, and for those in management positions, how to investigate and manage a complaint. Managers and supervisors need to be aware of typical bullying and harassment behaviours that perpetuate an unhealthy culture and develop strategies to change these behaviours.

Appropriate behaviour needs to be embedded in training programs, with the link between appropriate behaviour, safe working environment and patient safety being clearly set out.

There is a willingness on the part of jurisdictions (employers) to do more to address sexual harassment in the workplace and the College needs to work closely with jurisdictions to put in place the right policies, processes and culture.

Do you have comments on the following?

- *Refocus training to prevent discrimination, bullying and sexual harassment by emphasising patient safety as well as compliance*

- *Review current professional development and traineeship education about discrimination, bullying and sexual harassment.*
- *Undertake site visits or surveys to confirm staff awareness of reporting requirements.*

The above steps are all reasonable actions to take as part of a suite of broader measures that are needed to tackle bullying and harassment in a meaningful way.

2. The culture of surgery

Beyond its persistence in the health sector generally, what is it about the culture of surgery that has not prevented discrimination, bullying and sexual harassment?

a. Gender inequity

- *What else can be done to address gender inequity or promote gender equity?*
- *Is there a link between gender inequity and discrimination, bullying and sexual harassment? If so, what is it?*
- *How can the College and/or employers better address gender inequity?*

Despite increased participation from females in the medical workforce, women are still under-represented in the upper tiers of leadership. If medicine is to continue to progress as a profession, the issue of gender inequality needs to be scrutinised more closely.

Factors that influence a woman's ability to enter and progress through surgical training include limited female role models and mentors, long working hours and rigid training requirements that fail to recognise the needs for women to be able to balance work and family, and deep-seated cultural norms. Surgery in particular is still very male dominated, and discrimination and harassment continue to contribute to lower rates of female representation.

Ensuring that female trainees have strong, supportive role models remains a challenge;¹ the way that success is defined in the profession may have the effect of preventing women with significant parenting and caring responsibilities from progressing to the higher levels of the profession. This may then impact on the availability of a diverse range of role models of women in higher positions.² Innovative programs must be developed to meet the needs of current female faculty members, and to ensure attracting the brightest individuals of both genders.³

The College and jurisdictions should adopt policies that promote the intentional inclusion of females so that they are able to fully participate in the medical workforce (e.g. flexible employment and training opportunities). To achieve this, the College will need to work with jurisdictions to ensure that relevant policies are aligned and that more than lip service is paid to these policies. Unless policies are backed by meaningful opportunities in the workplace, they are largely meaningless.

¹ AMSA (2015) Sexual Misconduct a Barrier to Ensuring Gender Equality for Future Doctors, Press Release, 12 March 2015.

² Victorian Equal Opportunity and Human Rights Commission (2012) Changing the rules: The experiences of female lawyers in Victoria.

³ Woodrow, S. I., Gilmer-Hill, H., & Rutka, J. T. (2006) The neurosurgical workforce in North America: A critical review of gender issues, *Neurosurgery*, 59, 749-755.

Many of the barriers are the result of, or compounded by, the frequent imbalances between the parties to workplace bullying and harassment. Moreover, whether through active discrimination or as the unintended consequences of the way the reporting structures are designed and operate, individuals from groups at heightened risk of vulnerability often face additional cultural and social impediments to accessing, using and benefiting from these structures. Particular attention should be given to the rights and specific needs of such groups at each stage of the remedial process: access, procedures and outcome.

Research consistently indicates there are a number of factors which may increase the risk of workplace bullying and harassment occurring in the workplace. These include the presence of work stressors and workforce characteristics.⁴ Gender inequity has a proven causal relationship with the incidence of discrimination, bullying and sexual harassment of female employees. It is important that sexual harassment, discrimination and non-sexualised incivility is acknowledged as a manifestation of broader gender inequality.

There are few clear and agreed target typologies, however it is generally accepted that women are more likely to be targets than men and that targets tend to be non-confrontational and unlikely to 'fight back'. The attribute common to all targets is that they are unwilling or unable to react to unwarranted aggression with aggression any more than sexual harassment targets invite undesirable assaults, and in a majority of cases bullies are targets' supervisors or managers.⁵ Reporting to an immediate supervisor is a particular problem if that supervisor is the person using the unacceptable behaviours.⁶ It follows that in workplaces where leadership positions are predominately occupied by males, there is an ingrained acceptance of unreasonable workplace behaviours and little recourse is available, women are more at risk of being exposed to discrimination, bullying and sexual harassment.

Dr Skye Saunders' research on sexual harassment in rural workplaces notes that 'masculinity' marked workplaces have a high incidence of sexual harassment. The research confirms that the variable that positively correlates with group type (pack behaviour) harassment was the proportion of women in the workplace. Respondents from workplaces with low numbers of women were significantly more likely to experience this type of behaviour.⁷

In another example of a masculine, hierarchical profession, a 2012 survey conducted by the Victorian Equal Opportunity and Human Rights Commission⁸ into the experiences of female lawyers in Victoria found that 24% had experienced sexual harassment while working as a lawyer or legal trainee in Victoria. 74% did not make a complaint. The report revealed themes of hostility, pressure to work more hours, lack of support from managers, lack of flexible working arrangements, negative attitudes towards working mothers and lack of action or victimisation as contributing to a broader workplace culture that condoned sexual harassment.

How can the College and/or employers better address gender inequity?

⁴ Safe Work Australia (2013) Guide to Preventing and Responding to Workplace Bullying.

⁵ Kelly, D.J. (2005) Reviewing Workplace Bullying: Strengthening Approaches to a Complex Phenomenon, University of Wollongong Research Online.

⁶ Caponecchia, C. & Wyatt, A. (2011) Preventing Workplace Bullying: An Evidence Based Guide for Managers and Employees. Allen & Unwin.

⁷ Saunders, S & Eastaer, P 2013, 'The nature, pervasiveness and manifestations of sexual harassment in rural Australia: Does 'masculinity' of workplace make a difference?', Women's Studies International Forum, vol. 40, pp. 121-131.

⁸ Victorian Equal Opportunity and Human Rights Commission (2012) Changing the rules: The experiences of female lawyers in Victoria.

There remains some confusion about what role colleges should play when they are not the actual employer of trainees. Breaking down the cultural barriers contributing to the problem may be difficult but effective in the long term if appropriately implemented.

The AMA makes the following recommendations:

1. *Achieving gender balance in senior roles*

Studies have suggested that in work environments which are systemically male-dominated and privileged, it is important to provide explicitly articulated opportunities for women to collectively and democratically participate in order to challenge prevailing regimes of control and strive for a more inclusive environment⁹. A self-regulation approach to achieving gender balance in senior roles could be adopted initially. Gender specific pressures need to be alleviated to ensure the roles can be fulfilled by females. Rather than simple policy statements on entitlements to flexible working arrangements, the solutions need to be practical.

2. *Strengthening a mentoring program*

Ensuring that female trainees have strong, supportive role models remains a challenge. A mentoring program is a popular approach and should be investigated further to develop an effective model.

3. *Providing for professional development participation by female trainees*

The College should work with the AMA and recognised industrial organisations to ensure that industrial arrangements and policies do not discourage professional development, including participation in internal and external committees.

4. *Flexibility is an important starting point to open up organisations for women.*

Historically, the health system has not been good at providing flexible work places. Health service management and colleges need to work together to provide opportunities to improve flexibility in employment practices.

Having access to flexible work opportunities has been identified as an important issue for medical trainees. Of the factors that are actionable through policy change, work experience and flexibility of hours are most highly rated by junior doctors when considering specialty choice. The 2014 AMA Specialist Trainee Survey Report of Findings, February 2015¹⁰ (STS) found that while 50 per cent of trainees felt the college supported them in accessing flexible training options, and 43 per cent felt that it would not disadvantage their career if they undertook part time training, a significant number of trainees replied 'not sure' to these statements (ranging from 24 and 46 per cent).

⁹ J Eveline and M Booth, 'Gender and sexuality in discourse of managerial control: the case of women miners' (2002) 9(5) *Gender, Work & Organization*, pp. 556-578, in AHRC 2011, *above* n 15.

¹⁰ <https://ama.com.au/article/2014-ama-specialist-trainee-survey-report-findings-february-2015>

Similarly, at the recent AMA trainee Forum held in February this year, trainees still reported that they had difficulty in accessing flexible work options in certain specialties in respect of access to maternity leave and again when returning from leave. The AMA Roundtable on Sexual Harassment also identified access to flexible work options as a key strategy in support of intentional inclusion of females in the medical profession.

The intention of these recommendations must be to effect lasting change at a cultural and organisational level by addressing the complex and intertwined root causes of the problem with prevention and intervention efforts.

Do you have comments on the following?

- *Identify and eliminate potential barriers for females entering and staying in the profession.*
- *Bring in targets or quotas for women in surgery or leadership positions (similar to that used by the Australian Stock Exchange for voluntary/compulsory quotas of the percentage of women at partnership levels) and provide training and mentoring to help female surgeons reach these positions.*
- *Make gender equity a strategic priority, championed by the College in partnership with other medical colleges and the medical profession.*
- *Develop a voluntary Code of Practice (or memorandum of understanding) with key institutions, including targets and key performance indicators aimed at promoting gender equity, linked to a public reporting cycle. For example, annual publishing of hospital profiles, reporting on the percentage of women in leadership positions; number of employees working flexibly; number of complaints made based on gender; number of other discrimination complaints; number of sexual harassment complaints lodged internally and externally; and the outcome of these complaints.*

The AMA would support a voluntary Code of Practice, or similar document with key institutions with the aims stated above. The AMA supports in principle targets for women in surgery leadership positions, but acknowledges the practical challenges of such targets. Nonetheless, advice suggests that ‘intentional inclusion’ strategies and targets are necessary to crystallise intent and that without this, change will not happen because the system is deeply rooted in the male norm. Any targets should be realistic and continue to use merit as the main criterion for promotion.

An example often cited as an empirical gender balancing solution is the quota system, arising from the Women on Boards quotas in the EU. The low rate of representation of women on boards can be explained by persistent unequal access to economic, social and cultural resources between women and men, by inequalities in the share of paid and unpaid work, and by insufficient work-life balance policies for both women and men. Legislative efforts to achieve gender parity in the boardroom are being increasingly accepted in both political and business spheres. Both the European Commission and the European Parliament have given the green light to EU-wide legislation ensuring that women hold at least 40% non-executive positions in large publicly listed companies.

In Australia, there has been some success in boosting the number of women on boards. By August 2014, 18.3% of directors on ASX 200 boards were women, up from 8.3% in 2008, according to the Australian Institute of Company Directors (AICD). Over the past four years, the percentage has almost doubled, and the number of Australian boards with no women dropped from 87 to 42. The AICD gets some of the credit for the increase in female board representation in Australia, as its diversity initiative includes a chairmen's mentoring program that has led to a number of female director appointments since it was implemented. The AICD-backed ASX diversity reporting guidelines were adopted in 2010 and started a board training program for women in the corporate pipeline.

The quota or positive discrimination measures discussed above are a persuasive example of a movement that actively addresses gender inequity. However, quotas will not be sustainable unless other gender parity efforts are put in place. Where there is a poor track record of investment in women's empowerment more broadly, the removal of quotas would be unlikely to have any lasting effect. There is no doubt that quotas distort in the short term, but they are also one of the most effective tools available to create a more level playing field in the long term. They help set a goal and they help address underlying barriers and spur for rapid change.

NSW Health has also implemented a range of positive initiatives.¹¹ These include the You're safe survey which focuses on workplace culture; the establishment of an anti-bullying hot line; the incorporation of anti-bullying and harassment values into its code of conduct, and an investment in cultural improvement programs.

c. *The boys' club*

- *What is it about the culture of surgery that contributes to discrimination, bullying and sexual harassment?*
- *What will it take for this to change?*
- *How does the apprenticeship model of training contribute to the problem?*

Research consistently indicates there are a number of factors which may increase the risk of workplace bullying and harassment occurring in the workplace:

- Presence of work stressors – high job demands, limited job control, organisational change, role conflict and ambiguity, job insecurity, an acceptance of unreasonable workplace behaviours or lack of behavioural standards, unreasonable expectations of clients or customers;
- Leadership styles – autocratic behaviour that is strict and directive and does not allow workers to be involved in decision making; or laissez faire behaviour where little or no guidance is provided to workers or responsibilities are inappropriately and informally delegated to subordinates;

¹¹ Presentation to AMA Sexual Harassment Roundtable. Ms Susan Pearce, NSW HETI. 1 April 2015.

- Systems of work – how work is organised, scheduled and managed, lack of resources, lack of training, poorly designed rostering, unreasonable performance measures or timeframes;
- Work relationships – poor communication, low levels of support or work group hostility; and
- Workforce characteristics – groups of workers that are more at risk of being exposed to workplace bullying.

Changing the culture of the profession must start with senior male members of the profession taking a leadership role and making it clear that sexual harassment is unacceptable.

The enabling, motivating, and precipitating structures and processes that contribute to bullying and harassment explain why it might be rewarded (perceived power imbalance, low perceived costs, and dissatisfaction and frustration), and why it might flourish (high internal competition and a politicised climate). Tackling the problem of bullying and harassment rests on changing the culture within organisations. It is generally agreed that bullying and harassment thrive in a workplace culture where it progresses unchallenged, and is ignored or treated with a ‘head in the sand’ mentality.

It is the medical profession’s duty to provide an academic environment that exemplifies the values it wants trainees to embody and does not require trainees to withstand abuse in the name of learning. Mistreatment is generally understood to stem from the teacher-learner power differential inherent in the hierarchy of medical education, which leads to a ‘cycle of abuse’ in which medical students who are mistreated go on to become doctors who mistreat other medical students.

The apprenticeship model arguably enhances the autocratic nature of the relationship between mentor and mentee. While it has many positive aspects, it is highly stratified and may reinforce the effect of power imbalances between senior members of the profession and those in training.

Do you have comments on the following?

- *More training/CPD for College Fellows, potentially compulsory training for supervisors, in providing constructive feedback to trainees and communicating about difficult issues.*
- *Review and provide clear information about the roles and responsibilities of surgical trainees and supervisors, particularly about discrimination, bullying and sexual harassment.*
- *Make an unequivocal statement of commitment from health sector leaders about equity and inclusion.*
- *In partnership with employers, other medical colleges and health sector leaders, implement a unified strategy to address sexual harassment or make structural change to the profession and integrate the relevant KPIs in the performance plans of senior health sector leaders and managers.*

The AMA would support each of the above proposals.

d. *Problems are worse in procedural specialties*

- *Why are these problems worse in procedural specialties, including surgery?*
- *Are surgeons trained well enough to manage the stress of the job?*
- *Has inappropriate behaviour become normalised in stressful (procedural) environments?*

It would seem that these issues appear more extreme in procedural specialties as these tend to have a higher profile in the medical workplace. It may be that they are more extreme in substance, rather than in volume, due to the relatively higher stress in the workplace and higher stakes involved for trainees – i.e., gaining a position in a procedural specialty is extremely difficult, so the pressure to hang on to it is more intense.

Inappropriate behaviour may be somewhat normalised in high pressure environments such as surgery, partly because it is ‘handed down’ from trainer to trainee, then repeated in the next cycle.

The AMA notes that surgical practice is not confined to the operating theatre and not all surgical lists require "life or death" decisions. Other areas of specialty practice can be equally intense and face the same environmental pressures.

Do you have comments on the following?

- *What kind of educational interventions could be helpful to better equip surgeons to manage stress?*
- *What workplace support or programs could be helpful to support behavioural change?*

The AMA supports any training to equip surgeons to manage stress, but not at the expense of an appropriate, safe working environment. Surgery will always be a stressful environment, with high pressure perhaps leading people to behave in ways that they may not normally behave but surgeons and trainees need to understand where even in a stressful environment certain behaviour is not appropriate.

3. Bystanders are silent

Discrimination, bullying and sexual harassment in the practice of surgery, in medicine and in the health sector is discussed and witnessed. So why don't people speak out?

- *What stops bystanders speaking up when they hear about or witness discrimination, bullying and sexual harassment?*
- *What in the culture of medicine – or surgery – makes these issues someone else's job or responsibility to fix, or prevents someone from taking responsibility for addressing these issues? What actions can be taken by individuals, teams and organisations to prevent and address*

There may be two different reasons bystanders do not speak up when witnessing unacceptable behaviour. The bystander may; 1) not recognise the behaviour as discrimination, bullying or sexual harassment, or 2) harbour distrust in the complaint

mechanism - that the complaint will not be taken seriously, that someone else's word will be taken over theirs, that victimisation will ensue, or that it would ultimately not be in the best interests of the victim to raise it.

While it is unlawful for someone to subject or threaten to subject the other person to any detriment because they have asserted their rights, made a complaint, helped someone else make a complaint or refused to do something because it would be discrimination, sexual harassment or victimisation¹², the potential for victimisation is a real or at least perceived obstacle to bystander action.

There is considerable distrust by clinicians of managers. The decreasing level of trust between clinical staff and their managers is in part due to the pressures that managers have upon them to reach certain goals and the fact they do not have the resources to provide for the needs on the ward. Public sectors have changed markedly in recent years in response to globalisation and the business orientation of governments. Most notable in the public sector have been new forms of organisation, management and accountability and, as a corollary, multiple demands including tighter budgets and demands to generate new forms of income; thus the pressure on managers to meet multiple and competing requirements, the most important of which is clearly signalled as short-term financial gains which is not conducive to a socially responsible workplace.

This is compounded by the reality that many individuals are placed in leadership or supervisory roles with little or no training or support. Appropriate management and leadership training must be provided to those in managerial positions. The problems of requiring line managers to deal with complex situations involving conflict and unacceptable behaviours with little management training were recognised in the findings of the inquiry into the NSW Ambulance Service. An essential piece of the puzzle to tackling workplace bullying and harassment lies with line managers; organisations that genuinely wish to minimise the risks associated with workplace bullying should give priority to interpersonal skills when deciding who to appoint to managerial positions.

The majority of employers notified about bullying and harassment incidents either do nothing or worsen the situation by fostering retaliation against the complainant. Employers need to give managers authority to resolve people management issues and hold them accountable when they failed to treat people properly.

Advising targets to report to the next highest supervisor does not circumvent the conflicts of interest in the reporting lines, which make them inappropriate for dealing with workplace bullying and harassment claims. Conflicts of interests must be engineered out of reporting lines for unacceptable behaviours if the reporting process is to be fair. There needs to be a distancing of decision-making relating to the investigation from the immediate area where the complaints arise. When employers provide an opportunity to speak in confidence and without fear of reprisal, many potential formal complaints are precluded. There is power in providing for an individual voice and an opportunity just to be heard. Formal action may follow but only if the individual chooses.

¹² Sex Discrimination Act 1984 (Cth); Anti-Discrimination Act 1977 (NSW); Industrial Relations Act 2009 (NSW) s210.

Confidential ombudspersons or practical listeners can provide this informal service. From this evidence, two conclusions may be drawn: managers need appropriate training and the reporting structure needs to change.

Jurisdictions need to work with the profession, including the College, to address sexual harassment in the workplace, putting in place the right policies, process and culture. Reporting processes must offer a 'safe space' for complainants so that they can raise issues of sexual harassment, free of shame, stigma or repercussions. Employers need to have good performance management processes in place to avoid reasonable management actions escalating into bullying complaints.

In her address to the AMA Sexual Harassment Roundtable in April this year, Ms Elizabeth Broderick, Sex Discrimination Commissioner, suggested that four things are essential to enable people to report instances of sexual harassment in the workplace:

- They need to believe they work in a profession or an organisation where there is zero tolerance.
- They need to believe they work in a profession or an organisation where something will happen.
- People need to believe they will not be victimised if they speak up.
- People need to believe their complaint will be acted upon in a timely manner.

Colleges must have systems in place that provide for a fair and safe appeals and remediation process and must ensure that trainees are aware of how to access grievance and remediation processes if required. These processes must be validated as professional, independent, confidential, and timely, and must result in an outcome. In relation to bullying and harassment, they must provide trainees with a safe place to bring forward complaints – free of shame, stigma or fear of repercussions.

The Australian Human Rights Commission Encourage. Support. Act! Report¹³ recommends a number of strategies to encourage bystander interventions, which have real potential to increase reporting and reduce the incidence of sexual harassment in Australia. Development of training programs, grievance procedures, multiple complaints channels, incentives for bystanders to make valid reports of sexual harassment, and assuring bystanders of anonymity and immunity from legal action and victimisation are some of the suggestions.

Workplace education and training

Work on bystander approaches in violence prevention would suggest that those who witness sexual harassment subsequent to being educated about it can challenge the attitudes and norms, behaviours, institutional environments and power inequalities which feed into violence in all its forms, including sexual harassment. Effective workplace education must take place across all hierarchical levels and also address the fundamental links between sexual harassment and wider inequalities, for example by interrogating the constructions of gender and sexuality in a particular organisational context. These constructions inform men's

¹³ Australian Human Rights Commission (2012) Encourage. Support. Act! Bystanders Approaches to Sexual Harassment in the Workplace. <http://www.humanrights.gov.au/our-work/sex-discrimination/publications/encourage-support-act-bystander-approaches-sexual> (accessed 30 March 2015).

and women's differing perceptions of sexual harassment and help explain the way gendered forms of power manifest in organisations.¹⁴

There is a small but growing body of evidence demonstrating that bystander intervention strategies can increase participants' willingness to take action, their sense of efficacy in doing so and their actual participation in pro-social bystander behaviour.

For example, in 2002 legislation was enacted in Belgium 'relating to protection from violence, moral harassment (bullying) and sexual harassment at the workplace'. This legislation requires employers to put in place a series of preventative measures to reduce the risk of violence or moral harassment in the workplace including adjustments to the physical organisation of the workplace, providing help for targets, the fast and impartial investigation of complaints of moral harassment and the provision of information and training. The statute also emphasises the responsibility of all levels of management to prevent stress on employees. The legislation provides for a number of avenues of redress, including through an adviser on prevention or a manager. It also stipulates that the burden of proof lies with the individual accused and that throughout the course of these procedures the working relationship between the complainant and the employer cannot be terminated or modified.

Positively endorse reporting

The concept of 'bystander' can be broadened to apply to organisations. This definitional move would have value in highlighting the roles of organisations in allowing and sustaining such behaviours.

An impartial, external complaints handling mechanism is essential to allow victims and bystanders to report incidents outside the chain of command that is responsible for their career progression. Concurrent, ongoing support must accompany the complaint mechanism to prevent victimisation.

Do you have comments on the following?

- *Work with health sector employers to establish a framework for post-incident debriefing, so it becomes a safe practice to 'call out' incidents in a no-blame way, to better inform general and specific education and training.*
- *Draw on aviation industry experience, and establish a 'red flag' system so health sector workers can easily and safely identify when they see boundaries starting to be crossed.*
- *Increase training and skills for Trainees (through education) and surgeons (through CPD) about discrimination, bullying and sexual harassment – including training in 'no-fault' communication.*
- *Establish leadership and mentoring programs.*
- *Work with health sector employers to introduce random workplace audits of staff awareness of and compliance with reporting requirements.*

¹⁴ Australian Human Rights Commission (2012) Encourage. Support. Act! Bystanders Approaches to Sexual Harassment in the Workplace. <http://www.humanrights.gov.au/our-work/sex-discrimination/publications/encourage-support-act-bystander-approaches-sexual> (accessed 30 March 2015).

The AMA supports all of the above proposals. Others include:

- Having a clear and well publicised policy to tackle harassment issues.
- Establishing good examples through role models.
- Providing confidential counselling and other support for trainees to enable to deal with unreasonable behaviour which, left unchecked, could lead to harassment.

4. Complaints

Good data – enabling evidence-based analysis – is known to help drive organisational and cultural change. However, complaints about discrimination, bullying and sexual harassment are under-reported, making it harder to quickly identify trouble spots and emerging issues promptly, and therefore analyse trends in a timely way.

- *What prevents people from complaining about discrimination, bullying and sexual harassment in the practice of surgery or by surgeons?*
- *How does the power imbalance between perpetrator and victim impact on this?*
- *What confidence is there in existing complaints a pathway – in the workplace and at the College?*
- *How does lack of awareness about how to make a complaint*

What prevents people from complaining about discrimination, bullying and sexual harassment in the practice of surgery or by surgeons?

The incentives to challenge bullying behaviour, or make a complaint about discrimination or harassment are outweighed by the incentives to remain silent, hence an aggressive culture is perpetuated which selects people who can survive it – these people may then become role models for future generations of bullies.¹⁵ Medical trainees can be made to feel that they must conform to these behavioural norms in order to ensure their success, or may feel that failure to adhere to such an unspoken code of conduct will harm their career.¹⁶

What confidence is there in existing complaints a pathway – in the workplace and at the College?

The 2014 AMA Specialist Trainee Survey Report of Findings, February 2015¹⁷ (the STS) provides evidence of the low level of confidence in college processes, among other findings. For example, the STS noted ‘Responsiveness to cases of bullying and harassment’ as a key area for improvement (p 6) and only 12% of respondents strongly agreed that their college responded to cases of bullying and harassment in a timely and appropriate way. Only a third of trainees reported they were aware of college policies on bullying and harassment (p 30).

The STS concludes that ‘there is still a significant amount of work to be done to address bullying and harassment within the profession’ and states that ‘bullying and harassment in the workplace creates a poor learning environment due to the continued erosion of confidence, skills, and initiative of the doctor, and can create a negative attitude toward their chosen specialty’ (p31). Further, the results ‘align with anecdotal evidence about the pervasive nature of bullying and harassment issues within the medical profession and the workplace, and the need for the profession and employers to implement further measures to address them.’ (p 35). From this it is clear that confidence in existing complaints pathways is not strong and requires greater clarity, consistency and accessibility.

¹⁵ BMA Health Policy and Economic Research Unit (2006) Bullying and harassment of doctors in the workplace. British Medical Association, London.

¹⁶ The Royal Australasian College of Physicians (2013) Health of Doctors Position Statement.

¹⁷ <https://ama.com.au/article/2014-ama-specialist-trainee-survey-report-findings-february-2015>

Power imbalances may prevent people from complaining. Alleged unsatisfactory performance may lead to a counter claim of sexual harassment or bullying. Proof is central to enforcement; if the complainant cannot prove their complaint, then, in effect, they have no right.

It is clear that there needs to be a distancing of decision-making relating to the investigation from the immediate area where the complaints arise.

Some harassment suffered may not fall strictly into the definition of sexual harassment, but is nonetheless sex-based and creates a hostile working environment. An early case described the nexus with discrimination as follows: ‘It is an act of discrimination to deny an employee a benefit connected with the employment such as accrues to other employees. A benefit of employment is the entitlement to quiet employment, that is, the freedom from physical intrusion, the freedom from being harassed, and the freedom from being physically molested or approached in an unwelcome manner. If molestation, physical and sexual affronts are permitted by an employer, it is denying a benefit and permitting detriment to those employees who suffer such unwelcome intrusions vis-a-vis those who do not. It gives rise to the possibility of [unlawful] discrimination by an employer against an employee on the ground of sex.’¹⁸

One of the perceptions reported by doctors and students who choose not to report inappropriate behaviour is that reporting may not result in consequences for the perpetrator. By contrast, it is perceived that making a complaint may have significant, if not permanent consequences on a career.

It is therefore important that complaints processes clearly articulate the possible consequences of proven instances of inappropriate behaviour, including where necessary sanctions available through the Medical Council/Medical Boards under the Health Practitioner Regulation National Law Act 2009 or appropriate legislation.

Colleges have an obligation to provide high-quality training programs and, in providing that training, should ensure that it is provided in a safe and appropriate manner. Colleges would therefore be able to work in conjunction with hospitals and jurisdictions with regard to options such as the removal of the right to supervise trainees or other appropriate sanctions.

In considering pathways for making complaints, it is essential that complaints are able to be managed in a single and clearly defined pathway. Multiple complaints processes and or investigations are seen to limit the rights and fairness afforded to all parties. Multiple complaint processes also reduce the ability to ensure that there are suitably trained and experienced staff to manage complaints and undertake review processes.

Legal barriers in the complaints pathway

There exists a significant evidentiary hurdle for employment complaints as alleged discrimination can quickly become interwoven with bona fide considerations of merit; unless the conduct is unequivocal, such as including a written component, the burden of proof can be virtually insuperable.¹⁹ Comparable countries, such as the United States and the United

¹⁸ *R v Equal Opportunity Board; Ex parte Burns* [1985] VR 317, 322, per Nathan J.

¹⁹ Thornton, M. (1995) Revisiting Race in *Racial Discrimination Act 1975*: A Review.

Kingdom, take a different approach and have reduced the complainant's burden. Some of the alternative mechanisms used in these countries pre-date Australia's anti-discrimination legislation, yet they were not adopted here.

The effectiveness of the *Sex Discrimination Act 1984* was assessed in 2008 by the Senate Standing Committee on Legal and Constitutional Affairs. The Senate Committee recommended that positive duties should be imposed on employers.

The *Sex Discrimination Act* has been amended since 2008, including amendments in 2011 strengthening protections against sexual harassment in workplaces and schools and amendments in 2013 extending the list of circumstances to be taken into account as part of the test for sexual harassment.

However, there remains no 'positive duty' on public sector organisations, employers, educational institutions and other service providers to eliminate sex discrimination and sexual harassment.

The legal barriers for a complaint will require legislative reform, but the process at the College level should be more streamlined. Within the bounds of procedural fairness College accreditation standards should include an onus on employers to take positive steps to eliminate discrimination and harassment.

Do you have comments on the following?

- *Centralise knowledge of complaints about discrimination, bullying and sexual harassment so they can be monitored, effectively managed individually and analysed collectively, to make sure the general issues they raise are addressed.*
- *In partnership with employers, assess the effectiveness of current data-collection methods in identifying these issues and collate data across institutions.*
- *Undertake site visits and talk to hospital staff when data analysis identifies potential systemic issues.*
- *Host annual or regular roundtables for relevant stakeholders to identify and share best-practice models or initiatives that have been successful in addressing discrimination, bullying and sexual harassment.*

The AMA supports a centralised, accessible database about discrimination and related complaints for effective, on-going management. As previously noted, the AMA supports the collection of data to enhance evidence-based responses to sexual harassment.

Bullying and harassment should be the topic of surveys of trainees with the College being required to act when there is evidence of an ongoing issue in a hospital.

In this respect the AMA believes that the implementation of a national training survey is essential to provide data on which training programs and locations are managing bullying and harassment well and where there is room for improvement. It would be useful if the College could support this initiative moving forward.

To illustrate this point, in the United Kingdom, the General Medical Council (GMC) runs a national training survey annually. Each year the survey asks doctors in training if they have

experienced bullying or undermining in their workplace. In 2014 it found that around one in 10 trainee doctors had experienced bullying with a further 14 per cent having witnessed bullying. Its subsequent investigation and report, *National Training Survey 2014: Bullying and Undermining*, has confirmed that many additional cases of bullying are went undetected owing to a lack of confidence in reporting services. Evidence suggests there was a reluctance to speak out about bullying and undermining both from fear of reprisals and from lack of faith that anything would be done. The British Medical Association (BMA) has called for greater openness and support over incidences of bullying within the health service, warning that a lack of action to address this could jeopardise patient care.

The AMA has already taken a lead role in the hosting of a roundtable on sexual harassment in early 2015. The roundtable was extremely valuable and we would support regular roundtables and other events for stakeholders to share experiences and best practice models for addressing discrimination and harassment.

b. Fear of reprisal

- *How does fear of reprisal stop people making complaints?*
- *What would change that?*
- *What can the College do – alone or in partnership with employers – to make it safe to complain and take a stand against unacceptable behaviour?*

Fear of reprisal stops people from making complaints because they may feel insecure in their role. A lot is at stake for a trainee. Any risk to their ongoing training may be too much to risk.

Individuals, most often women, may remain silent about sexual harassment. This may be due to a range of factors, including:

- Fear of losing their job or damaging their career prospects, especially when the harasser is a senior colleague
- Embarrassment
- Not wanting or feeling able to confront the pervasive culture of the workplace or industry in which they work
- A desire to cope
- A feeling that their complaints will not be taken seriously
- The need to continue working for financial reasons, particularly in casual jobs where no sick leave is available
- Feelings of insecurity and being unsure whether the harassment will be viewed as harassment by their employer
- Difficult, unclear or non-existent reporting process.

Addressing these issues in policy directives and accreditation arrangements with employers would go some way to tackling the silence around sexual harassment.

Do you have comments on the following?

- *Conduct group interviews during ‘quality assurance visits’ where surgical trainees are placed.*
- *Investigate and address the issue in partnership with hospitals, health sector employers and other experts.*
- *Increase independent oversight in the College’s complaints process, for concerns about discrimination, bullying and sexual harassment.*

The AMA supports all of the above proposals. Further, the AMA believes that health departments and hospitals should maintain reporting statistics (de-identified) to develop an ongoing database to accurately target problem areas on an ongoing basis.

c. Response to complaints

The EAG is interested in your views about organisational responses to complaints of discrimination, bullying and sexual harassment, for example by employers, professional associations such as medical colleges, including the Royal Australasian College of Surgeons, and regulators, such as the Medical Board of Australia and the Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Council of New Zealand.

- *How effectively do you think organisations use the powers they have to sanction this kind of inappropriate behaviour?*
- *Do existing complaints management and appeal processes allow for fair and equitable treatment (for example, recognising unconscious bias on the basis of gender or race)? Or how could these be improved?*
- *Is there enough transparency when sanctions are imposed?*
- *How effectively are these sanctions followed up?*
- *What do you think would be effective in generating lasting behaviour*

The key to lasting change will be whole-of-profession approach. The College cannot solve this issue in isolation. It needs cooperation with relevant stakeholders, as well as all members of the profession to take a leadership role. The Committee of Presidents of Medical Colleges could also help to develop and roll out standard policies and processes addressing this issue.

Attachment: Additional comments from AMA Queensland