Royal Australasian
College of Surgeons

Building Respect, Improving Patient Safety Action Plan

Phase 2 Evaluation
Final Report

October 2021

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Executive Summary

Background

Action Plan history

In 2015 an Expert Advisory Group (EAG) established by the Royal Australasian College of Surgeons (RACS) to investigate the extent of reported unacceptable behaviour within the surgical profession, uncovered widespread discrimination, bullying and sexual harassment in the practice of surgery.

RACS responded to these issues by developing an Action Plan, *Building Respect, Improving Patient Safety* (Action Plan) (Attachment 1), which outlines how RACS intends to counter and drive out unacceptable behaviours from surgical practice and surgical training.

Goals

The Action Plan describes the actions needed to address each of the EAG recommendations. It contains eight goals, arranged under the three key action areas identified by the EAG. These goals are supported by a comprehensive workplan, which has been prioritised and gradually implemented.

Context

Implementation of the Building Respect Action Plan has taken place within a dynamic environment of government policy, world events, media issues and public opinion, all of which have influenced the planned program outcomes. Community awareness and expectations of the need to improve behaviours in the workplace have been significant enablers for implementation, as has the increasing alignment of workplace policies with Action Plan goals. The global pandemic has limited the extent to which some parts of the Action Plan could be implemented and has impacted workplaces in ways that are difficult to estimate.

The Phase 2 evaluation

This was the first outcomes evaluation of the Building Respect Action Plan. It focussed on the short-term outcomes as described in the Program Logic Model (Attachment 2). The scope for this evaluation covered:

- Measure whether program implementation (delivery of policy framework to underpin respectful behaviours; education initiatives; complaints management process); governance and oversight are proceeding as intended.

- Measure whether short-term outcomes (awareness of standards of respectful behaviour and approaches to address unacceptable behaviours; key partnerships formed; better educator skills; focus of surgical education on principles of respect, transparency, and professionalism) are being achieved as intended.

- Identify program strengths, what is working well, barriers to progress.
- Make recommendations on areas for program adjustment or improvement, based on findings.

The evaluation was conducted by collecting evidence against six Key Evaluation Questions (KEQ) focussed on Action Plan implementation, governance and outcomes. A number of evidence sources were used, including documents, reports, presentations, a survey of College members, and in-depth interviews with randomly selected Fellows, Trainees and Specialist International Medical Graduates (SIMGs), RACS staff and Executives and external stakeholders to explore emerging issues. The findings and draft recommendations were validated with the Project Reference Group (PRG) before being finalised in this report.

Findings

What could be expected from the Action Plan at this stage of implementation?

It is important to remember, when reading the findings, that this is the first outcomes evaluation for the Building Respect Action Plan. The changes that could be expected, according to the Program Logic (Attachment 2) include changes in awareness, knowledge, skills, and attitudes. Although some data collection has focussed on behaviour change, this has been done to inform further planning and to create a baseline for future evaluations.

The Key Evaluation Questions (KEQ) are shown below, together with a summary of their related findings.

KEQ 1: Has the Action Plan been implemented as intended to date?

Overall assessment of findings for this KEQ

RACS' membership actively supports the College in its Building Respect Action Plan, with support increasing even from the very strong numbers seen in 2019. However, some are concerned about the impact on standards in surgery of diversity initiatives such as targets for women within training. External stakeholders are very supportive of the Action Plan, see RACS as a leader in this space and are keen to form multidisciplinary partnerships.

Implementation of the Action Plan faced a significant challenge with the COVID-19 pandemic, however, whilst having to postpone implementation of some activities, the College was able to develop new initiatives and implement planned activities face-to-face where possible and online where necessary. This response to the pandemic continues at the time of writing this report. There is a perception amongst, staff, Councillors, and the membership of a loss of momentum of the Action Plan, which could be COVID-related or indicate that it is timely to review and refresh the plan including messaging.

Despite the strong support for the Action Plan overall, only two thirds of members believe that the leaders in their workplaces and at RACS demonstrate respectful

behaviours. This includes senior surgeons within the structure at RACS, including committee members, and has led to some undermining of RACS' credibility amongst members, in its promotion of cultural change.

Successes

- Clear setting of Council's expectations regarding respectful behaviours.
- Strong communications and training led to very high support for the Action Plan within the RACS membership.
- Increased support for the content of OWR messaging.
- RACS is seen as a leader in this space by external stakeholders.
- Keen interest from external stakeholders to work in partnership with RACS.
- Implementation pivoted in response to COVID-19.

Barriers

- Not all surgical leaders, including committee members, model respectful behaviours.
- Perceived loss of momentum for the current Action Plan.
- Some messaging fatigue despite support for the Action Plan.
- The surgical population does not represent the diversity of the community.
- Concerns about standards relate to misunderstanding of how access and equity are applied in practice.

KEQ 2: Is program governance and oversight effectively supporting delivery of the Action Plan?

Overall assessment of findings for this KEQ

While the Action Plan is closely monitored at regular meetings, the focus has been on activities and outputs rather than outcomes, making it challenging for Council and senior management to assess the overall performance of the implementation. This applies to most of the Diversity and Inclusion Plan, apart from the target and timeline for inclusion of women. A significant effort is put into activity reporting, which could be better utilised in a series of outcome reports based on agreed timelines and performance indicators. Despite these issues, implementation of the Action Plan was successfully pivoted in response to the challenge of the COVID-19 pandemic.

Successes

- Action Plan outputs and activities are closely monitored making it possible for changes in direction in response to barriers and challenges.
- Implementation pivoted in response to COVID-19 challenges.
- The Action Plan has a clear coordinator and advocate.

Barriers

- Outcome monitoring of both the Building Respect and Diversity and Inclusion Plans, relies on regular external evaluations, making it challenging to measure and adapt to the ongoing performance of the plans and contributing to a governance issue for Council.

- The effort put into detailed activity reporting does not translate into improved accountability and transparency.
- The Diversity and Inclusion Plan lacks a coordinator or champion meaning it can be overlooked amongst other priorities.

KEQ 3. To what extent has awareness of the standards for respectful behaviour increased across the surgical profession?

Overall assessment of findings for this KEQ

The change model that underpins the program logic involves a series of changes that are expected to occur over several years. The first changes are in awareness about and attitudes towards respectful behaviours, followed by increasing knowledge about how to respond to unacceptable behaviours and how to act respectfully, and then finally resulting in changes to behaviour. The interplay between changes in awareness, attitude, and knowledge as precursors to behaviour change is not linear or necessarily sequential, and is affected by a range of interpersonal, social, and environmental factors. It is generally acknowledged that behaviour change outcomes are long term in nature.

Overall, the RACS Building Respect program is on track with respect to the changes expected. Awareness of the standards for respectful behaviour and awareness of what constitutes respectful behaviours has increased across the membership, knowledge and attitudes are trailing awareness but are still high, and expected behaviours are beginning to emerge.

Successes

- Awareness of standards of respectful behaviour and what constitutes unacceptable behaviours is very high, with 99% of members accepting the need to demonstrate respectful behaviours.
- Most members say they can recognise unacceptable behaviour in others and themselves.
- There is strong support for continuing to raise awareness.
- Knowledge levels about addressing unacceptable behaviours is high – most people say they know what to do if they see or experience unacceptable behaviours.
- Attitudes towards respectful behaviours are very positive. Attitudes towards diversity while positive are not as supportive as attitudes towards respectful behaviours.
- Behaviours aligned to building diversity and increasing respectful behaviours are emerging.
- There is considerable optimism for the impact of generational change, with many reporting that younger people are less tolerant of unacceptable behaviours.
- People are more likely to take action - about DBH but not sexual harassment.

Barriers

- Fellows with more than 10 years' experience, potential influencers of culture, are least aware of respectful behaviours or the impact their own biases have on their behaviours.
- As expected, there is a gap between the knowledge to recognise and address unacceptable behaviours and actual demonstration of that behaviour.
- Reported incidence of DBH has decreased, but reported incidence of sexual harassment has increased, with the greatest increase in reports by males.
- The nature of unacceptable behaviours has shifted towards microaggressions.

KEQ 4. To what extent are RACS processes to manage unacceptable behaviour working as intended?

Overall assessment of findings for this KEQ

RACS has revised its complaints process and developed clear communications about its role and limitations. Importantly, communications about the new process were launched at the same time as this evaluation, so low awareness figures and poor understanding of the process do not reflect the outcome of this new communications effort. However, there remains an opportunity for the College to manage the expectations of members regarding the possible and most beneficial outcomes of complaints. There is a culture of negative consequences for people who raise a concern about behaviour in the workplace and this prevents a large number of people in less powerful positions from reporting incidents. Despite this, the College has gained ground in its relationship with Trainees, by increasing trust of the RACS complaints process in this group.

Successes

- Clear but recent communication to members of RACS role in complaints process.
- Efforts to engage Trainees appear to be increasing trust in the College.

Barriers

- Still a poor understanding of the RACS complaints process.
- Expectations of members do not match with RACS' powers.
- Real fears of repercussions hamper reporting of unprofessional behaviour.

KEQ 5. To what extent have relationships of trust, confidence, and cooperation on DBSH issues supported progress towards RACS Action Plan goals?

Overall assessment of findings for this KEQ

RACS has strong credibility amongst external stakeholders, due to its early and definitive leadership in addressing cultural change. The strong messaging from RACS leaders including the Council, Key Opinion Leaders and senior Executives about the expectations of the College was seen as a critical success factor for the Action Plan.

The external engagement approach has focussed on dissemination of the annual Progress Report to an extensive stakeholder list, information sharing regarding

complaints notifications and the piloting of different ways of engaging with hospital partners, to find a sustainable way of achieving MOU goals.

External stakeholders are very keen to work in partnership with RACS, opening up an opportunity to rethink the way the College engages with its external stakeholders and leverage off its strong reputation as a leader in this space to engage in a two-way dialogue and develop joint activities in the next phase of the Action Plan.

Successes

- Strong credibility amongst external stakeholders regarding improving the culture of surgery.
- Many other organisations have leveraged RACS' collateral to introduce cultural change programs of their own.
- RACS' leadership in this space has led to a keen interest from a broad range of external stakeholders in partnering on cultural change initiatives.

Barriers

- The resource intensive nature of working on some partnerships – particularly individual hospital partnerships.

KEQ 6. To what extent has surgical education incorporated the principles of respect, transparency, and professionalism?

Overall assessment of findings for this KEQ

Despite significant efforts from RACS to improve supports for both Supervisors and Trainees, the surgical training environment remains an area of concern for reports of unacceptable behaviour. Contributing factors are systemic. They include the devolved structure of surgical training, which creates governance and accountability issues, workplace practices which create opportunities for unacceptable behaviours and lack of recognition and support for supervision in the workplace.

Successes

- RACS has introduced significant improvements in support for Trainees and supervisors including training courses, resources and training supports.
- Most Trainees report a positive learning experience.

Barriers

- COVID-19 has limited the ability of RACS to deliver face-to-face training.
- The significant variation in the quality of training placements relates to the quality of supervision and the influence of local culture.
- Performance feedback remains challenging in surgery, as in other professions.
- Supervisors fear the potential consequences of giving negative feedback which leads some to pass on Trainees without addressing performance issues.
- There is a culture of non-transparent, informal feedback between Supervisors, which can be undermining for Trainees.
- The devolved structure of surgical training delivery is a barrier for implementation of profession-wide initiatives.

- Workplace practices contribute to some poor behaviours.
- The role of supervision, whilst a critical success factor for surgical training, is not well supported in the workplace.

Conclusions

The Action Plan has been very positively received both within RACS membership and externally amongst its stakeholders and peers. Knowledge regarding respectful behaviours is now widespread across the surgical profession, with more people talking about respectful behaviours in the workplace. Attitudes towards diversity and what is regarded as acceptable behaviour are changing towards an expectation of professional behaviours.

Behaviour, a long-term goal of the Action Plan, is already beginning to change towards the desired outcomes. As expected, there is a gap between knowledge and behaviour, with variations in people's level of confidence to take action when witnessing or experiencing an incident.

Complaints processes, both within RACS and at workplaces, are still poorly trusted due to fears of repercussions on careers and reputations. Surgical training is a locus for reports of unprofessional behaviours, with systemic and structural issues contributing to the problem.

External stakeholders are implementing cultural improvement programs within their own workplaces and are keen to partner with RACS on multidisciplinary approaches to cultural change. The strength of support, both internally and externally, provides an opportunity for RACS to leverage off the work to date to develop the next phase of the Action Plan.

Recommendations

The recommendations from this evaluation have been developed to inform the next Building Respect Action Plan.

1. Influence organisation culture to build desired group norms

1.1 Leverage RACS' reputation and the global momentum for workplace change to form external partnerships to align messaging and address systemic barriers to respectful behaviours in workplaces.

1.2 Work in partnership with employers and governments to promote workplace environments (policy and cultural) that position '*calling it out*' as normative and supported behaviour.

1.3 Ensure the surgical workforce more closely represents the diversity of the community.

1.4 Work in partnership with Specialty Societies to reduce the contribution to unacceptable behaviours of systemic and structural issues in surgical training.

2. Influence awareness to build desired attitudes

2.1 Leverage the strengths and successes of the Operating With Respect communications by continuing the strong messaging, and address fatigue by refreshing messaging content.

2.2 Clarify messaging about surgical selection to ensure understanding that the diversity and inclusion process does not jeopardise surgical standards.

2.3 Improve trust and understanding of the RACS complaints process, by clarifying messaging about its limitations, how it operates in practice, and reporting on deidentified outcomes where possible.

2.4 Disseminate evidence of effective locally developed actions that impact on culture change and patient safety.

3. Influence knowledge, skills, and competencies to improve perceptions of behavioural control

3.1 Focus skill building activities on bridging the gap between knowledge and behaviour.

3.2 Expand delivery of OWR face to face training to include all surgeons, to more comprehensively equip the surgical workforce to call out unprofessional conduct with their peers.

3.3 Provide practical modelling, training, resources, and communications to support surgical leaders to gain skills in the critical success factors for leading to achieve cultural change.

3.4 Provide training and communication to increase surgeon insight into the need for respect of non-surgical team members to underpin optimal team performance and patient outcomes.

4. Ensure transparent governance and agile implementation

4.1 Underpin the new Action Plan with a commonly agreed Theory of Change, measurable outcomes and a revised Monitoring and Evaluation Framework.

4.2 Incorporate Action Plan outcomes into Key Performance Indicators for RACS leaders and incorporate responsibility for managing behaviours into all RACS committee chair roles.

4.3 Monitor the impact of the Action Plan on surgical culture by conducting an annual cultural snapshot using a simplified prevalence survey.

4.4 Develop monitoring and progress reports in appropriate detail for each governance level, including an outcomes-based dashboard for Council.

4.5 Regularly review monitoring reports and adapt implementation priorities according to findings and context.

1. Introduction

1.1 Background

Action Plan history

In 2015 an Expert Advisory Group (EAG) established by the Royal Australasian College of Surgeons (RACS) to investigate the extent of reported unacceptable behaviours within the surgical profession, uncovered widespread discrimination, bullying and sexual harassment in the practice of surgery.

RACS responded to these issues, and the consequent concerns for the wellbeing of surgical teams and the safety of patients, by developing an Action Plan, *Building Respect, Improving Patient Safety* (Action Plan) (Attachment 1). This Action Plan describes how RACS intends to deliver its vision to '*build a culture of respect in surgical practice and education.*'

Goals

The Action Plan has been developed to reflect the principles of the Vanderbilt Model[1]. Its long-term goals aim at achieving:

- Improved patient safety.
- Surgical workplaces that are safe and free from unacceptable behaviours.
- A surgical profession that is more representative of the cultural and gender diversity across the community.

The Action Plan addresses eight goals, arranged under the three key action areas identified by the EAG. These goals are supported by a comprehensive workplan, which has been prioritised and gradually implemented.

Action area 1: Cultural Change and Leadership

Goal 1: Build a culture of respect and collaboration in surgical practice and education.

Goal 2: Respecting the rich history of the surgical profession, advance the culture of surgical practice so there is no place for discrimination, bullying and sexual harassment (DBSH).

Goal 3: Build and foster relationships of trust, confidence and cooperation on DBSH issues with employers, governments and their agencies in all jurisdictions.

Goal 4: Embrace diversity and foster gender equity.

Goal 5: Increase transparency, independent scrutiny and external accountability in College activities.

[1] Hickson GB, Pichert J, WEBB LE, Gabbe SG. A complementary approach to promoting professionalism: identifying, measuring, and addressing unprofessional behaviors. Acad. Med. 2007 Nov;82(11):1040-8

Action area 2: Surgical Education

Goal 6: Improve the capability of all surgeons involved in surgical education to provide effective surgical education based on the principles of respect, transparency, and professionalism.

Goal 7: Train all Fellows, Trainees and Specialist International Medical Graduates (SIMGs) to build and consolidate professionalism including:

- Fostering respect and good behaviour.
- Understanding DBSH: legal obligations and liabilities.
- 'Calling it out'/not walking past bad behaviour.
- Resilience in maintaining professional behaviour.

Action area 3: Complaints Management

Goal 8: Revise and strengthen RACS complaints management process, increasing external scrutiny and demonstrating best practice complaints management that is transparent, robust, and fair.

1.2 Context

Implementation of any program takes place within a dynamic environment of government policy, world events, media issues and public opinion, all of which may influence the planned program outcomes. This is particularly so for long-term programs such as the Building Respect Action Plan and should be considered as part of the evaluative reasoning process. Some major influences are described below.

Community awareness and expectations are continually changing

Since the launch of the Action Plan, there have been ongoing significant events which have increased community awareness of the need to improve standards of behaviour in workplaces. The #metoo campaign was at the forefront during the last evaluation period and has more recently been complemented by publicity relating to alleged unacceptable behaviour in high profile workplaces such as the Australian Parliament and the Aotearoa New Zealand legal profession. This has brought the issue of sexual harassment, in particular, to the forefront of discussion and opinion, increasing awareness of what constitutes unacceptable behaviour in the workplace. While this issue is an enabler for implementation of the Action Plan, the increased awareness could also have increased reporting of unacceptable behaviours and sexual harassment.

Workplaces are increasing alignment with Action Plan goals

With the rise in awareness of the level of unacceptable behaviours in workplaces, employers, especially in the health sector, have introduced policies, training, and protocols to improve the workplace culture. Surgeons working in these settings are now receiving messages about respectful behaviours from their employers in addition to RACS. This alignment is likely to have enabled the implementation of the Action Plan by normalising the issue and standards of behaviour, however, the multiple communications may have contributed to messaging fatigue.

COVID-19 has impacted all workplaces

The global pandemic and the consequent lockdowns, have changed the way people interact, forcing much interaction online and limiting the program's ability to deliver face-to-face training and conferences. In many locations, elective surgery has been paused for weeks or months at a time, and infection control protocols have reduced the number of patients that can be seen, significantly impacting the way surgeons and other operating theatre staff participate and interact in the workforce. The impact of this on the incidence and reporting of DBSH is difficult to estimate.

1.3 Phase 2 Evaluation

Scope

This evaluation was the first outcomes evaluation. The purpose of this evaluation of the Building Respect Action Plan was to evaluate the short-term outcomes of the Action Plan, as outlined in the Program Logic Model (Attachment 2).

The focus was to:

- Measure whether program implementation (delivery of policy framework to underpin respectful behaviours; education initiatives; complaints management process); governance and oversight are proceeding as intended.
- Measure whether short-term outcomes (awareness of standards of respectful behaviour and approaches to address unacceptable behaviours; key partnerships formed; better educator skills; focus of surgical education on principles of respect, transparency, and professionalism) are being achieved as intended.
- Identify program strengths, what is working well, barriers to progress.
- Make recommendations on areas for program adjustment or improvement, based on findings.

The Key Evaluation Questions (KEQ) were the research questions guiding this evaluation. The KEQs were supported by sub-questions, to structure data gathering by ensuring collection of appropriate information to answer each KEQ in detail.

KEQ 1: Has the Action Plan been implemented as intended to date?

1.1 Have the program elements been delivered according to the plan to date?

1.2 Are the program elements reaching the intended audiences?

1.3 What are the reactions of the program's target audiences to the program activities?

1.4 What are the barriers/enablers for program implementation?

1.5 Have there been any unintended consequences, positive or negative, of program activity?

KEQ 2: Is program governance and oversight effectively supporting delivery of the Action Plan?

2.1 Is the program appropriately resourced?

2.2 Is program progress being appropriately monitored?

2.3 Are adjustments being made to the program in light of emerging data trends and/or practical barriers?

2.4 Is RACS reporting transparently to members and the public about progress towards building a culture of respect?

KEQ 3: To what extent has awareness of the standards for respectful behaviour increased across the surgical profession?

3.1 Can Fellows, Trainees and Specialist International Medical Graduates identify unacceptable behaviours?

3.2 Can Fellows, Trainees and Specialist International Medical Graduates identify what constitutes respectful behaviours?

3.3 Have attitudes towards unacceptable behaviours changed across the surgical profession?

KEQ 4: To what extent are RACS processes to manage unacceptable behaviour working as intended?

4.1 Has RACS provided information about mechanisms, supports and pathways to address unacceptable behaviours to Fellows, Trainees and Specialist International Medical Graduates?

4.2 Are Fellows, Trainees and Specialist International Medical Graduates aware of avenues to address unacceptable behaviours?

4.3 Is the RACS complaints management process appropriate, transparent, and fair?

KEQ 5: To what extent have relationships of trust, confidence and cooperation on Discrimination, Bullying, Sexual Harassment issues supported progress towards RACS Action Plan goals?

5.1 Have partnerships with employers, health departments, university medical schools and others recognised common goals, roles and responsibilities?

5.2 Have internal partners (eg Specialty Training Boards and Specialty Societies) committed to the RACS Action Plan vision?

KEQ 6: To what extent has surgical education incorporated the principles of respect, transparency and professionalism?

6.1 Have surgical educators gained skills in providing respectful and constructive feedback to Trainees?

6.2 Are surgical educators delivering feedback to Trainees in a more timely, constructive and respectful manner?

Evaluation audience

The findings of this evaluation will be reported to the following:

- RACS Council and major committees.
- Building Respect Implementation Group.
- Building Respect Expert Advisory Group.
- RACS Fellowship/ Trainees/(SIMGs).

Structure of this report

This report documents the Phase 2 evaluation of the Building Respect, Improving Patient Safety Action Plan, covering the period 2019-2021.

Section 1, the *Introduction,* provides the background and context to the Action Plan and the scope and purpose of this evaluation.

Section 2 presents the detailed *Methodology* for the conduct of the evaluation.

Section 3 presents the *Findings* from all data sources, presented under each of the six KEQs.

Section 4 presents the overall *Conclusions* followed by the *Recommendations.*

Section 5 presents the *Attachments* to this report:

Attachment 1: Building Respect, Improving Patient Safety Action Plan

Attachment 2: Building Respect Program Logic Model

Attachment 3: Building Respect Program Evaluation Framework

Attachment 4: Stakeholder Engagement Plan

Attachment 5: Evaluation Survey Questions

Attachment 6: Semi-structured Interview Questions

Attachment 7: Definitions and Common Terminology

Attachment 8: 2021 Prevalence Survey Report

Attachment 9: 2021 Prevalence Survey Questions

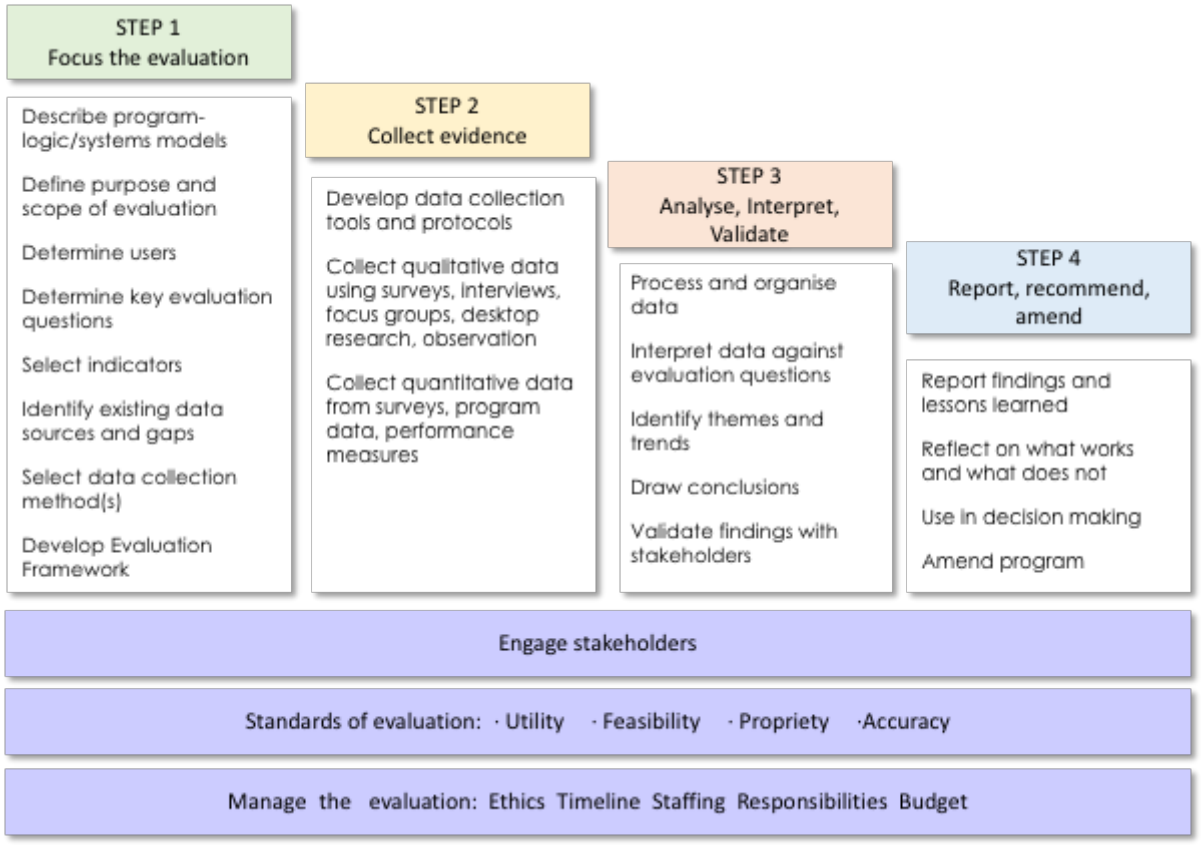
2. Methodology

2.1 Overall evaluation approach

Evidence based model for Program evaluation

The evaluation model used for this evaluation was a four-step, evidence-based modification of the University of Wisconsin evaluation model as shown in the figure below. This approach also complies with the NSW Government Program Evaluation Guidelines (2016), widely used for evaluations of government agencies across Australia. The evaluation was structured around the Building Respect Program Evaluation Framework, developed in 2018, (Attachment 3) and conducted in an iterative way, with each step building upon the outputs of the previous step, informed by consultation throughout the process.

Figure 2.1 Evidence-Based Evaluation Model



Adapted from Taylor-Powell and Henert, University of Wisconsin, 2008

Use of best practice principles

The evaluation approach was guided by the following, evidence-based principles, sourced from the model above and from government program evaluation guidelines widely used in Australia[2].

Principle	How it was expressed
1. Build evaluation into Program design	A detailed program logic model was developed during the evaluation design stage (Attachment 2). This logic model informed the development of the key evaluation questions. The resulting Evaluation Framework (Attachment 3) guides this and future evaluations.
2. Base evaluation on sound methodology	The Evaluation Framework was developed using methodology adapted from the recognised University of Wisconsin model (Step 1 in Figure 2.1 above). The design of this evaluation follows the Evaluation Framework, the NSW Government Program Evaluation Guidelines (2016) and the evidence-based principles of utilization focussed evaluation[3].
3. Include resources and time to evaluate	The Building Respect Action Plan includes resources and timing for evaluations. The Evaluation Framework includes a schedule of evaluations. This evaluation was conducted with an approved work plan, timeline and budget which allocated appropriate resources to conduct the evaluation to the required standard.
4. Use the right mix of expertise and independence	The evaluation was conducted by The Thread Consulting (TTC), a professional independent evaluator. The methodology was based on significant stakeholder engagement to ensure the findings represent a range of viewpoints and experiences and to ensure contextual understanding in interpretation of findings and development of recommendations.
5. Ensure proper governance and oversight	The project governance framework for this evaluation included a work plan agreed at the beginning of the evaluation, regular written progress reports and regular progress meetings with the Building Respect Executive Lead. The evaluation was guided by a Project Reference Group including CEO John Biviano; Executive Project Lead, Building Respect Improving Patient Safety, Judy Finn; EGM Education, Julian Archer; Manager Fellowship Services, Paul Cargill; Head of Research, Tamsin Garrod; Communications Consultant, Nicole Newton. This group reviewed and approved each deliverable during the evaluation.
6. Be ethical in design and conduct	Ethical considerations were incorporated into the evaluation design to ensure access for stakeholders and confidentiality of interview and survey information. All evidence and findings have been presented in de-identified form. TTC consultants are members of the Australasian Evaluation Society and abide by its *Code of Conduct for Ethical Evaluations*.
7. Be informed and guided by relevant stakeholders	Data collection was conducted via individual interviews, a survey and examination of documents, to ensure a broad range of input to the findings. In addition, PRG workshops, circulation of drafts, and extensive consultation with the PRG and the Executive Project Lead was conducted to provide oversight and input into each deliverable, to ensure the validity of interpretations and to incorporate contextual factors into the analysis and recommendations.
8. Consider and use evaluation data meaningfully	Evaluation data were organised against the KEQs and analysed for emerging themes, trends and meaning, within the context of the practical realities of the program. Findings and interpretations were validated by the PRG, after which recommendations for improvement were developed.
9. Be transparent and open to scrutiny	An agreed work plan with timelines, responsibilities and deliverables was used to ensure transparency and support good project management throughout the evaluation.

[2] NSW Government Program Evaluation Guidelines. Department of Premier and Cabinet [Internet]. 2016 [cited 2017 Aug 17]. Available from: https://arp.nsw.gov.au/sites/default/files/NSW%20Government%20Program%20Evaluation%20Guideline%20January%202016_1.pdf
Government Program Evaluation Guidelines (2016)

[3] Patton MQ. Essentials of utilization-focused evaluation. Thousand Oaks, California: Sage; 2012

Stakeholder consultation

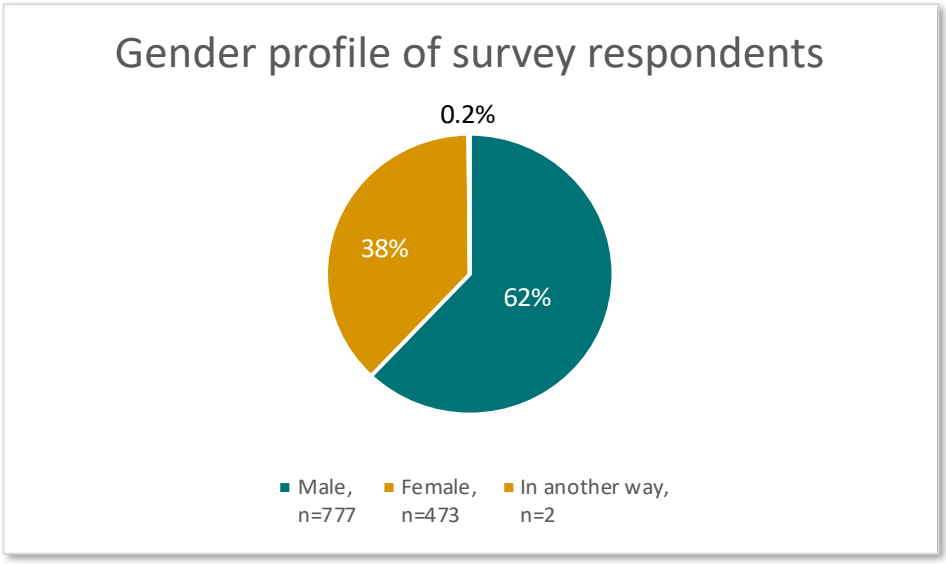
Internal stakeholder consultation was built into every step of the evaluation, to ensure broad input into the evidence, validation of the findings and interpretations, and support for the evaluation approach from the people who have the most detailed knowledge of the Action Plan. The consultation methods included a variety of access points to ensure stakeholders had an opportunity to provide input to the evaluation:

- Two interactive workshops with the PRG to confirm the evaluation methodology and validate findings.
- Circulation of draft surveys and interview guides to the PRG for comment and input.
- Semi-structured and open-ended interviews (in-depth zoom interviews) with 8 Fellows, 5 Trainees, 4 SIMGs, 5 RACS Committee Chairs, CEO, 2 RACS Executives, 6 RACS staff, 1 external academic, and 6 Councillors.
- Semi-structured interviews with 18 external stakeholders including hospital CEOs and CMOs, CEOs of professional associations (RACMA, AHHA, RACSTA), CEOs and Presidents of nursing colleges (NZNO, ACORN, ACN), and representatives from ANZCA.
- A survey sent to 4780 Fellows, Trainees and SIMGs with a 26% response rate.
- Meetings with the CEO and Executive Project Lead to confirm the approach, validate findings, discuss the practical application of draft recommendations, and ensure input of contextual information.
- Presentations to the RACS Council, the Building Respect Implementation Group and the Expert Advisory Group (EAG) to report on findings.
- Circulation of the draft report to the PRG and other relevant RACS staff for comment.

Interviewees from the fellowship were selected by random, stratified sampling to provide representation across geographic regions, specialties and gender. External stakeholders were purposively selected, to ensure broad coverage of the relevant stakeholder groups and geographical locations.

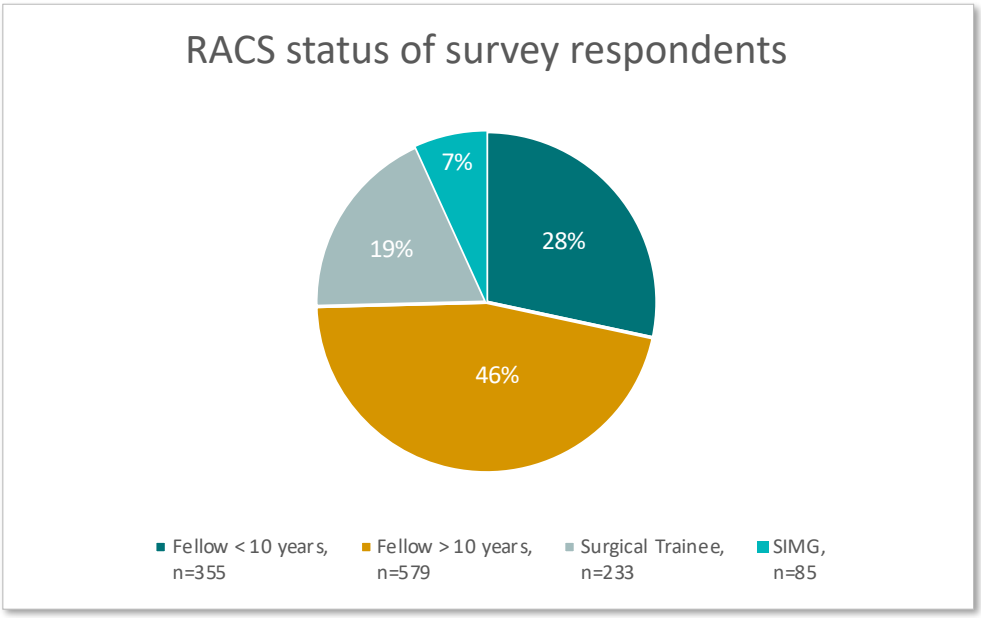
Analysis of survey respondents indicated there were 934 Fellows (777 males: 62%; 473 females: 38% and 2 who described their gender in another way) (Figure 2.2).

Figure 2.2



Three quarters of respondents (74%) were Fellows, with more than half of that figure Fellows with greater than 10 years' experience (Figure 2.3). 243 respondents were from Aotearoa New Zealand (19%) and the remaining 1009 were from Australia (81%).

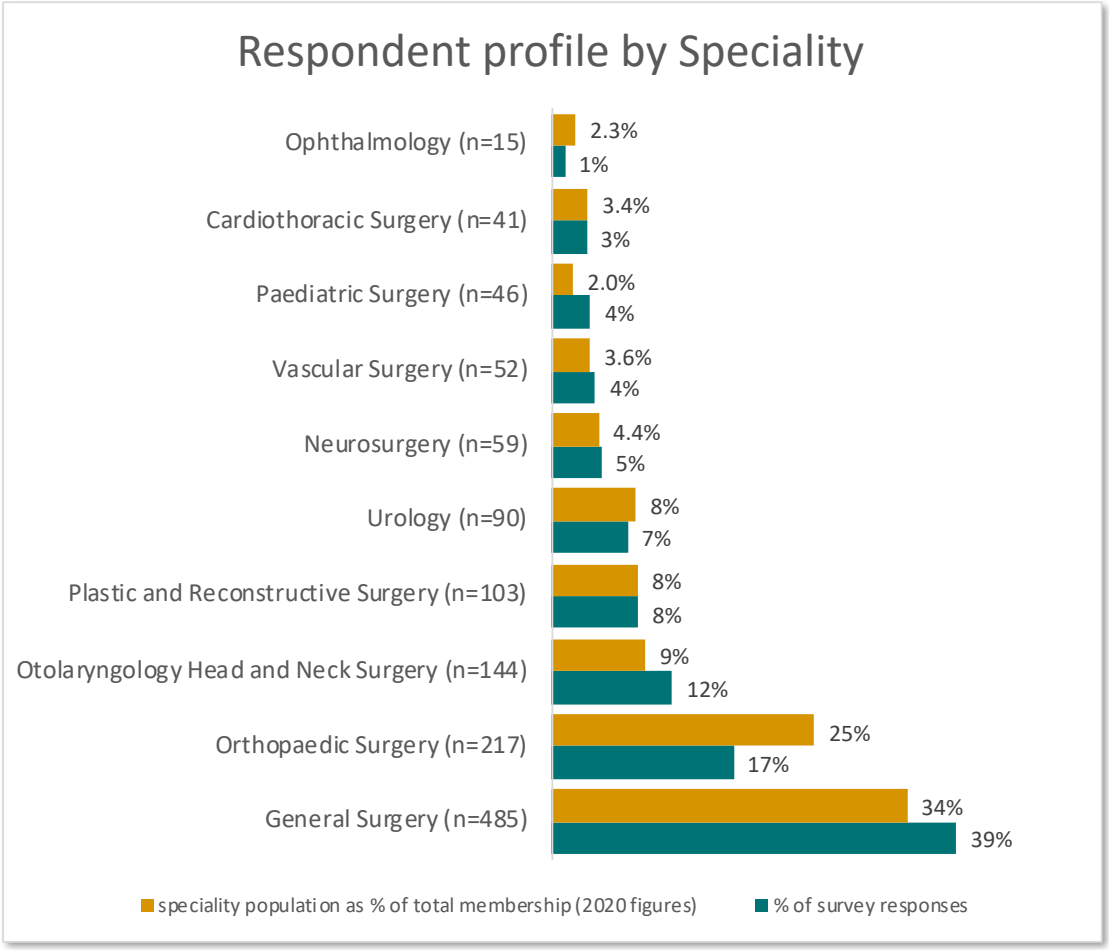
Figure 2.3



Almost half of the respondents (44%) were not involved with RACS in any way. Surgical supervisors comprised 24% of respondents, committee members, 11% and councillors 1% of respondents.

Respondents from each specialty were approximately proportional to their representation amongst the RACS membership, with the exception of General Surgery, which was slightly overrepresented and Orthopaedic Surgery, which was slightly underrepresented (Figure 2.4)

Figure 2.4

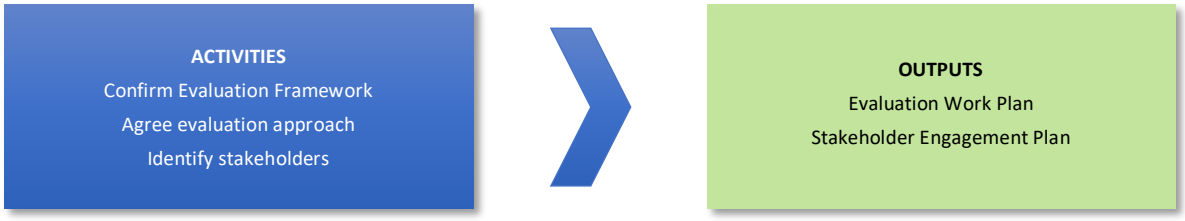


Differences in response between Fellows, SIMGs, Trainees, males and females have been noted where they occurred.

Project governance

The project was delivered according to an agreed work plan with timelines, budgets and an approved stakeholder list. Regular progress reports were provided to the Executive Project Lead against the agreed work plan. All project deliverables were approved by the PRG before being finalised.

2.2 Focussing the evaluation



Confirmation of the Evaluation Framework and evaluation approach

The evaluation began with an in-depth discussion with the PRG about the current context, planned evaluation approach and stakeholders to be consulted. The purpose of this discussion was to identify the potential challenges, risks and practical issues that could arise during the evaluation, in particular during the data collection phase. The relevance of the Evaluation Framework and the KEQs were confirmed with minor changes, and an evaluation approach taking into consideration the current context was agreed.

The following deliverables were produced:

- Evaluation Work Plan.
- Stakeholder Engagement Plan (Attachment 4).

2.3 Collection of evidence

Ensuring validity of data

One of the central issues in evaluation is ensuring that findings and recommendations are based on valid data. Quantitative data are quoted in numerical terms and tested for statistical significance. Qualitative data are tested for their substantive significance through presentation of findings, patterns and themes. In mixed methods evaluations, both types of data are used to establish and confirm the validity of the findings.

The validity of findings can be demonstrated by ensuring:

- Confidence that data highlight what is really happening in the program.
- An agreed approach for dealing with outliers.
- Minimisation of bias.
- Confidence in the inferences drawn from the data.

A number of data collection and analysis strategies were used to address these issues:

- Multiple data sources were used, from a range of geographical and demographic perspectives, to ensure a range of views from which to draw conclusions. Gathering information from a range of sources serves to triangulate the findings, with each source confirming and extending understanding of the findings from the other sources, to increase confidence in the validity of the findings and reduce the impacts of bias. This evaluation included examination of a range of data sources (policy documents, progress reports, external reviews, statistics and business plans); 56 interviews (via zoom) with Fellows, Trainees, SIMGs, RACS staff and Executives, Councillors, and external stakeholders; and an online survey sent to a statistical sample of Fellows, Trainees and SIMGs.
- Quantitative data were collected, via the online survey. These data provided an answer to the question: What is happening? in relation to the KEQ.
- Quantitative information was supplemented with deep contextual information from qualitative data sources such as in-depth interviews. Additional qualitative data was included from the comments and major themes taken

from the open-ended response section of the survey. The qualitative data was not intended to provide statistical information and is therefore not presented in a quantifiable manner. It was collected to explore issues "in-depth" and provide an increased understanding of Action Plan successes, strengths and weaknesses at a deeper level and within the realities of program delivery. The data enabled identification of the contextual situation which provided some explanation of the question: *Why is this happening?*

- Data were analysed and cross referenced to support triangulation of the data i.e. ensure a number of data sources as well as a number of data collection methods to support and corroborate each finding and to identify outliers, views or inputs that significantly differ from the main findings. In this report, each finding has been reported from multiple data sources and methods, where available, to demonstrate validity and corroboration and increase confidence in the finding.

- Findings were further validated, whilst maintaining the independence of the external evaluator, firstly by discussion with the Executive Program Lead, and secondly by presenting them to the PRG (knowledgeable stakeholders) who provided practical knowledge to discuss, challenge or confirm the plausibility, relevance and utility of the findings, interpretations and proposed recommendations. This consensual validation of the findings, by three sources (consultant, Action Plan experts, and the Program Managers) is the standard for validating and reporting of qualitative data.

Data collection included quantitative and qualitative methods

A survey was used as the major quantitative data collection instrument and distributed to a statistical sample of RACS members. This included all females, all Trainees and SIMGs and a randomly selected sample of male Fellows. A total of 4780 people received the survey, and 1252 (26%) responded. The aim of this selection was to minimise survey fatigue where possible, whilst ensuring a sample large enough from which we could draw conclusions about the whole population with 95% confidence. The survey was developed using a mixed methods approach to ensure it addressed issues and used language relevant to the target audiences. This was achieved by conducting 12 exploratory open-ended interviews with purposively selected stakeholders representing a range of Fellows, Trainees and SIMGs from different geographical locations and of different gender. Whilst the KEQs formed the basis for the survey, the themes and issues identified in the exploratory interviews provided the detail within each question (Attachment 5: Evaluation Survey Questions).

Semi-structured in-depth zoom or telephone interviews were conducted with a further 44 people. Consistency between interviews was supported by the use of an interview guide, developed from the KEQs, the initial, exploratory interviews and in consultation with the Executive Project Lead and PRG. Different aspects of the interview guides were used, depending on the interviewees, for example, the governance questions

were not asked of people who did not have a role in the Action Plan governance. (Attachment 6: Semi structured Interview Questions).

Interviews provided important contextual information on unintended consequences, very early outcomes and the lived experience of Fellows, Trainees, SIMGs, RACS staff and executives in addition to the views of external stakeholders. This information supplemented the more quantitative data from the survey and provided stories and examples from which meaning and context could be better extracted.

Documents and reports included policy documents, progress reports, external reviews, statistics and business plans. Information from these documents was extracted and organised against the KEQs, to support other findings and provide more detailed understanding.

2.4 Analysing, interpreting and validating findings

Structured data analysis and interpretation

The KEQs, as taken from the Evaluation Framework, were the research questions for this evaluation, forming the backbone of the evaluation. The sub questions provided detail to help more specifically answer the KEQs by breaking down the information required. Findings were arranged against the KEQs to collect the evidence which formed the answer to each research question.

Raw quantitative and qualitative data were organised against the KEQs to reveal patterns and trends. Numerical responses and ratings from survey data were presented as graphs. Interviews, comments and open-ended questions from the survey were analysed to identify emerging issues, perceptions and strengths. Action Plan data was analysed for trends and evidence of effective implementation.

The relationships between the data were tested, and examined for corroboration of findings between data sources, until the most important findings emerged for each KEQ.

Quotes from respondents were identified to represent the emerging findings, with some quotes included to identify conflicting views, where present, to ensure a balanced reporting of those views against the rest of the findings. Where available the position of the respondent has been included.

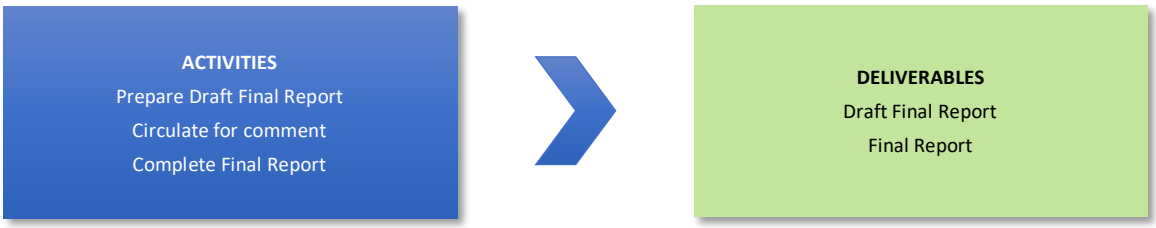
Themes and data trends were considered within the consultant's understanding of cultural and contextual factors, developed through the interviews and discussions with the Executive Project Lead and the PRG. This supported interpretation of the meaning and significance of the findings, highlighting strengths and opportunities for improvement.

Recommendations have been developed to inform the next Building Respect Action Plan.

Validation of findings

Findings and interpretations were presented firstly to the PRG and then to the Building Respect Implementation Group and RACS Council for discussion, contextual input and analysis, including testing of assumptions, conclusions and draft recommendations for practicality and feasibility.

2.5 Final Report



Preparation of Report

Feedback from the validation workshop was incorporated into a Draft Report and circulated for comment before completion.

3. Evaluation Findings

The evaluation findings are presented under each of the KEQ used to define the scope of this evaluation (Attachment 3: Evaluation Framework). The sub-questions that appear in the evaluation framework under each KEQ were used to structure data gathering to ensure appropriate information was collected.

What could be expected from the Action Plan at this stage of implementation?

It is important to remember, when reading the findings, that this is the first outcomes evaluation for the Building Respect Action Plan. The changes that could be expected, according to the Program Logic (Attachment 2) include changes in awareness, knowledge, skills, and attitudes. Although some data collection has focussed on behaviour change, this has been done to inform further planning and to create a baseline for future evaluations.

KEQ 1. Has the Action Plan been implemented as intended to date?

Overall assessment of findings for this KEQ

RACS' membership actively supports the College in its Building Respect Action Plan, with support increasing even from the very strong numbers seen in 2019. However, some are concerned about the impact on standards in surgery of diversity initiatives such as targets. External stakeholders are very supportive of the Action Plan, see RACS as a leader in this space and are keen to form multidisciplinary partnerships.

Implementation of the Action Plan faced a significant challenge with the COVID-19 pandemic, however, whilst having to postpone implementation of some activities, the College was able to develop new initiatives and implement planned activities face-to-face where possible and online where necessary. This response to the pandemic continues at the time of writing this report. There is a perception amongst, staff, Councillors, and the membership of a loss of momentum of the Action Plan, which could be COVID-related or indicate that it is timely to review and refresh the plan including messaging.

Despite the strong support for the Action Plan overall, only two thirds of members believe that the leaders in their workplaces and at RACS demonstrate respectful behaviours. This includes senior surgeons within the structure at RACS, including committee members, and has led to some undermining of RACS' credibility amongst members, in its promotion of cultural change.

Successes

- Clear setting of Council's expectations regarding respectful behaviours.
- Strong communications and training led to very high support for the Action Plan within the RACS membership.
- Increased support for the content of OWR messaging.
- RACS is seen as a leader in this space by external stakeholders.
- Keen interest from external stakeholders to work in partnership with RACS.
- Implementation pivoted in response to COVID-19.

Barriers

- Not all surgical leaders, including committee members, model respectful behaviours.
- Perceived loss of momentum for the current Action Plan.
- Some messaging fatigue despite support for the Action Plan.
- The surgical population does not represent the diversity of the community.
- Concerns about standards relate to misunderstanding of how access and equity are applied in practice.

Detailed findings

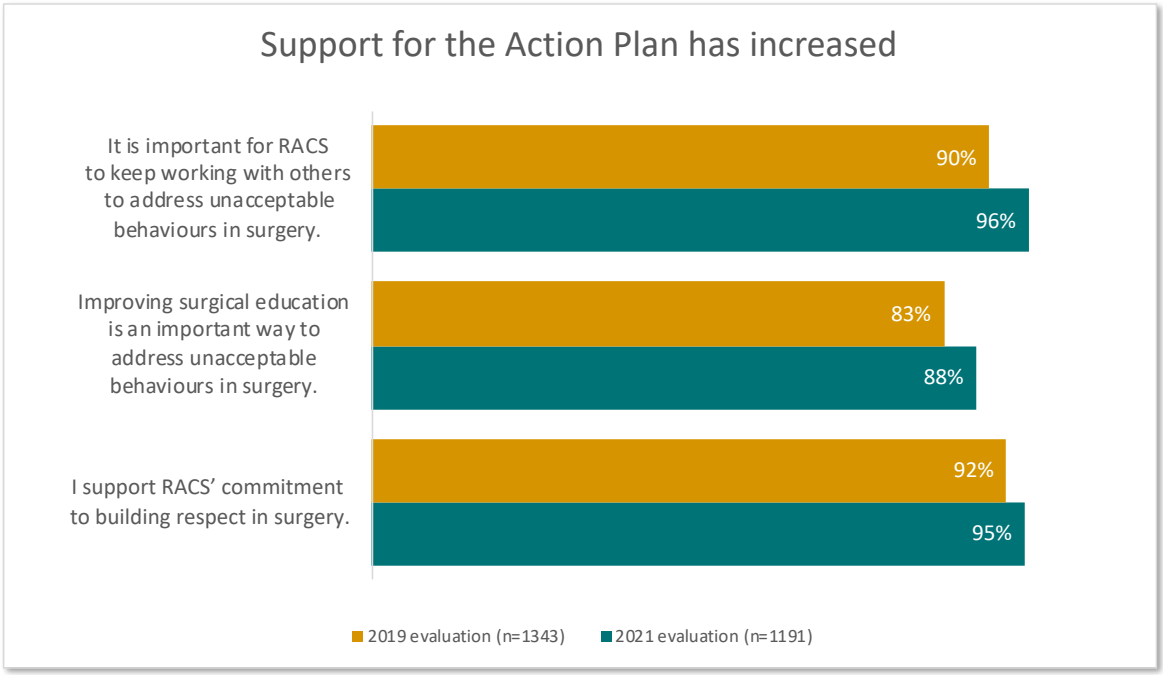
RACS has strong credibility amongst internal and external stakeholders

Interviews with external stakeholders highlighted that RACS has established a significant profile amongst other medical and nursing colleges, within the Australian and Aotearoa New Zealand health sectors and internationally. The Action Plan is seen as something visible RACS has done to set concrete expectations in policy. External stakeholders believe that there has been much progress achieved, especially as at the beginning, there was little understanding of the nature and scope of the problem. They reported that there is now widespread awareness of the issues around respectful behaviour, and whilst acknowledging the global context and other influences on workplace culture such as the #metoo movement, surgeons are seen as the profession which is standing up for respect and against discrimination, bullying and sexual harassment.

Within RACS membership, support for the major activities of the Action Plan has increased since the previous evaluation in 2019 (Figure 3.1). Most comments from interviewees or survey respondents were in support of the Action Plan:

> *"RACS has set the standard for the other Colleges." Anaesthetist*
>
> *"I do feel like the College of Surgeons is a leader. I feel like they've done more than most other colleges to really have a good hard look at themselves and I think that they've got a role to play in leadership for the other colleges as well." External stakeholder*
>
> *"I think is an important statement about what the College of Surgeons stands for and what we value and where we think the way forward is. And in absolutely mandating that people are treated respectfully and equally." Councillor*
>
> *"Credit to RACS for taking the lead and no longer tolerating poor behaviour and for setting professional standards." Fellow*
>
> *"It started a discussion. And if nothing else, that discussion needed to happen. It's a kind of building block for further work in future." Trainee*
>
> *"The College has gone strategically from disaster to leader in the space." Staff*

Figure 3.1



However, some felt that RACS has not been sincere in its approach. This may be due to perceptions of RACS leaders not displaying professional behaviours, or it may be related to the variation in workplace cultures, with some experiencing more changes than others.

> *"I think they're going through the motions, but not necessarily really truly believing what they're trying to pretend to be doing." Fellow*
>
> *"I've seen RACS talk about it but that's about it." Survey respondent*
>
> *"Lip service. Very little actual change. Hugely disappointed in RACS." Survey respondent*

Not all surgical leaders are modelling respectful behaviours

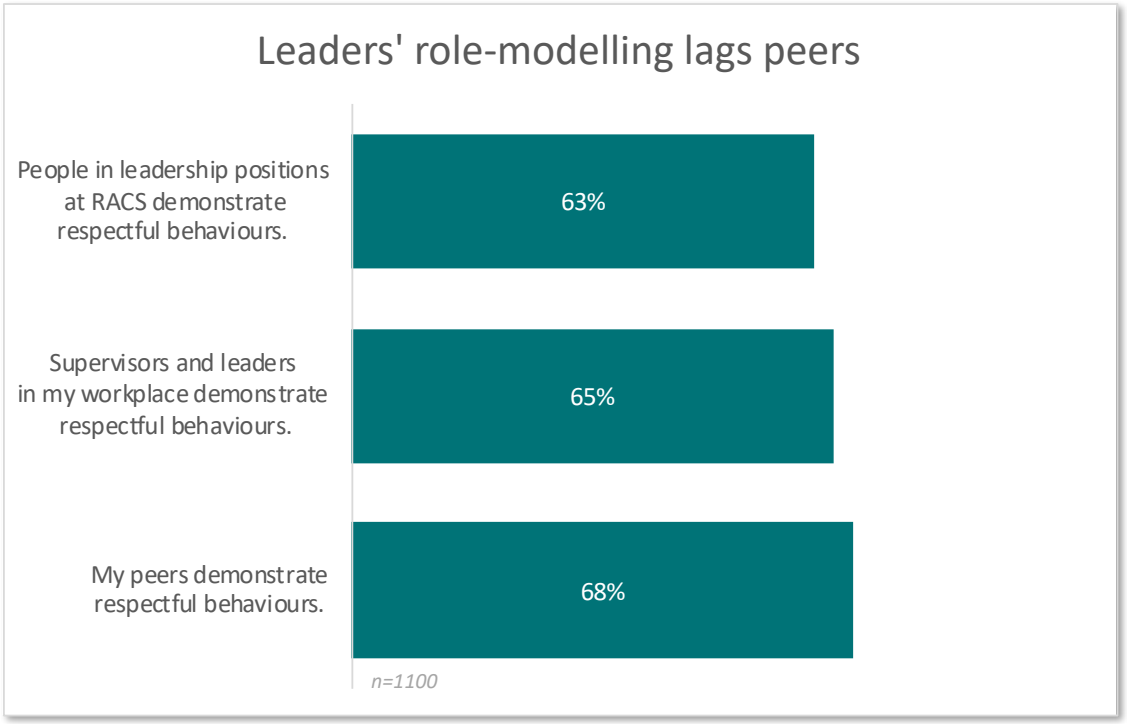
Leadership is a fundamental lever for behaviour change, and promotion of Key Opinion Leaders is an integral part of the Action Plan. The strong and visible leadership of Council and the senior Executive Team at RACS has been a critical success factor of the Action Plan. However, whilst 94% to 96% of members support the Action Plan overall, there is a perception that some leaders in surgery are not role-modelling respectful behaviours.

Although high, support for RACS' leadership on respectful behaviours is significantly lower than support for the Action Plan, at 84%. A contributing factor to this is the perception amongst the membership that Fellows within the structure at RACS, including some committee members and surgeons who have been promoting the Operating With Respect messages, are not modelling respectful behaviours themselves. Only two-thirds (63%) of members agreed that leaders within RACS

demonstrate respectful behaviours (Figure 3.2 below). Interviewees and survey respondents gave powerful feedback stating that people known for their unprofessional behaviours occupy senior positions at the College. Similar feedback has been received from RACS staff. This issue has been problematic within RACS offices and is a risk to the credibility of RACS in promoting cultural change.

However, a similar number (65%) of members felt that Supervisors and leaders in the workplace or their peers (68%) demonstrate respectful behaviours (Figure 3.2). This implies that senior surgeons, both within RACS and in the clinical setting, are not leading cultural change by modelling professional behaviours, but are actually behaving in the same way as everyone else. This perception contributes to feelings of fear in reporting incidents and presents a risk to the effective implementation of cultural change.

Figure 3.2



"Senior staff set the tone." Fellow

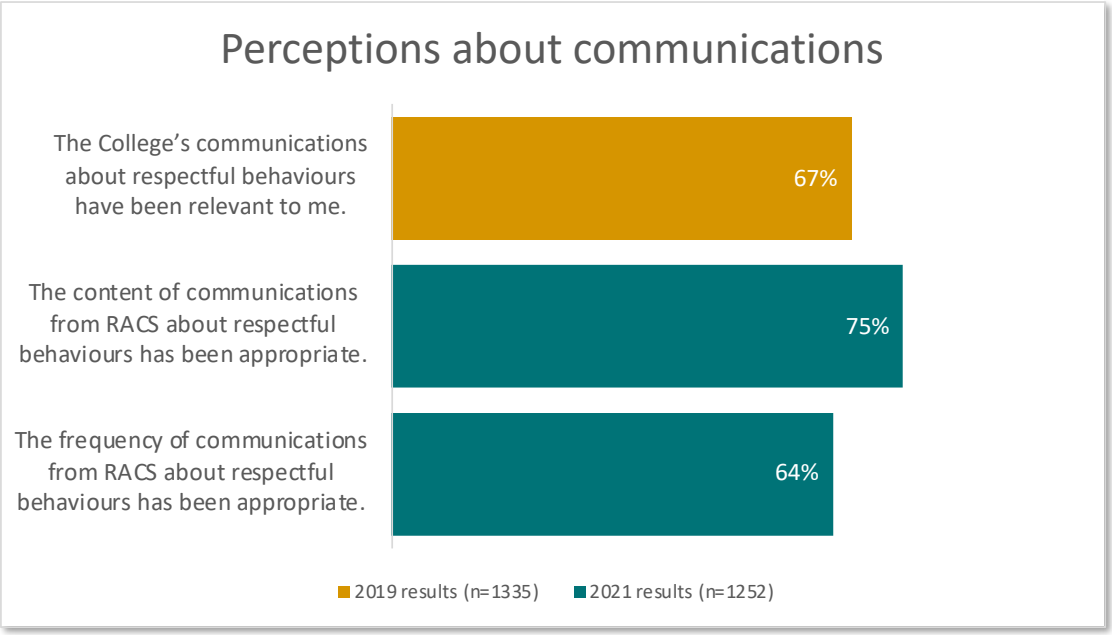
"Numerous examples throughout my training where people in positions of power came out with very overtly sexist statements, veiled as a joke, and those people are still in positions of power… are still the people who are now pretending that this is important. I know that's not their underlying attitude." Female Fellow

"Having a known bully for decades to then lead a task force on bullying is exactly why the College needs to change… are you kidding us?" Survey respondent

Increased support for the OWR messaging, but some are overwhelmed

Messaging about respectful behaviours has been very effective and has reached the target audiences as intended (see KEQ 3). Three quarters (75%) of Fellows, Trainees and SIMGs believe the content of communications from RACS about respectful behaviours has been appropriate, an increase from a comparable question in 2019 where 67% believed the communications were relevant to them (Figure 3.3). In 2021, 64% believed the frequency of communications has been appropriate.

Figure 3.3



Most interviewees were supportive of maintaining OWR communications.

> *"Keep the messaging up, the issue will fade or lose currency if left." Survey respondent*
>
> *"Continue to raise the issue and provide the deidentified feedback of dealing with the offenders." Survey respondent*
>
> *"Encourage more fellow awareness through publication/emails about what constitutes unacceptable behaviour and what to do if it is encountered." Survey respondent*
>
> *"Continuous training and raising awareness. Improving soft skills assessment in trainers and trainees' assessments and selections." Fellow*
>
> *"Make it an important part of RACS conferences." Fellow*

However, there is a significant minority that feel overwhelmed by the messaging. Some interviewees believed that most surgeons have reflected on their behaviours and adjusted, but now feel like they are being '*punished for the actions of a few*'.

"'Respect in Surgery' has become so pervasive in everything you publish and circulate that I think it is now counterproductive… Swamping surgeons week after week with the same stuff means I no longer read it…Difficult to get the balance right." Survey respondent

I think the initial push was very measured and reasonable and involved introducing a lot of education, encouraging discipline for bullies etc. However, more recent changes are unclear to me as I generally skim information sent to me. Survey respondent

Diversity and inclusion focus has been on women and indigenous peoples

As part of its action to improve the culture of surgery, RACS made a commitment to increasing the diversity of the surgical profession. The practical realisation of this was the Diversity and Inclusion Plan, launched in 2016. The major focus of this plan has been to increase the representation of females and indigenous peoples in the surgical profession.

Additional work has resulted in development of the Reconciliation Action Plan in Australia and the Maori Health Action Plan in Aotearoa New Zealand, both of which include initiatives to improve indigenous health in addition to increasing indigenous representation. More recently, the College launched the Indigenous Surgical Pathways Program, aimed at increasing the representation of Aboriginal and Torres Strait Islanders in the surgical profession.

As part of the Diversity and Inclusion Plan, aspirational targets were set for representation of women in surgical training and on RACS committees. RACS commissioned research on the barriers for women to enter and complete surgical training, to inform the next Action Plan. In August 2021, the phasing out of gendered titles for surgeons commenced, with surgeons now referred to as 'Doctor'. During 2021, a new cultural competency was developed as the tenth surgical competency.

Indigenous inclusion is progressing from cultural acknowledgement to selection of trainees

The College has developed cultural competence training for both Aboriginal and Torres Strait Islander and Māori inclusion and understanding. This has been complemented by advocacy activities, relationship building with indigenous organisations, promotion of research in relation to health disparities and increasing the cultural presence of both indigenous groups across the College.

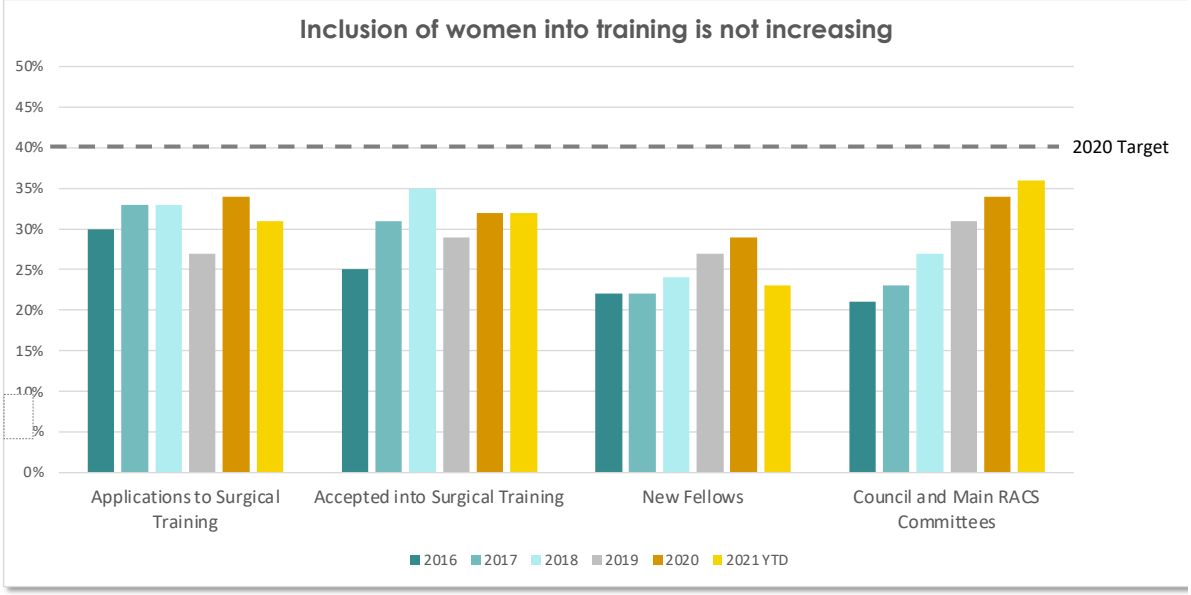
The first surgical Trainee selected under the Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative began training in 2019. By the end of 2019, eight of the nine Surgical Training Boards had adopted this initiative. RACS scholarships to support Aboriginal and Torres Strait Islander medical students and doctors have increased from $15,000 in 2016 to $77,500 in 2020, with a similar increase for scholarships to support Māori doctors. All the selection committees for Aotearoa New Zealand based training have altered their systems to acknowledge applicants'

knowledge / skills in te ao Māori. From selection processes in 2018, 7 Māori doctors were selected for surgical training.

Selection of female Trainees lags representation of women on committees

The aspirational targets set for inclusion of women in surgery were to increase the proportion of women in SET from 29% in 2016 to 40% by 2021, and on committees and other leadership roles to 20% by 2018 and 40% by 2021. Although representation on committees has significantly increased, to 36%, and there is currently a female President, these targets have not been met (Figure 3.4). Female representation in SET has only increased from 29% to 32%, with applications to surgical training not increasing over time, but fluctuating between 27 and 34% over the six years.

Figure 3.4



The number of invited female speakers to major conferences has increased nationally in Australia and Aotearoa New Zealand, however, in contrast, the states actually showed a decrease (shown in red) between 2018 and 2019 (Table 3.1). More recent numbers are not available as conferences were cancelled in 2020 and, apart from the Annual Scientific Congress (ASC), have not yet been held in 2021.

Table 3.1 % Invited female speakers

Meeting	2018	2019	2021*
RACS ASC	22%	32.6%	36.3%
ACT ASM	39%	28%	
NZ Surgery (ASM)	30%	38%	
QLD ASM	N/A	37.5%	
SA/WA/NT ASM	26%	21%	
Tasmanian ASM	39%	33%	
Victorian ASM	29%	27%	

*No meetings in 2020 due to COVID-19

Uptake of flexible training is low but increasing

A major activity of the Diversity and Inclusion Plan was the focus on introduction of flexible training, with an aim to remove barriers for people with carer responsibilities. Strong messaging from RACS about its support for flexible training was accompanied by reporting to Specialty Societies on different models for flexible training so that locally appropriate models could be trialled. Flexible training uptake is closely monitored by RACS, and while still low, has increased since its introduction in 2016, most notably for males (Table 3.2).

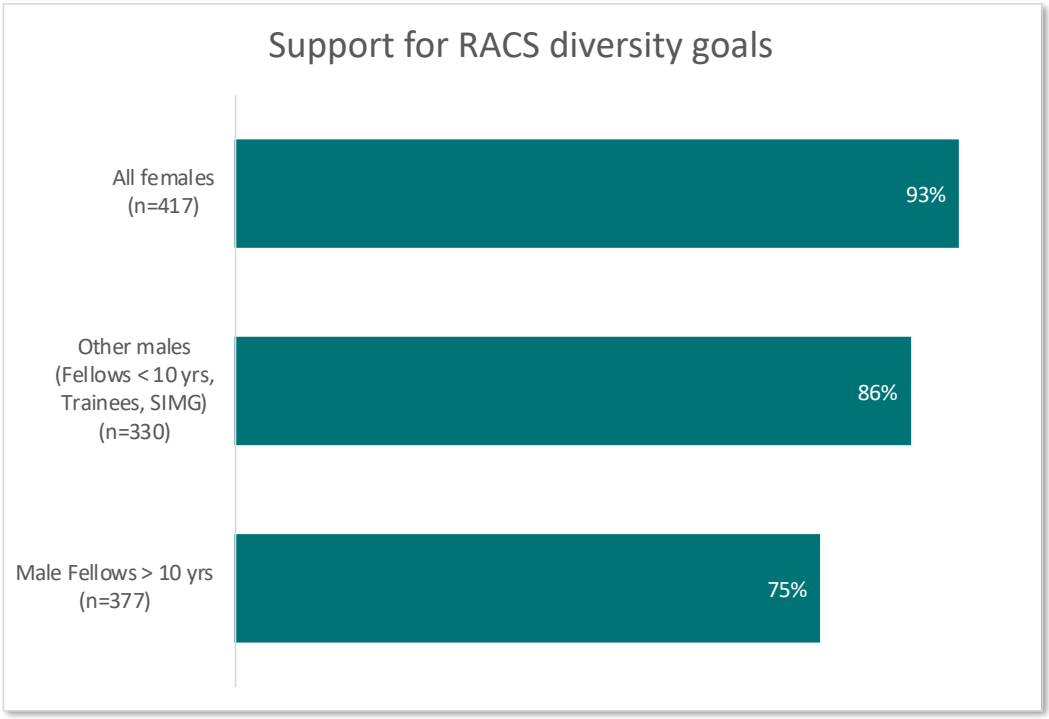
Table 3.2 Uptake of flexible training

	2016	2017	2018	2019	2020
Females	5	6	10	10	NA
Males	1	1	0	9	NA
Total	**6**	**7**	**10**	**19**	**27**

RACS diversity goals are generally well supported

The RACS diversity goals were well supported by the majority of members (85%) however, as shown in Figure 3.5, there is a significant difference in support between females and males, with older male Fellows being the least supportive. These numbers are similar to 2019, when 92% of females and 75% of males supported the diversity goals.

Figure 3.5

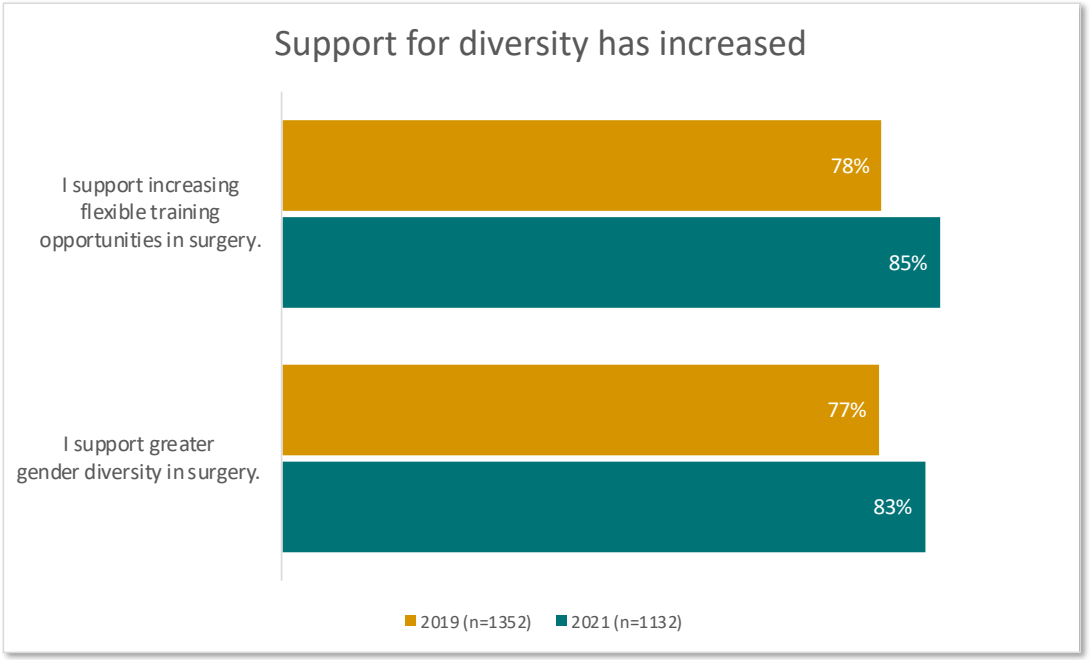


Support for flexible training has increased from 78% in 2019 (n = 1352) to 85% in 2021 (n = 1132) (Figure 3.6). As with other diversity initiatives, females were more supportive of flexible training (93%) than males (82%).

> *"Do not let the issue of diversity slide. The momentum must be maintained until the college is representative of society." Female Fellow*

Support for gender diversity has also increased over the same period, from 77% in 2019 to 83% in 2021. In 2021 84% of the membership supported increased indigenous representation in surgery (88% females, 79% males, n = 1132).

Figure 3.6



Some members are concerned about the impact of increasing diversity

Concerns about lowering of standards

Some interviewees and survey respondents, whilst supportive of diversity initiatives in general, raised concerns that opening enrolments to a broader group could lower standards of surgery. Setting target numbers for female representation was perceived as creating a situation where standards are reduced, and women are given an advantage. There was a lack of understanding of the barriers to entry for some groups in addition to a poor understanding of how the RACS selection process is applied to incorporate diversity. Phrases used to support these views included expectations of 'merit-based selection' and 'competence'.

> *"RACS must not lower standards to allow gender diversity, which is what I hear from surgeons around me." Male Fellow*

> *"Build a culture of competence - make it independent of sex/diversity etc." Male Fellow*

> *"I've been told by the management team, we're looking for female surgeons …whether they're good enough or not is irrelevant if they're female they have an advantage, which to me is reverse sexism." Male SIMG*

Concerns about not being taken seriously

Some female Fellows expressed concerns that they may not be taken seriously due to gender targets being misunderstood. They reported that they experience discrimination in their daily lives, often to a level of exhaustion and that gender targets, when misunderstood, contributed to the problem.

> *"I don't like labels, and I don't like identity politics, I don't like 'women in surgery' because that implies there's something different. Maybe not as good." Female Fellow*

> *"I think advertising that a more gender and indigenous cohort is coming can seem like people will be accepted without them actually deserving. Being from a minority I don't want it said I got to where I am because I'm from a minority. I want it to be said I earned this place fairly up against all other applicants. To encourage diversity, it should be advertised as support for the minority groups to ensure they have a fair shot at entering training and supporting them through it like everyone else. Singling them out makes it seem like the whole process is unfair and "bullying" other groups." Female Trainee*

> *"The older middle aged to old male dinosaurs, who still don't see women as surgeons, I'm just tired of being judged in every capacity of my work and just constantly being made to feel like I'm not quite the way they are. And it's wearying." Female Fellow*

Concerns about overloading women

Another concern raised about setting targets was the impact on the smaller specialties. In smaller specialties, such as in neurosurgery, where women comprise 5-10% of the total Trainees, meeting the goal of 40% female representation on every committee or at conference presentations, would create a situation where women are overloaded with responsibilities. This was reported to be already happening in some specialties.

Call to increase the breadth of focus for diversity activities

Interviews with staff and Councillors highlighted the view that the Diversity and Inclusion Plan does not go far enough in identifying target groups for inclusion. They believe that the review of the Action Plan provides an opportunity to broaden the focus of diversity so that surgery will more accurately represent the community.

> *"Our diversity focus has been quite narrow, just women and indigenous communities. We don't look at other ethnic communities, people with disabilities, LGBTI… and I think this comes under building respect." Staff*

Perception of loss of momentum for the Action Plan

There is a widespread perception within Fellows, Trainees and SIMGs and including RACS staff and some Councillors, of a loss of momentum regarding Action Plan messages and activities. This could be linked to the challenges of delivering Action Plan activities during the pandemic or to feedback that the messages are perceived as repetitive. This feeling of repetition may have been exacerbated by similar messages coming from numerous sources across the health sector, as more organisations have become aware of the significance of unprofessional behaviour and followed the lead of the College.

Some staff felt that the original Action Plan was too ambitious and too broad, which made it challenging to deliver outcomes across all areas, given the level of resources available. Another reason given was the governance structure within the College, which requires extensive approvals and consultation, and has been described by staff and Councillors as '*slow*,' '*cumbersome*' and '*not agile*.' This was reported to slow the progression of actions and contribute to loss of momentum or focus.

> *"Other things take precedence, will take priority and people drop everything." Councillor*

Anticipation is building for the next Action Plan

There is recognition that the Action Plan has achieved much with its significant focus on communicating messages highlighting awareness of inappropriate behaviours and what professional behaviours look like. However, RACS staff, Councillors and members believe it is now time to re-energise the Action Plan to achieve the energy and momentum seen at the beginning of the Plan. Most of the feedback related to a need to focus on taking action, how to translate that strong awareness into behaviour change. External stakeholders, although not feeling any loss of momentum, see the refreshing of the Action Plan as an opportunity to restate the College's commitment to cultural change and to work with partners to achieve the goals.

> *"I think we really need to move away from that (messaging on awareness), the next step being taking action… what do I do about it, where do I go, how do I take action?" Staff*

> *"I think it (the Action Plan) needs a push and momentum now." Councillor*

> *"This is an extraordinary time for the College to restate its values and expected behaviours." External Stakeholder*

KEQ 2. Is program governance and oversight effectively supporting delivery of the Action Plan?

Overall assessment of findings for this KEQ

While the Action Plan is closely monitored at regular meetings, the focus has been on activities and outputs rather than outcomes, making it challenging for Council and senior management to assess the overall performance of the implementation. This applies to most of the Diversity and Inclusion Plan, apart from the target and timeline for inclusion of women. A significant effort is put into activity reporting, which could be better utilised in a series of outcome reports based on agreed timelines and performance indicators. Despite these issues, implementation of the Action Plan was successfully pivoted in response to the challenge of the COVID-19 pandemic.

Successes

- Action Plan outputs and activities are closely monitored making it possible for changes in direction in response to barriers and challenges.
- Implementation pivoted in response to COVID-19 challenges.
- The Action Plan has a clear coordinator and advocate.

Barriers

- Outcome monitoring of both the Building Respect and Diversity and Inclusion Plans, relies on regular external evaluations, making it challenging to measure and adapt to the ongoing performance of the plans and contributing to a governance issue for Council.
- The effort put into detailed activity reporting does not translate into improved accountability and transparency.
- The Diversity and Inclusion Plan lacks a coordinator or champion meaning it can be overlooked amongst other priorities.

Detailed findings

Action Plan outputs and activities continue to be closely monitored

As detailed in the previous evaluation, the Action Plan is coordinated by a dedicated Executive Lead position which reports directly to the CEO. Monitoring and adaptation of the Action Plan occurs via the Building Respect Implementation Group, which is chaired by the CEO and includes the Executive Team, Executive Directors of Surgical Affairs, Building Respect Executive Lead, the officer supporting the Operating With Respect committee and the relevant line managers and officers responsible for implementing the various aspects of the Action Plan. This meeting is an information exchange and program coordination forum which receives a detailed activity and outputs report against every aspect of the Action Plan.

Program outcomes are being evaluated but could now be monitored

The Building Respect Action Plan is a long-term behaviour change program with outcomes that can take years to become evident and measurable. The program has a Program Logic model (Attachment 2) which highlights both the longer term outcomes such as increased feeling of safety in the workplace, broader

representation of community diversity across the surgical profession and decreased attrition of Trainees because of unacceptable behaviours; and short and intermediate term outcomes such as increased confidence in speaking up about unacceptable behaviours, increase in flexible training options and improved access to supports for people experiencing unacceptable behaviours. Outcomes have been measured by regular evaluation of the Action Plan, with an Evaluation Framework established to ensure evaluations at the 3, 5 and 10 year post implementation time points. Some upstream outcomes, such as representation of women on committees, selection of women into training and the number of flexible training opportunities are being closely monitored. There is an opportunity for RACS to expand on this type of outcomes reporting by focussing on outcomes which can be readily monitored without the need to wait for external evaluations. This could include conducting annual cultural snapshot surveys designed to collect information about the intermediate outcomes such as confidence, knowledge and skills, and behaviour change.

Implementation has pivoted in response to COVID-19

As noted in the previous evaluation, most of the Action Plan activities have been implemented, however a significant change in approach was needed in response to constraints imposed by the COVID pandemic. This included pausing delivery of face-to-face training sessions, with gradual resumptions where possible in between lockdowns; pausing of MOU activity; delay of multisource feedback until completion of the new tenth surgical competency so that cultural competency could be built into the assessment tool; extension of timelines for approval of the new accreditation guidelines due to COVID related workload increases at the Specialty Training Boards; postponement of planned OWR communications for several months until a new COVID safe approach was developed for production.

Despite these interruptions, a number of significant achievements were made including completion of a tenth surgical competency on cultural competency, with COVID delays providing the opportunity to ensure all training materials and information aimed at addressing this competency were completed before launch; inclusion in the updated accreditation arrangements of the information sharing protocol between employers and RACS on complaints related to surgical practice; development and implementation of a new Reconsideration, Review and Appeal model; introduction of new Standards for Surgical Supervisors; new complaints information resources to accompany the implementation of the updated complaints process; development of a pilot online version of the FSSE course; revisiting key OWR messages, developed in response to feedback from Fellows, Trainees and SIMGs; improving Trainee representation across college committees; new materials on flexible training; and significant advocacy at the intercollege and government levels to advance the wellbeing agenda.

Importantly, the communications focus was shifted to acknowledge the difficulties posed by working in times of uncertainty and stress, and the need to safeguard

mental health and wellbeing, whilst linking to messages associated with OWR. The planned conference on *Creating Healthcare Cultures of Safety and Respect* was delivered online instead of face-to-face which resulted in attendance numbers significantly above expectations.

Action Plan reporting is detailed but lacks overview and targets

A significant amount of effort is put into reporting on Action Plan progress. Action Plan reports sighted by this evaluation, including the Annual Report and the Building Respect Implementation Group report, were long and detailed, focussing on output and activity progress against every activity of the comprehensive Action Plan. However, the lack of visible targets and timelines, summary of issues, risks, or successes, makes it difficult to assess the overall progress of the Action Plan.

Council reports provide detail on activities such as training or conference attendance figures and are often supplemented by a paper on a specific issue for discussion or decision. Outcomes reporting has focussed on the 3, 5 and 10 year evaluations, a reasonable approach to date as the outcome of behaviour change is long term. However, the Council and Implementation Group only receive reports on some upstream indicators of outcomes such as female representation on committees, flexible training and females in surgical training. Council reports could be improved with indications of progress towards the longer-term outcomes, such as annual reports on attitude, response to communications, skills developed from training programs or leadership confidence. Outcomes reporting could be improved in this way to strengthen accountability and governance of the Action Plan.

Members are generally supportive of the progress reporting about the Action Plan, with 60% saying the information is relevant and 65% saying the amount of information they receive is appropriate. External stakeholders are aware that the College has an action plan, without being aware of the details within that plan, apart from the mandatory training aspects.

Some Councillors find it hard to keep track of overall Action Plan progress

The Council and the Board of Council receive a written report at every meeting as part of the regular CEO report. This includes complaints data, mandatory training data, other issues by way of progress update, plus papers for decision, discussion or noting, as required. Some Councillors felt that they are being adequately informed of key achievements of the Action Plan, however, others find it hard to keep track of all the areas and to know if activities are on track to deliver the anticipated outcomes. The lack of timelines and targets was cited as an example of the challenge for Council to know if the implementation was on track. Feedback suggests that the reports are dense and detailed, making it hard to extract the most significant information or understand the risks to the College. This feedback extended to all the Council papers, not just the Action Plan updates.

"Having a visual summary (of progress against targets and timelines), that's a lot more informative because that will give us the opportunity to ask the critical questions." Councillor

"When we set targets, we have a much better idea of how we're tracking." Councillor

Diversity and Inclusion Plan progress is hard to assess

Staff reported that the implementation of the Diversity and Inclusion Plan was challenging due to a major organisational restructure and staff turnover within the College. The lack of an owner for the Diversity and Inclusion Plan was also cited as a barrier for success, in comparison with the Building Respect Action Plan, which has a clear coordinator and advocate. Staff perceived that the priority of diversity and inclusion was lost amongst all the activities of the College, despite overall agreement that this is a very important initiative.

Unlike the Action Plan, which has a dedicated Executive Lead to coordinate delivery, the College has adopted an integrated delivery model for Diversity and Inclusion with the aim of maintaining a college-wide focus for this work. Accountability is shared across the College with each member of the Executive team responsible for a section of the delivery. Reporting to Council is through the Building Respect Executive via the CEO, in a similar manner to the Building Respect Action Plan. The annual Diversity and Inclusion report is detailed, but most of the planned actions do not have timelines or targets, so, as with the Building Respect Action Plan, it is difficult to assess overall progress. The only area with clear targets and timelines has been the inclusion of women into surgical training, onto RACS committees, and as invited speakers to conferences, making it possible to report and measure the progress that has been achieved.

KEQ 3. To what extent has awareness of the standards for respectful behaviour increased across the surgical profession?

Overall assessment of findings for this KEQ

The change model that underpins the program logic involves a series of changes that are expected to occur over several years. The first changes are in awareness about and attitudes towards respectful behaviours, followed by increasing knowledge about how to respond to unacceptable behaviours and how to act respectfully, and then finally resulting in changes to behaviour.

Overall, the RACS Building Respect program is on track with respect to the changes expected. Awareness of the standards for respectful behaviour and awareness of what constitutes respectful behaviours has increased across the membership, knowledge and attitudes are trailing awareness but are still high, and expected behaviours are beginning to emerge.

Successes

- Awareness of standards of respectful behaviour and what constitutes unacceptable behaviours is very high, with 99% of members accepting the need to demonstrate respectful behaviours.
- Most members say they can recognise unacceptable behaviour in others and themselves.
- There is strong support for continuing to raise awareness.
- Knowledge levels about addressing unacceptable behaviours is high – most people say they know what to do if they see or experience unacceptable behaviours.
- Attitudes towards respectful behaviours are very positive. Attitudes towards diversity while positive are not as supportive as attitudes towards respectful behaviours.
- Behaviours aligned to building diversity and increasing respectful behaviours are emerging.
- There is considerable optimism for the impact of generational change, with many reporting that younger people are less tolerant of unacceptable behaviours.
- People are more likely to take action - about DBH but not sexual harassment.

Barriers

- Fellows with more than 10 years' experience, potential influencers of culture, are least aware of respectful behaviours or the impact their own biases have on their behaviours.
- As expected, there is a gap between the knowledge to recognise and address unacceptable behaviours and actual demonstration of that behaviour.
- Reported incidence of DBH has decreased, but reported incidence of sexual harassment has increased, with the greatest increase in reports by males.
- The nature of unacceptable behaviours has shifted towards microaggressions.

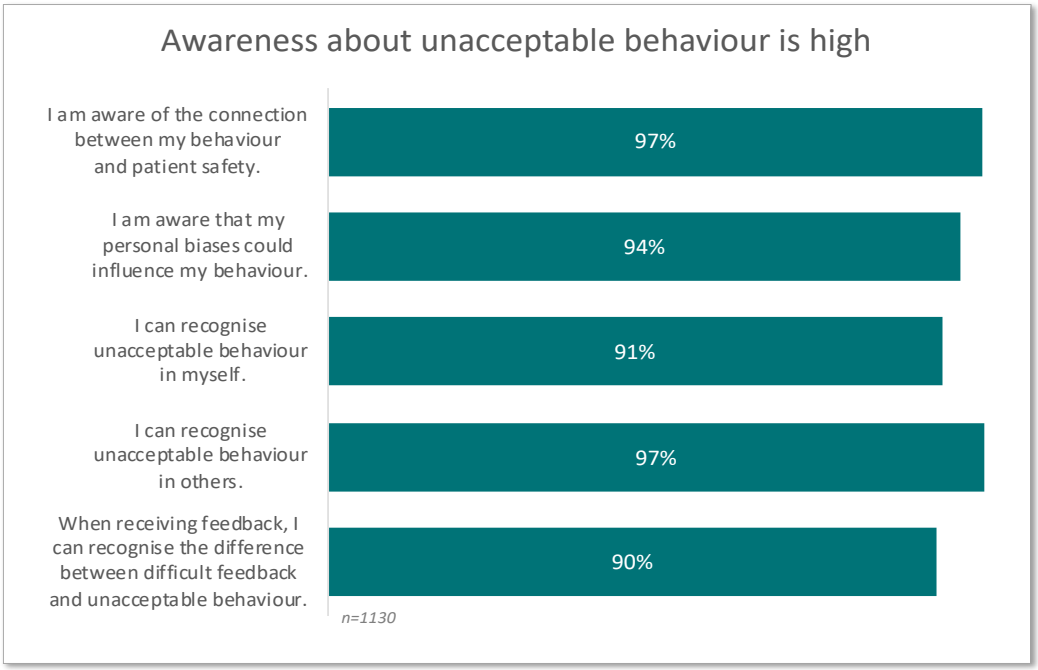
Detailed findings

High level of awareness of unacceptable behaviour

In 2019, a very large proportion (95%) of survey respondents reported that they could recognise unacceptable behaviours in others. This number has increased to 97% in 2021 (Figure 3.7). 91% of members reported that they can recognise unacceptable behaviour in themselves.

Although awareness of what constitutes unacceptable behaviour is high overall, there is a gender and age-related difference in some aspects of self-awareness. Females are more likely than males to recognise that their personal biases could influence their behaviour (97% females, n = 419; to 92% for males, n = 714) and are also more aware of the impact of their own behaviours on patient safety than males (99.5% females to 95.2% males).

Figure 3.7



Fellows with greater than 10 years' experience are significantly less aware of the impact of their personal biases on their behaviour (91%, n = 542) than less experienced Fellows (95%, n = 311), Trainees (98%, n = 204) and SIMGs (95%, n = 77). This is concerning as this group includes culture-influencers – they influence because they are powerful as a result of their experience, their networks, and their positions of power (for example, as Supervisors, RACS committee members, Speciality Training Board members).

In 2021, 87% (n = 1132) of members said they are aware of how to comply with the RACS Surgical Competence and Performance Guide, a similarly high proportion as in 2019 (91%, n = 1358).

> *"I do think surgeons are more aware of their own behaviour and know that when they cross the line, they could be reported. Trainees are more comfortable bringing up poor behaviour that they have experienced. When I was training, there was no way you would say anything for fear it would destroy your career" Female Fellow*

> *"There is a better understanding of what is acceptable and not acceptable behaviour. Increased presence of women, especially in leadership roles." Female Fellow*

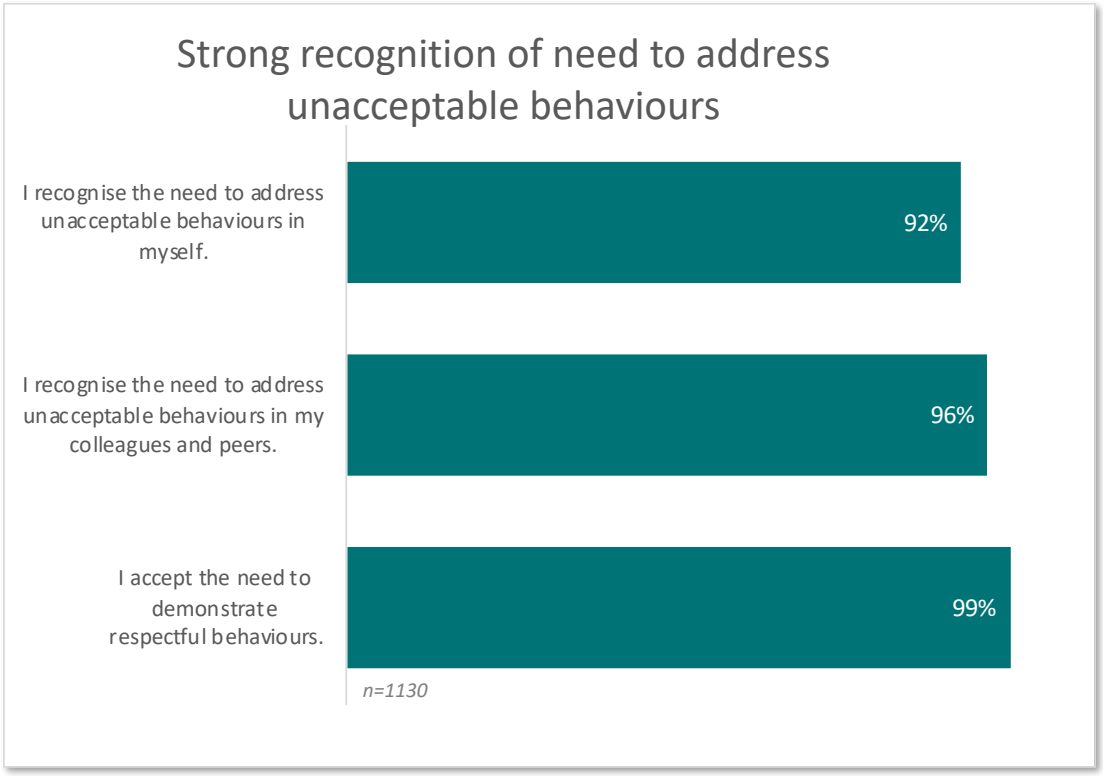
> *"The positive I took from the College's moving forward, was the formalization in courses and giving tools and techniques to be able to deal with those things, to call it out, to have the ubiquitous cup of coffee conversation, to be able to have a framework where you're dealing with these things." SIMG*

Strong acceptance of the need to address unacceptable behaviour

A striking finding is that 99% of respondents now accept the need to demonstrate respectful behaviours (Figure 3.8).

Although there was no comparable question asked in 2019, anecdotal evidence indicates that there was a far lower level of acceptance or even acknowledgement that there was an issue regarding respectful behaviours in the surgical workforce in 2015, when the Action Plan was developed. Together with the very high recognition of the need to address unacceptable behaviours in the self (92%) and in colleagues and peers (96%), this indicates a major success for the Action Plan in influencing the attitudes of surgeons.

Figure 3.8

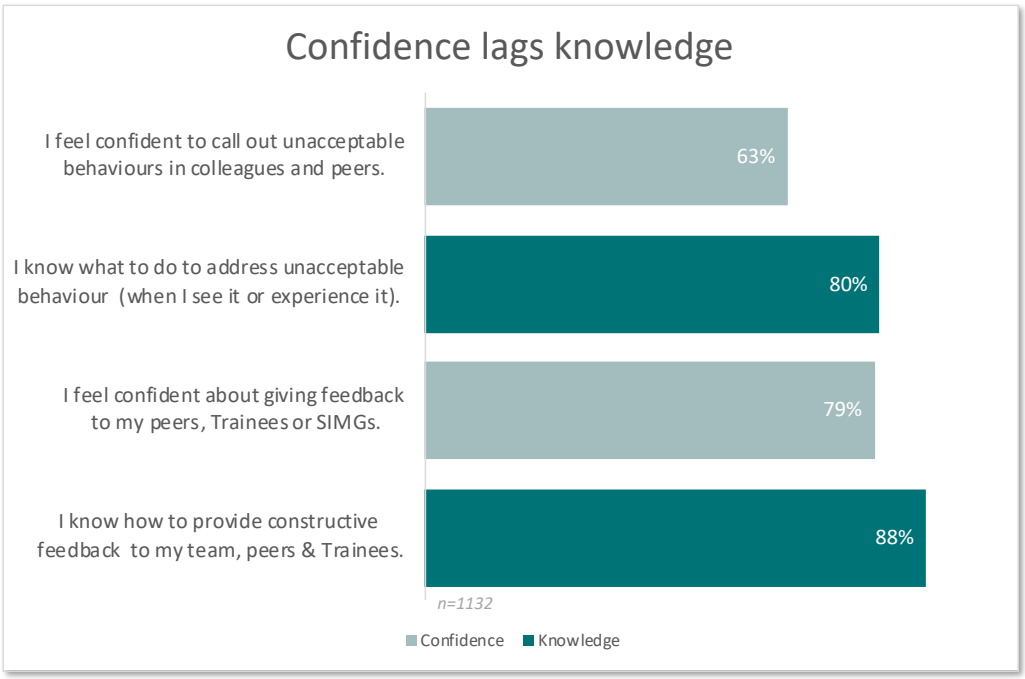


Confidence lags knowledge

Knowledge about providing constructive feedback (88% of 1132) and how to address unacceptable behaviours (80% of 1132) is very high in 2021, with no comparable figures for 2019.

Although a large percentage of respondents felt they have the knowledge to recognise and address unacceptable behaviours, fewer said they had the confidence to do so (Figure 3.9).

Figure 3.9



Lack of confidence in calling out unacceptable behaviours appears to be related to self-perception of power and fears of repercussion. This was most pronounced for Trainees (41% confident, n = 204), females (56% confident, n = 419, compared to males 68%, n = 714), with the older males showing the most confidence (male Fellows > 10 years 76% confident, n = 542). Interviewees reported that their lack of confidence is driven by fear of repercussions in workplaces where the culture does not support reporting unprofessional behaviours.

> *"If you just laugh and move on with the joke, then that's what you've accepted and that's not great." SIMG*

> *"Trainees and those supervised by other consultants are in an extremely vulnerable position and feel very scared of voicing their opinions due to fear of retribution." Fellow*

However, a large proportion of survey respondents (63%) said they did feel confident to call out unprofessional behaviours. Interviewees gave examples of workplaces where leaders set the tone and encourage staff to speak up about issues relating to behaviours or patient safety. Others reported that the Operating With Respect training

had contributed to an atmosphere where calling it out was now acceptable, and they felt comfortable demonstrating that behaviour. Examples mentioned in interviews included consultants calling each other out, non-medical staff being welcomed by consultants to raise concerns about patient safety, more nurses and other specialists being willing to call out unprofessional behaviour directed at surgical Trainees and increasing discussion about what constitutes appropriate and inappropriate behaviour.

> *"As a Fellow, I witnessed and observed, and was subject to things, mostly by surgeons, that nowadays, I think I would say that's inappropriate, unprofessional, or someone else in the room would say that's not on." Female Anaesthetist*

Several interviewees mentioned examples where senior surgeons were called out by hospital management for their behaviour and threatened with dismissal if they did not show improvement. This was seen as powerful modelling of the expected standards of behaviour at those workplaces.

> *"There has been an increased awareness of speaking up about poor behaviour however in reality if the leaders do not demonstrate it then it is difficult for juniors to practically do this without fear of creating more problems." Female Fellow*

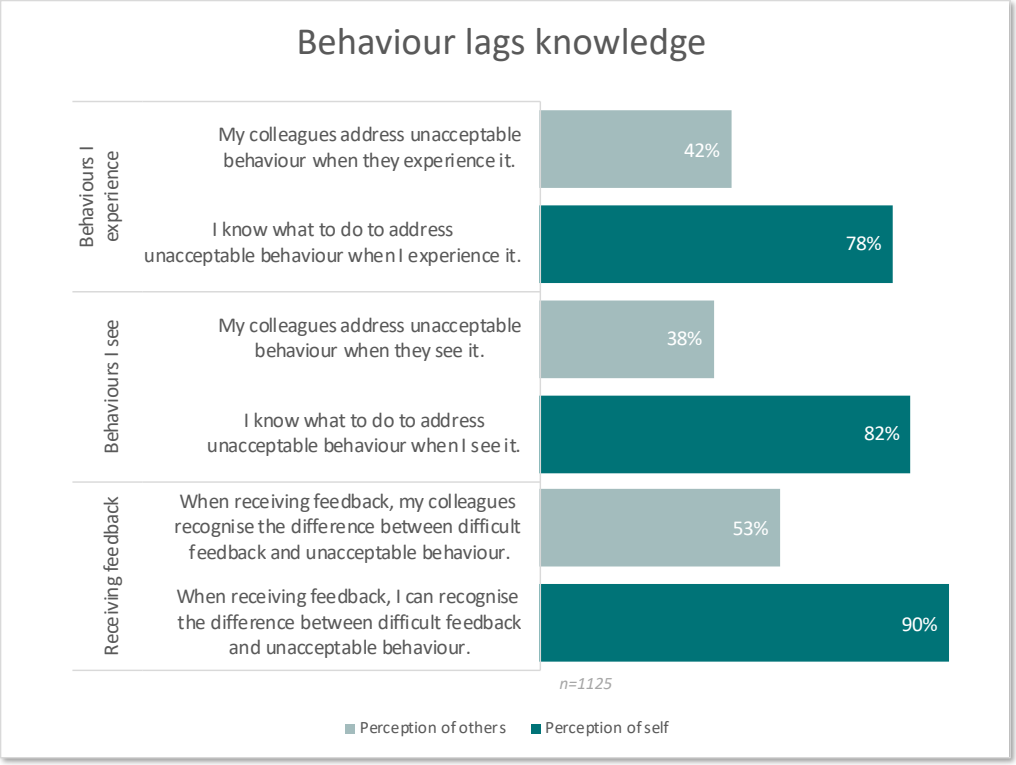
A strong theme to emerge from the interviews was the optimism of generational change. People strongly felt that younger people coming into surgery are less willing to tolerate bad behaviour and feel more entitled not to accept it. They are optimistic that some older surgeons with entrenched attitudes will retire in the next few years and that will contribute to a positive change.

> *"I feel like there'll be a much bigger proportion of younger consultants who care about looking after their juniors, who care about doing the right thing, who care about well-being and physician welfare." Fellow*

Addressing unprofessional behaviour is still challenging

When asked about their knowledge on how to address unacceptable behaviours when they see them or experience them, most members rated themselves highly (Figure 3.10). However, when asked if their colleagues actually demonstrated these behaviours, there was a consistent difference, across multiple behaviours. For example, Figure 3.10 shows that 90% of respondents said they can recognise the difference between difficult feedback and unacceptable behaviour, yet only 53% of the same group of respondents believe that their colleagues do so in practice. Similarly, 78% said they know what to do to address unacceptable behaviour when they experience it but only 42% say their colleagues actually address unacceptable behaviour in practice. This disparity is predictable, as behaviours are expected to change over a longer period of time than knowledge and attitudes. The gap between knowledge and behaviour is likely to reduce over time as attitudes and cultural norms shift, and practical skills to address unacceptable behaviours develop.

Figure 3.10



Addition to KEQ 3: Has prevalence of DBSH changed since 2015?

This evaluation was the first outcomes evaluation, based on the program logic and behaviour change model underpinning the Action Plan. Behaviour change, in this model, is a long-term outcome and was not expected to be significant at this early stage of program implementation. However, it was important to develop a baseline for measurement of future behaviour change and, with this objective, a survey to measure the prevalence of DBSH i.e. the actual behaviour, was conducted.

Analysis of the full survey findings and a copy of the survey questions are included in this report as Attachments 8 and 9.

KEQ 4. To what extent are RACS processes to manage unacceptable behaviour working as intended?

Overall assessment of findings for this KEQ

RACS has revised its complaints process and developed clear communications about its role and limitations. Importantly, communications about the new process were launched at the same time as this evaluation, so low awareness figures and poor understanding of the process do not reflect the outcome of this new communications effort. However, there remains an opportunity for the College to manage the expectations of members regarding the possible and most beneficial outcomes of complaints. There is a culture of negative consequences for people who raise a concern about behaviour in the workplace and this prevents a large number of people in less powerful positions from reporting incidents. Despite this, the College has gained ground in its relationship with Trainees, by increasing trust of the RACS complaints process in this group.

Successes

- Clear but recent communication to members of RACS role in complaints process.
- Efforts to engage Trainees appear to be increasing trust in the College.

Barriers

- Still a poor understanding of the RACS complaints process.
- Expectations of members do not match with RACS' powers.
- Real fears of repercussions hamper reporting of unprofessional behaviour.

Detailed findings

RACS has revised its complaints process

The College has historically committed to the Fellowship that it would support Fellows, SIMGs and Trainees in the challenging area of making complaints about unprofessional behaviours. RACS has tried and reviewed several different approaches over a number of years. The lessons learned from these reviews have clarified what the College can and cannot do in this space and have resulted in development of a centralised complaints and feedback process where people are referred to the appropriate channels for lodging complaints.

RACS launched its updated complaints handling process in early 2021. Information is now available on the RACS website and has been disseminated through numerous publications. The website contains contact numbers for further information about complaints, links to other relevant agencies and the contact for Converge International, the agency which provides the RACS Support Program.

This updated process clarifies the role of the College including taking an advisory, feedback and support role; fostering profession-led conversations that are non-judgemental and aimed at encouraging self-reflection and behaviour change; and referral to the appropriate agency with the legal powers to manage the issue. Importantly, it clarifies the limitations of the College's powers to take legal or

disciplinary action in response to notifications. This revised process is strongly supported by hospital stakeholders, who felt that it is the role of employers to manage complaints by their staff and that involvement of the College is more appropriately in a supporting role

There is still a poor understanding of the RACS complaints process

Only 42% (n = 1078) survey respondents said they were aware of the RACS revised complaints process. However, these results should be understood in the context of the timing of this evaluation, which was conducted at the same time as communication about the new feedback and complaints system was launched.

A higher proportion of members (60%, n = 1081) knew where to find information to help them access support and 57% (n = 1079) knew where to find information about lodging a complaint. The proportion of people who know about the RACS support program, provided by Converge International, has remained at a similar level since 2019 (54%, n =1075 in 2021 compared to 56%, n = 1681 in 2019).

Interviews with Trainees indicated that they have a poor understanding of the complaints process, including what is involved, how confidentiality is maintained, and the types of outcomes that can be reasonably expected. Other interviewees reported that although there is information available on the website, it is too dense, and the contact information is not easily found.

> *"The subtleties of how the process could accommodate the wishes of the complainant are not well understood." Trainee*

> *"Way too much information on the RACS website… actually looks to be discouraging people from lodging a complaint… phone number is at the bottom of a large amount of information." Fellow*

Expectations of members do not match with RACS powers

The historical lack of clarity around the College's role in complaints about professional behaviours, together with the need to maintain confidentiality about specific actions taken, have contributed to the general lack of confidence about the College's ability to resolve these issues. There is a perception amongst Fellows, Trainees and SIMGs that the appropriate actions for the College to take in response to findings of bullying or harassment should include removal of perpetrators from employment or having their fellowship status removed, and this contributes to frustration when the College instead, takes a more collegiate approach and counsels the accused or negotiates some undertakings or sanctions for that person.

A few key elements of the complaints system stand out as opportunities for clearer communication to the Fellowship. These include informing members that the College's role is advisory only, and that complaints are more appropriately made through employers or the regulatory body. Additional messaging which could improve understanding of the system could include the fact that a protocol to support information sharing has been developed and included in the updated accreditation

guidelines for hospital training posts (to be implemented progressively, commencing 2022); it is possible to notify the College about issues relating to professional behaviours and maintain anonymity through the complaints process; multiple anonymous complaints can have an impact as they may result in the College raising the issue with the workplace.

RACS staff are also reluctant to call it out

RACS staff report that they experience unacceptable behaviour from surgeons at the College. Staff do not feel safe to call it out because of the power differential and their belief that Fellows would likely be more supported by the senior leadership of the College. However, discussion with senior College management indicates a significant level of concern about the behaviour of Fellows towards staff and a strong interest in improving the workplace culture for their staff.

> *"To me it almost feels a little bit like a pack mentality… 'you're sensitive'. I would just stay quiet, let it wash over…" RACS staff*

> *"You have to keep working with these people. There is a power differential. And I don't necessarily see results from when calling out has happened." RACS staff*

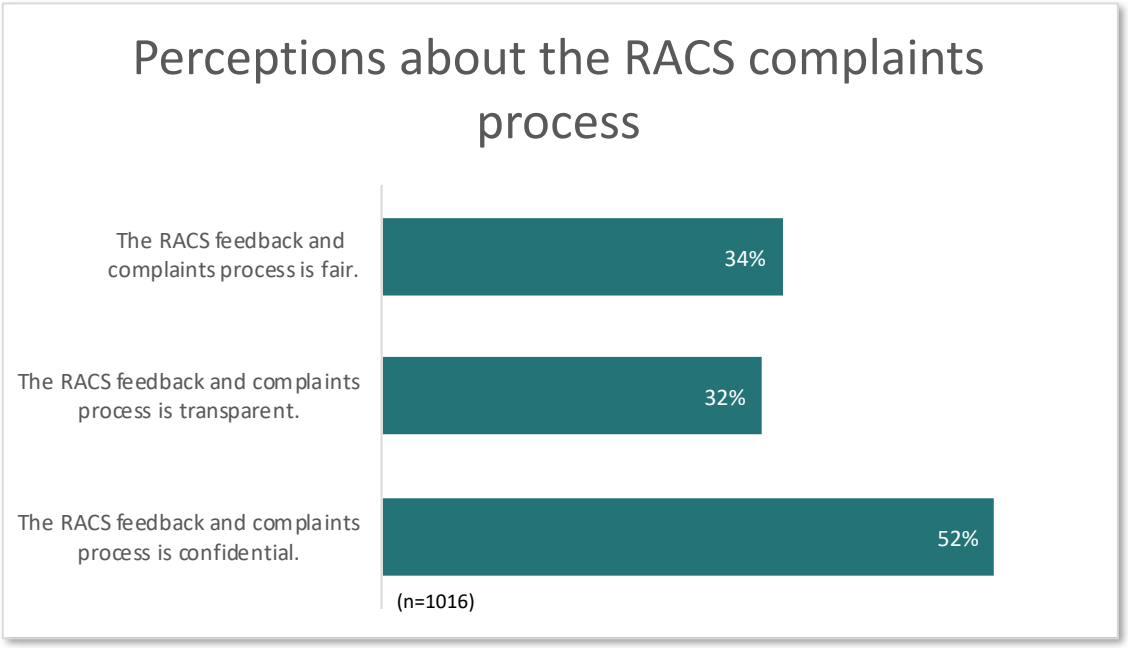
Complaints monitoring and reporting could be improved

The external review of the complaints process recommended, in December 2020, work to improve the collection and reporting of data regarding the complaints process. Recommendations included standardising the data and information categories contained in the Building Respect progress reports, reporting trend data over a series of years and including the summary results in the Annual Report. As discussed in KEQ 1 above, this evaluation has also found that outcomes reporting, and key performance indicators could be introduced to make performance monitoring more transparent and accessible.

Some mistrust persists regarding the RACS complaints process

Only a third of RACS members believe that its complaints process is fair (34%, n = 1016) (Figure 3.17). The difference largely correlates with age, with 19% (n = 16) of those under 30 agreeing it is fair, compared to 45% (n = 74) of those aged over 71. Similar figures were obtained when members were asked about transparency of the complaints system, with 32% (n = 1030) agreeing, with people aged over 71 most likely to agree (45%, n = 75), and those aged 41-50 least likely to agree (27%, n = 270). Just over half (52%, n = 1039) of the survey respondents agreed that the RACS complaints process is confidential. However, a large proportion of people (35-55%) answered neutrally for all three questions, indicating that many people may not have a strong opinion about a process with which they had not interacted.

Figure 3.17

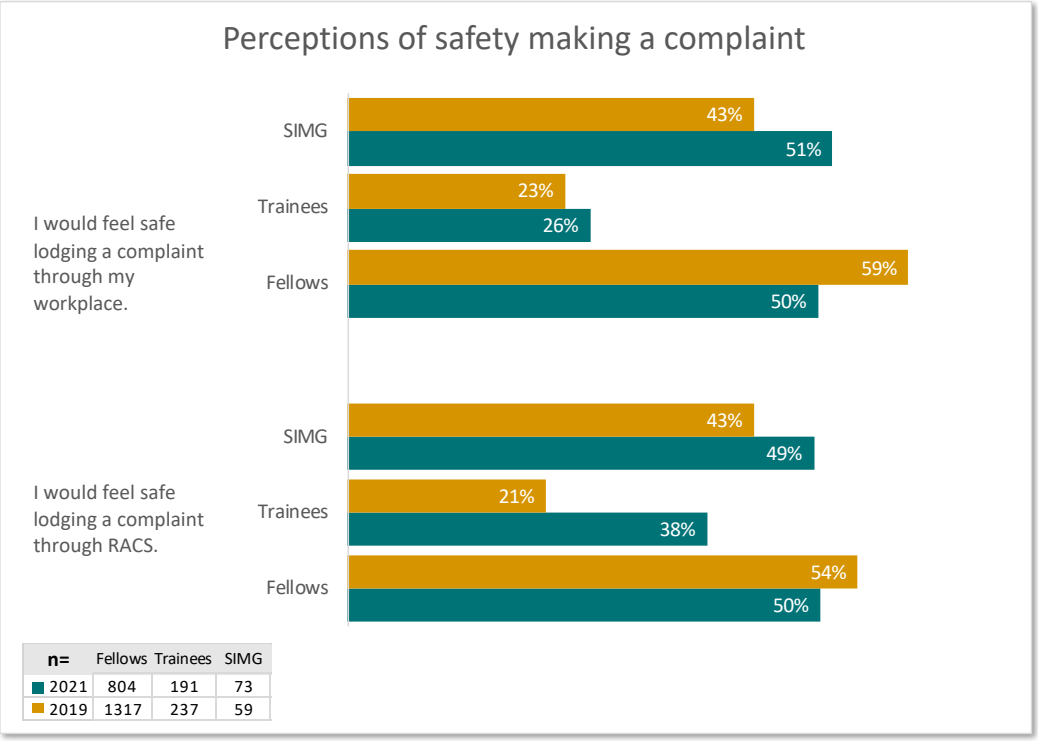


Trainees feel safer with the RACS complaints process

Attitudes towards the RACS complaints process are similar to those towards workplace complaints systems. Figure 3.18 below shows that in 2019, survey respondents had similar feelings of safety for the RACS and workplace complaints processes. In 2021, the figures remain largely the same, with the notable exception of the attitude of Trainees, who feel significantly safer lodging a complaint through RACS than their workplace (38% feel safe with RACS compared to 26% for the workplace, n = 237).

Of concern is that only 18% of female Trainees said they feel safe to report a complaint through their workplace, half the number of those who feel safe reporting through RACS (36%). The comparable figures for male Trainees are 32% feel safe making a complaint in the workplace and 40% through RACS. This increase in trust of RACS may be due to the focus on Trainee engagement and relationship building that has taken place in the period since the 2019 evaluation.

Figure 3.18



Trainees have a well-founded fear of negative consequences

Although Trainees feel safer with the RACS process, trust is still low. A significant issue is that Trainees fear the impact on their career of reporting unprofessional behaviour. This is not an unfounded fear and is not based simply on perceptions of a flawed College complaints process. Rather, it is based on very real experiences of undermining and reputational damage of Trainees perceived as 'trouble-makers.' A number of concerning examples were related during interviews, by senior hospital executives, Fellows and Trainees, who described surgeons sharing negative perceptions of Trainees who had spoken up or raised concerns, with consequent reputational damage which was career limiting. This information sharing is not being done through formal reference checking mechanisms but appears to be happening via informal networks. Apart from the negative consequences for the Trainee, this informal information sharing limits the ability of the Trainee to respond to or learn from negative feedback.

> *"Trainees are still afraid to speak out because they want to protect their training position, their progression through the training program….so they are generally very careful." Fellow*

> *"The reality of complaining against someone would be a different story, much easier if you had no interest in being employed at that centre or in that country." Trainee*

"That registrar's got no idea what she did…its going to make a difference between getting a public hospital job in our department or not…" (Fellow relating an incident of informal networks spreading negative feedback about a registrar)

This is not the perception of some consultants, who feel that Trainees have a much easier pathway for reporting issues and that the culture has shifted significantly.

"Just five years ago, I wouldn't know in my hospital what pathways exist to raise a concern, but now we have hotlines and reporting mechanisms, we have people who will champion it, we have hospital leadership take it seriously." Councillor

A significant fear is the lack of confidentiality. Interviewees raised the issue of being part of a small specialty, or working in a small department, meaning they could easily be identified. Trainees reported that they need to feel that there will be people around them to support them through a complaints process before embarking on an action that may isolate them professionally or mark them as difficult. They were also concerned that they would be marked as 'sensitive' or 'touchy' if they raised certain behaviours, many of which were subtle and hard to prove.

"Of course they'd know." SIMG about why they don't report bullying

"You've got five years to get through it. Just get to the other side, you'll be fine." Trainee

"In some way I am complicit because I'm not going to complain. I just want my end of term assessment done. I hate this rotation. I just want it to be done, I don't want to make waves. I need them to sign it off, and then I'm going to move on and hope that I never have to work at this place again. And then I'll just warn the next trainee that's going there and so the cycle goes." Trainee

"I'm in the tearoom and one of the guys who works on the committee awarding jobs for next year says, this one complains. Forget it, she's not getting the job." Female Fellow

"It's hard to prove those small constant microaggressions which people just say that you're overreacting to." Female Fellow

KEQ 5. To what extent have relationships of trust, confidence and cooperation on DBSH issues supported progress towards RACS Action Plan goals?

Overall assessment of findings for this KEQ

RACS has strong credibility amongst external stakeholders, due to its early and definitive leadership in addressing cultural change. The strong messaging from RACS leaders including the Council, Key Opinion Leaders and senior Executives about the expectations of the College was seen as a critical success factor for the Action Plan.

The external engagement approach has focussed on dissemination of the annual Progress Report to an extensive stakeholder list, information sharing regarding complaints notifications and the piloting of different ways of engaging with hospital partners, to find a sustainable way of achieving MOU goals.

External stakeholders are very keen to work in partnership with RACS, opening up an opportunity to rethink the way the College engages with its external stakeholders and leverage off its strong reputation as a leader in this space to engage in a two-way dialogue and develop joint activities in the next phase of the Action Plan.

Successes

- Strong credibility amongst external stakeholders regarding improving the culture of surgery.
- Many other organisations have leveraged RACS' collateral to introduce cultural change programs of their own.
- RACS' leadership in this space has led to a keen interest from a broad range of external stakeholders in partnering on cultural change initiatives.

Barriers

- The resource intensive nature of working on some partnerships – particularly individual hospital partnerships.

Detailed findings

RACS is regarded as a leader by external stakeholders

External stakeholders view RACS as a leader in this space, having been the first medical organisation to acknowledge the problem and to develop a robust framework to address it. Most external stakeholders interviewed were more aware of the mandatory e-module and the strong commitment of the Council and key RACS leaders to improve the culture, than any other details of the Action Plan.

> *"RACS has started a revolution in terms of changing the culture." External Stakeholder*

> *"RACS is actually walking the talk, as well…and that's the powerful thing." External Stakeholder*

RACS has adapted its external engagement approach

The original intention of developing and maintaining Memoranda of Understanding (MOUs) to pilot initiatives that could be scaled up across the system has proven unwieldy given the resource intensive nature of such projects and the inability to allocate dedicated resources at the College and in health institutions. The most notable successful examples include the development of an information sharing protocol with representatives of St Vincent's Health Australia and the mounting of the national summit 'Creating Healthcare futures of Safety and Respect' with St Vincent's, Macquarie University institute for Health innovation and RACMA. Different approaches to address the resourcing issue have been trialled. With hospital partners, these approaches have included the involvement of regional offices and trialled the merits and limitations of one on one versus state level, and national level gatherings. Finally, due to circumstances, an online summit was trialled as a vehicle to promote engagement.

Engagement has also focussed on sharing knowledge and resources with health departments and health jurisdictions, university medical schools, and other medical colleges. Activities have included formal Statements of Intent which were negotiated to underline a shared recognition to address DBSH at a health system level, and agreements to use RACS materials as the basis for training or "recognition of prior learning" for surgeons. Some university medical schools have incorporated RACS training materials into their curricula and/or increased the focus on 'professionalism' in health care, in line with the now substantial body of evidence linking this to patient safety.

Many other cultural improvement activities in progress

There are other initiatives being implemented to improve workplace culture across both private and public hospital systems. Some are broad, national initiatives whilst others operate at a local level. A few examples include the Australian Healthcare and Hospitals Association (AHHA) focussing on workplace culture and safety, improving teamwork, and partnering with Deans of Medical Schools to improve the safety of medical students; St Vincent's Hospital's Ethos program implemented across its network; a multidisciplinary program initiated by a group of anaesthetists at their local health district, using real, de-identified incidents as part of the training.

Hospital and other medical college executives interviewed for this evaluation reported gaining benefit from being able to implement or adapt RACS' resources and policies to support their own cultural change programs. One example is Southern Cross, Aotearoa New Zealand, which reported reinforcing the RACS guidelines within its network and building professional behaviour standards into credentialing of its hospitals. These examples further reinforce RACS' position as a leader in this space.

Keen interest in partnering with RACS

Interviews with external stakeholders highlighted great interest in partnering with RACS to explore multidisciplinary approaches to improving workplace culture. Colleges representing nurses, anaesthetists, and hospital administrators, along with healthcare associations and hospital networks were keen to share information and work together to align and streamline messaging and address systemic barriers.

Representatives from the nursing colleges reported strong interest from nurses about the Action Plan elements, both at an organisational, college level and amongst individual nurses wanting to complete the online module.

KEQ 6. To what extent has surgical education incorporated the principles of respect, transparency, and professionalism?

Overall assessment of findings for this KEQ

Despite significant efforts from RACS to improve supports for both Supervisors and Trainees, the surgical training environment remains an area of concern for reports of unacceptable behaviour. Contributing factors are systemic. They include the devolved structure of surgical training, which creates governance and accountability issues, workplace practices which create opportunities for unacceptable behaviours and lack of recognition and support for supervision in the workplace.

Successes

- RACS has introduced significant improvements in support for Trainees and supervisors including training courses, resources and training supports.
- Most Trainees report a positive learning experience.

Barriers

- COVID-19 has limited the ability of RACS to deliver face-to-face training.
- The significant variation in the quality of training placements relates to the quality of supervision and the influence of local culture.
- Performance feedback remains challenging in surgery, as in other professions.
- Supervisors fear the potential consequences of giving negative feedback which leads some to pass on Trainees without addressing performance issues.
- There is a culture of non-transparent, informal feedback between Supervisors, which can be undermining for Trainees.
- The devolved structure of surgical training delivery is a barrier for implementation of profession-wide initiatives.
- Workplace practices contribute to some poor behaviours.
- The role of supervision, whilst a critical success factor for surgical training, is not well supported in the workplace.

Detailed findings

Significant improvements in support for Trainees and Supervisors

RACS has recognised the need for improvement in supports and resources available to both Supervisors and Trainees. Progress has been made in working in partnership with Specialty Societies on a range of initiatives. Significant efforts have been made to develop resources in the last two years, including a dedicated Supervisors Hub on the website; development of the Professional Skills curriculum; the Training Management Platform, intended to support Trainees in managing their learning objectives and competencies; and a course for Trainees on how to receive performance feedback. Table 3.3 highlights some of the recent developments in training. In addition, RACS has put significant effort into advocating for better recognition of the supervisor role and increased workplace supports for Supervisors.

Table 3.3: Courses planned for 2021

Course	Aim
Difficult Conversations with Underperforming Trainees	Assist Supervisors to undertake a procedurally fair conversation with a Trainee who is not meeting required standards despite feedback.
Surgeons as Leaders in Everyday Practice (SAL)	Practical suggestions for what surgeons can do to be effective leaders in their daily clinical practice.
Promoting Advanced Surgical Education (PrASE)	Explores learner-centred surgical education, trust and feedback, Trainees at risk, assessment and supervision, and leadership in surgical education.
Keeping Trainees on Track (KTOT)	Early recognition of underperforming Trainees.
Induction for Surgical Supervisors and Trainers	Improve understanding and implementation of RACS policies and procedures, clarify roles and responsibilities of a SET Supervisor and/or Trainer.
OWR-T	Pilot a modified version of the Operating with Respect Course adapted for Trainees.

A look at the July 2021 Fax Mentis highlights the efforts and challenges that RACS is experiencing. Of the twelve courses offered for the rest of 2021, nine (75%) are aimed at improving teamwork, supervision, and leadership. However, whilst many of the

face-to-face courses are still being offered in locations where they can be held, unpredictable COVID-19 restrictions have led to several cancellations.

> *"We really need to start demonstrating that we are supporting Supervisors, particularly when they have to have those difficult conversations." Councillor*

> *"Supporting trainers in the complexity of giving feedback is critical to moving forward." Specialty Society representative*

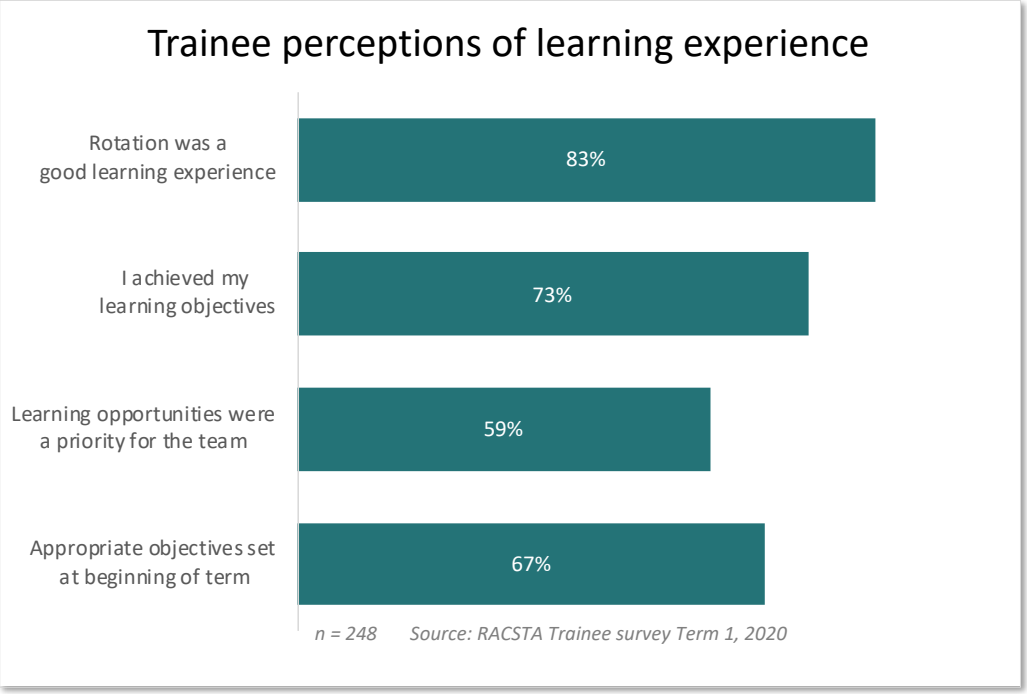
Despite these efforts, interviewees reported perceptions of a lack of support and recognition of both Supervisors and Trainees, highlighting the challenge of balancing RACS' efforts in this space.

Variation in perceptions of surgical supervision

Most Trainees report a positive learning experience but there is room for improvement

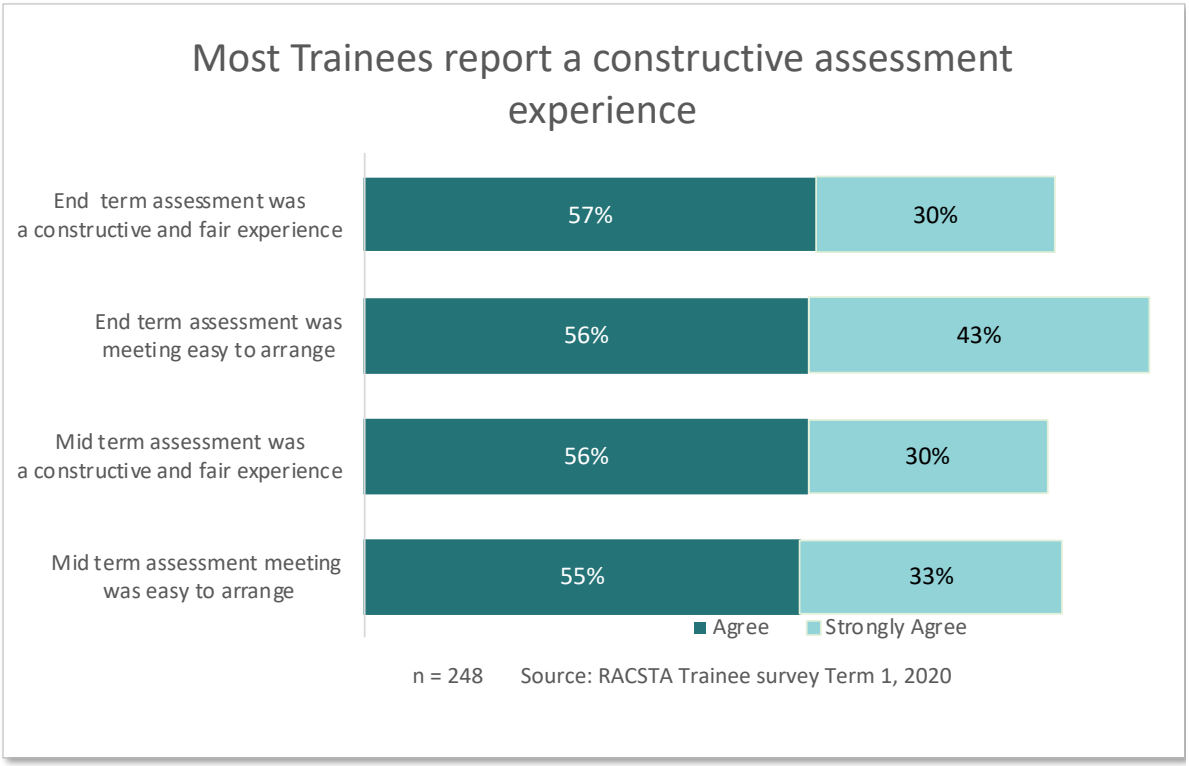
The RACS Trainee Association (RACSTA) survey of Trainees, 2020 Term 1 survey (Figure 3.19) shows that most Trainees (83%) reported that their rotation was a good learning experience. However, 10% disagreed or strongly disagreed. Almost three quarters (73%) believed they had achieved their learning goals. When viewed alongside the low numbers that felt their learning objectives were a priority for the team (59%), or that felt appropriate objectives had been set for the term (67%) it can be seen that the training experience is variable and there is room for improvement in setting and prioritising of learning objectives.

Figure 3.19



This contrasts with the very positive responses when Trainees were asked whether their assessment experience was constructive and fair (Figure 3.20). Ratings were high for both mid (86%) and end term (87%) placements. 99% of Trainees said their end term assessment meeting was easy to arrange. When asked about the adequacy of the feedback on their performance, 88% of Trainees said they received adequate feedback.

Figure 3.20



Interviewees reported varying levels of satisfaction with their training placements. These ranged from examples where Supervisors of Training did not conduct any formal end of term assessment or provide any feedback, but '*just signed the form*', to others where supervision was excellent and a positive learning opportunity. The range of responses points to the fact that the culture of surgical training is influenced by the local hospital culture, meaning that there are hundreds of different individual surgical cultures across Australia and Aotearoa New Zealand.

> *"Very hard to talk back when you have three bosses looking at you." Trainee*

> *"There are some really great consultants that are a pleasure to work with. They're brilliant." Trainee*

> *"I definitely think the younger consultants and fellows that I work with have good teaching skills and give valuable feedback. And there are still some of the older ones that still are good at that." Trainee*

Discrepancy in perceptions of feedback

As with other behavioural measures, perceptions of whether feedback has been delivered respectfully differed between Supervisors and the feedback recipients (Figure 3.21). Whilst 75% of Supervisors believed they gave respectful, timely and constructive feedback to their Trainees, only 61% of Trainees agreed, and only 64% of females agreed. Further analysis showed that more male Supervisors (80%) believed they gave respectful feedback than females (65%). These results indicate the expected lag between attitude and behaviour but may also highlight a lack of self-awareness of the impact of a person's behaviour on others. The positive self-perception of male Supervisors reflects a common pattern across all survey questions where male surgeons are generally more positive about their own performance than females.

Figure 3.21

A similar pattern was observed when asking about how feedback was received. 90% of respondents (n= 1129) said they could recognise the difference between difficult feedback and unacceptable behaviour, but when asked if their colleagues could do this, only 53% agreed. There was a significant gender difference in perception of how colleagues receive difficult feedback, with less females (46%, n = 410) than males (57%, n = 689) agreeing that their colleagues could recognise the difference between difficult feedback and unacceptable behaviour. When combined with evidence showing that only 59% (n = 1109) of respondents agreed that their colleagues provided constructive feedback to their team, peers and Trainees, it can be seen that there is opportunity for improvement in the area of performance feedback across all of surgery, not just in training. The College is working in this space by developing training modules for both Supervisors and Trainees on how to participate in performance feedback, but these are not compulsory.

"Trainee feedback is done universally badly across specialties." Anaesthetist

"There has been a positive shift in the general language used in surgical training however this has not translated across to behaviours and accepted behaviours at work. The trend noticed has been where the supervisors are more inclined to provide negative feedback in writing, rather than constructive feedback or positive feedback to build a trail of written evidence against trainees. I have personally experienced this and have known of similar experiences across trainees within minority groups." Trainee

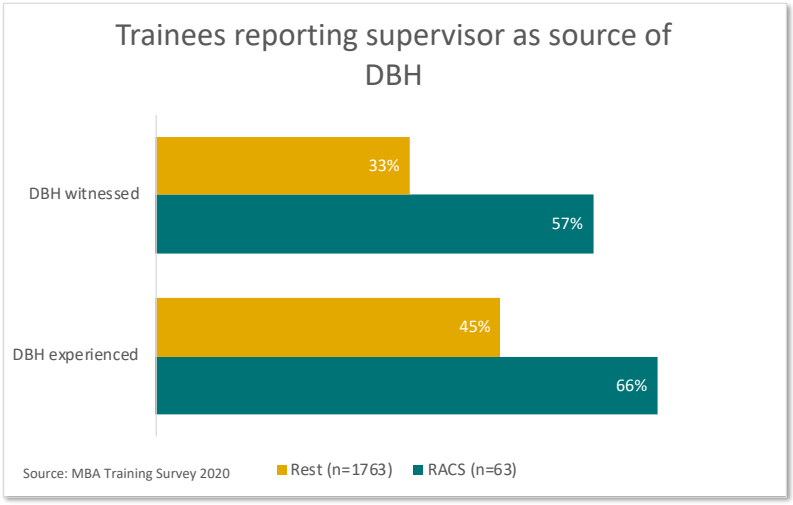
"More recent RACS appointees to the position of trainee supervisors appear fair and contribute to a more positive culture than in the past." Fellow

"They're more aware that they do actually have to give it (respectful feedback) and they've got the points, but I don't think that means they do it well." Councillor

Surgical Trainees report their Supervisor as a source of DBH more often than other specialist Trainees

Survey data from the Medical Board of Australia (MBA) Trainee Survey 2020 raises another concern about supervision in surgical training. Figure 3.22 shows that surgical Trainees report their Supervisor as the source of discrimination, bullying or harassment more often than Trainees in other medical specialties. This applies to both incidents experienced (66% of surgical Trainees compared to 45% of others) and incidents witnessed (57% of surgical Trainees compared to 33% of others). A possible explanation for this finding could be that surgical Trainees are more aware than other Trainees of what constitutes discrimination, bullying and harassment, due to their mandatory training and the OWR communication campaign. However, in the absence of confirming evidence, this trend should be monitored and contributing reasons explored.

Figure 3.22



Supervisors fear potential consequences of giving negative feedback

While 91% (n = 371) of Supervisors, trainers and SIMG assessors said they know how to give constructive feedback to their team, peers, and Trainees, significantly less (84%) felt confident about doing so. Interviewees reported that Supervisors in their teams or attending supervisor training have given repeated and strong feedback that they are hesitant to give negative performance feedback to Trainees for fear of being challenged or accused of bullying. Trainees can appeal or challenge the reports, often involving extended legal actions, which can be time consuming and stressful for Supervisors, and some do not feel they will be supported by the College. There were multiple reports that a small number of underperforming Trainees have vexatiously accused their Supervisors of bullying.

One unintended consequence of this hesitancy is that some underperforming Trainees are not given appropriate feedback but, instead, just 'passed on' to the next placement. This contributes to a significant problem down the track for some Trainees who may be deemed not to have achieved the required level of competence but have been progressed to their fourth or fifth year of training. It also creates a considerable risk of litigation for the College. A related unintended consequence was the concerning finding that informal feedback about Trainees is being passed between Supervisors, without informing the Trainee. It is significant that almost every interviewee working in a hospital environment, including hospital administrators, reported this. The lack of transparency along with the lack of feedback to Trainees could be what is contributing to the perception of undermining found in the 2021 Prevalence Survey.

> *"Supervisors don't want to get dragged through the law courts and they do their best, in an unpaid environment, to produce the right documents and they just don't want to be held accountable." Fellow*

> *"It is becoming increasingly difficult to provide negative feedback to trainees. I acknowledge that it was not done in the best fashion in the past, but some trainees have utilised this as an excuse for poor performance. Having said that, there are supervisors who are still difficult, and I still witness misuse of power. Yes, some supervisors are tougher than others, but I find it incredibly difficult as a peer to call out such behaviours." Fellow*

The challenge of how to manage underperforming Trainees is not restricted to surgery, it is common across all training environments. Supervisors interviewed gave some examples of the challenges they have faced. These include the increased pressure on them when giving feedback to female Trainees or those from a different cultural background. Most Supervisors were confident of giving feedback on the technical skills, however it is the area of non-technical skills where they experience the greatest challenge, because this feedback can seem subjective.

> *"Some negative feedback is given so gently that Trainees are unaware of it!" Fellow*

"Unless they are outright dangerous then obviously, I will have to escalate matters, but if they were doing okay then fine, but I'll just consider the positives." SIMG

"I would hate to have all the flavour and colour taken out of my personality and training style, just to make sure there are zero opportunities for offense." Fellow

"Being a surgical supervisor, it's a lot you're given, it's not necessarily the best person for the job." Fellow

Systemic issues in training contribute to DBSH

The Australian Medical Council (AMC) in its 2017 Accreditation report to the College[4] commended the "*enormous courage and leadership shown by the College in 2015 in establishing a broadly constituted Expert Advisory Group to undertake the substantial review of concerns relating to discrimination, bullying and sexual harassment*." It further commended the progress that had been made since the introduction of the Surgical Education and Training (SET) program in 2007. In granting accreditation until March 2022, the AMC made several detailed recommendations for improvement that substantially align with the findings of this evaluation. These cover the areas of governance, the structure of training delivery, monitoring and evaluation of the training program, policy, implementation of broad reaching programs such as the Building Respect Action Plan, consultation processes, development of competencies and curricula, improvements to selection and assessment, establishment of confidential feedback processes, reporting, support of supervision and diversity.

Similarly, in 2020, an external review of the RACS complaints process[5] found that the major challenge for RACS regarding complaints is "*the issue of DBSH behaviours within the training environment…serious DBSH complaints and complaints by Trainees about the alleged conduct of Fellows representing the College in the delivery of training services.*" It recommended that RACS consider whether and how to address this issue. This evaluation has similarly found that the training environment is a major locus of DBSH issues.

The findings fall into two major areas:

The structure of training delivery is a barrier for implementation of profession-wide initiatives

The devolved structure of surgical training, where surgical training is delivered through the Specialty Societies, is unique amongst medical colleges. This creates complexity in delivering a consistent training program across all specialties. It also contributes to

[4] Accreditation Report: The Training and Education Programs of the Royal Australasian College of Surgeons. Australian Medical Council. 2017

[5] External Review – Complaints: Discrimination, bullying and sexual harassment. Report to CEO. Jane Seymour, Counsel. 2020.

governance issues because while RACS has accountability for surgical standards and Trainee wellbeing, it has no little direct involvement in training delivery.

In this devolved structure, each Specialty Society sets its own policies and procedures in areas such as selection of Trainees, training curricula and assessment, and Supervisor selection and support.

RACS and the Specialty Societies have worked more closely together in recent years, with regular meetings between Societies and RACS at both staff and committee levels. However, not all Specialty Societies take up the opportunity to implement common initiatives. For example, a recent proposed Learning Plan to enable Trainees to set goals for each placement, was rejected by the Board of Surgical Education and Training (BSET).

A cooperative relationship between RACS and the Specialty Societies is key to implementation, not only of new curricula or assessment approaches, but of many aspects of college-wide initiatives such as the Building Respect Action Plan or the Diversity and Inclusion Plan. The challenge, both for RACS and the Specialty Societies, is working with a variety of approaches towards implementation, target setting and monitoring of complex initiatives to achieve a consistent, safe, and appropriate model of training delivery.

Workplace practices contribute to some poor behaviours

The 2021 Prevalence Survey Report (Attachment 8) shows that the type of behaviours being reported as DBH have changed in the six years since the first Prevalence Survey. The trend has been away from the more overt behaviours such as shouting or physical aggression towards microaggressions such as undermining, belittling and humiliation. A strong theme emerging from the interviews indicates that a contributing factor to these behaviours could be local workplace practices.

Interviewees gave examples including unpaid overtime, weekend work, inequitable decisions about leave applications, poor accommodation, inequitable rostering-sometimes regarding the type of cases allocated, other times regarding inappropriate expectations of working hours. These practices contribute to a negative perception of the workplace culture and a stressful training experience. A build-up of several practices contributes to feeling of being '*bullied*'.

Other practices including lack of workplace recognition of Supervisors, including expectations that this role will be performed for no payment without allocation of sequestered time for supervision, exacerbate the issues in surgical training.

RACS' power to make changes in workplaces is limited to its ability to implement accreditation standards for training posts. However, there is a significant opportunity for RACS to leverage its strong reputation and form partnerships with hospitals to address these issues.

4. Conclusions and Recommendations

4.1 Conclusions

The Action Plan has been very positively received both within RACS membership and externally amongst its stakeholders and peers. Knowledge regarding respectful behaviours is now widespread across the surgical profession, with more people talking about respectful behaviours in the workplace. Attitudes towards diversity and what is regarded as acceptable behaviour are changing towards an expectation of professional behaviours. RACS has contributed to these positive changes, within a globally and locally changing societal context where unprofessional behaviours are no longer tolerated. Whilst there is strong support for continued messages about Operating With Respect, there is an indication of messaging fatigue and a need for refreshing of messages.

Behaviour, a long-term goal of the Action Plan, is already beginning to change towards the desired outcomes. Many of the more blatant behaviours such as shouting or violence have decreased, however there are now reports of behaviours often described as micro aggressions including undermining, humiliation, and belittling. Reports of sexual harassment have increased, to now include behaviours that are less conspicuous and may not have been widely acknowledged as sexual harassment in the past. As expected, there is a gap between knowledge and behaviour, with variations in people's level of confidence to take action when witnessing or experiencing an incident. Many people, including some in influential leadership positions, remain unaware of the impact of their own behaviours on others. Some RACS leaders are not modelling respectful behaviours, and this is having an impact on the credibility of the Action Plan messaging.

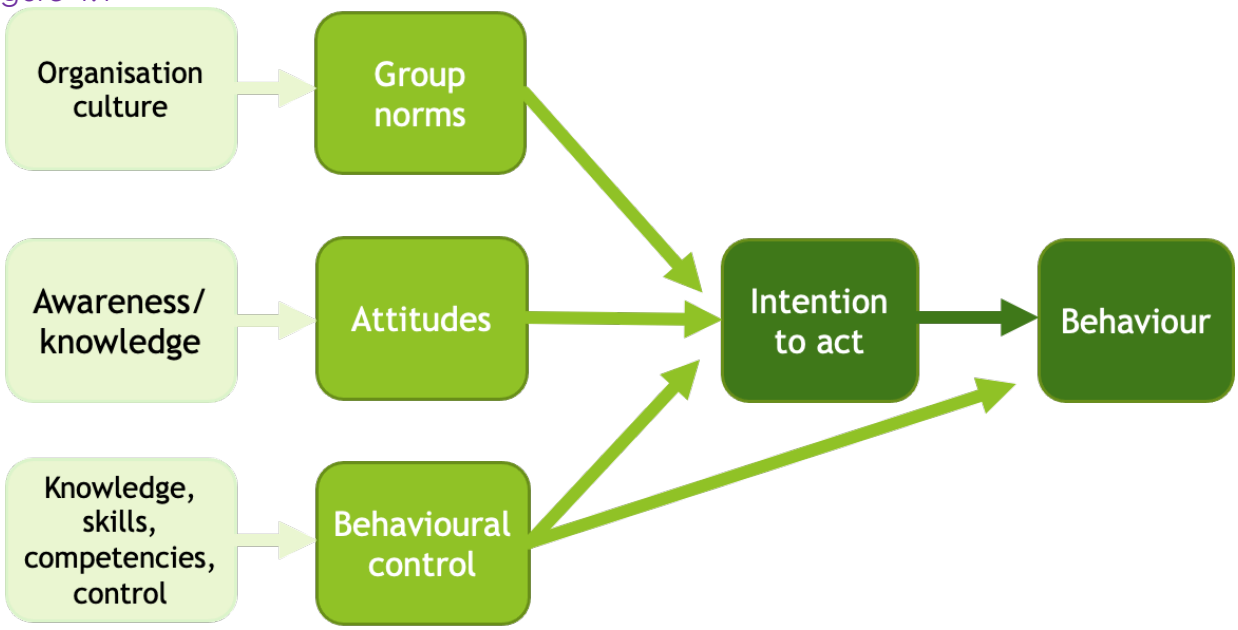
The revised complaint system and limitations of RACS's powers are still not well known and there remains a historical expectation that RACS could do more about this issue. Complaints processes, both within RACS and at workplaces, are still poorly trusted due to fears of repercussions on careers and reputations. Surgical training is a locus for reports of unprofessional behaviours, with systemic and structural issues contributing to the problem.

External stakeholders are implementing cultural improvement programs within their own workplaces and are keen to partner with RACS on multidisciplinary approaches to cultural change. The strength of support, both internally and externally, provides an opportunity for RACS to leverage off the work to date to develop the next phase of the Action Plan.

4.2. Recommendations

The recommendations from this evaluation have been developed to inform the next Building Respect Action Plan. They are based on the three areas of action to influence behaviour, as highlighted in the behaviour change model[6], in Figure 4.1.

Figure 4.1



1. Influence organisation culture to build desired group norms

1.1 Leverage RACS' reputation and the global momentum for workplace change to form external partnerships to align messaging and address systemic barriers to respectful behaviours in workplaces.

1.2 Work in partnership with employers and governments to promote workplace environments (policy and cultural) that position '*calling it out*' as normative and supported behaviour.

1.3 Ensure the surgical workforce more closely represents the diversity of the community.

1.4 Work in partnership with Specialty Societies to reduce the contribution to unacceptable behaviours of systemic and structural issues in surgical training.

[6] Based on the Theory of Planned Behaviour, Kan M.P.H., Fabrigar L.R. (2017) Theory of Planned Behavior. In: Zeigler-Hill V., Shackelford T. (eds) Encyclopedia of Personality and Individual Differences. Springer, Cham. https://doi.org/10.1007/978-3-319-28099-8_1191-1

2. Influence awareness to build desired attitudes

2.1 Leverage the strengths and successes of the Operating With Respect communications by continuing the strong messaging, and address fatigue by refreshing messaging content.

2.2 Clarify messaging about surgical selection to ensure understanding that the diversity and inclusion process does not jeopardise surgical standards.

2.3 Improve trust and understanding of the RACS complaints process, by clarifying messaging about its limitations, how it operates in practice, and reporting on deidentified outcomes where possible.

2.4 Disseminate evidence of effective locally developed actions that impact on culture change and patient safety.

3. Influence knowledge, skills, and competencies to improve perceptions of behavioural control

3.1 Focus skill building activities on bridging the gap between knowledge and behaviour.

3.2 Expand delivery of OWR face to face training to include all surgeons, to more comprehensively equip the surgical workforce to call out unprofessional conduct with their peers.

3.3 Provide practical modelling, training, resources, and communications to support surgical leaders to gain skills in the critical success factors for leading to achieve cultural change.

3.4 Provide training and communication to increase surgeon insight into the need for respect of non-surgical team members to underpin optimal team performance and patient outcomes.

4. Ensure transparent governance and agile implementation

4.1 Underpin the new Action Plan with a commonly agreed Theory of Change, measurable outcomes and a revised Monitoring and Evaluation Framework.

4.2 Incorporate Action Plan outcomes into Key Performance Indicators for RACS leaders and incorporate responsibility for managing behaviours into all RACS committee chair roles.

4.3 Monitor the impact of the Action Plan on surgical culture by conducting an annual cultural snapshot using a simplified prevalence survey.

4.4 Develop monitoring and progress reports in appropriate detail for each governance level, including an outcomes-based dashboard for Council.

4.5 Regularly review monitoring reports and adapt implementation priorities according to findings and context.

5. Attachments

Attachment 1: Building Respect, Improving Patient Safety Action Plan

Attachment 2: Building Respect Program Logic Model

Attachment 3: Building Respect Program Evaluation Framework

Attachment 4: Stakeholder Engagement Plan

Attachment 5: Evaluation Survey Questions

Attachment 6: Semi-structured Interview Questions

Attachment 7: Definitions and Common Terminology

Attachment 8: 2021 Prevalence Survey Report

Attachment 9: 2021 Prevalence Survey Questions

Attachment 1: Building Respect, Improving Patient Safety Action Plan

https://www.surgeons.org/media/22260415/RACS-Action-Plan_Bullying-Harassment_F-Low-Res_FINAL.pdf

Attachment 2: Building Respect Program Logic Model

The issue

In 2015, the Royal Australasian College of Surgeons (RACS) established an Expert Advisory Group (EAG) to investigate the extent of discrimination, bullying and sexual harassment within the surgical profession. EAG research revealed widespread discrimination, bullying and sexual harassment in the practice of surgery. This is of concern for the wellbeing of individual surgeons and surgical trainees, of surgical teams and especially for the quality of care and safety of patients.

The response

RACS responded by apologising to all people affected by these unacceptable behaviours, accepting all of the EAG's recommendations and developing an Action Plan, *Building Respect, Improving Patient Safety,* which outlines how RACS intends to counter and drive out these unacceptable behaviours from surgical practice and surgical training.

Values underpinning the Action Plan

- Every healthcare worker has the right to a workplace free of unacceptable behaviours and every student/Trainee has the right to an education free of unacceptable behaviours.
- Patient safety should be the absolute and common priority in the workplace and every patient has the right to expect that their healthcare will not be compromised by unacceptable behaviours.
- Every applicant, trainee and surgeon has the right to be treated equally and with respect, regardless of their gender or cultural background.
- Teams work most effectively when there is respect for the skills, experience and contribution of each member.
- The success of work-based teams is measured by the safety of the workplace and the educational environment and by the extent to which all team members recognise that what they achieve together is more valuable than anything they can achieve on their own.

The vision of RACS' Action Plan

The Action Plan's vision is *to build a culture of respect in surgical practice and education*, which will contribute towards:

1. Improved patient safety.
2. Surgical workplaces that are safe and free from unacceptable behaviours.
3. A surgical profession that is more representative of the cultural and gender diversity across the community.

Cultural Change and Leadership					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Revise and introduce new policies and procedures which incorporate standards of respectful behaviour and value diversity and collaborative practice Lead the surgical profession (Surgical Training Boards, RACS Committees and Specialty Societies) on introduction of policies and practices that promote respectful behaviours	Principles, policies, procedures, codes of conduct, terms of reference, RACS Code of Conduct, Standards of behaviour Terms of reference for Training Boards revised to include external representatives, access to medical education experts, female surgeons and Trainees	Implementation of a structure and policy framework to underpin desired behaviours Fellows, trainees and IMGs are aware of the expected standard of conduct	Specialty Societies, Specialty Society Training Boards and RACS collaborate on incorporation of respectful behaviours into policy and practice More diverse membership of Specialty Societies, Specialty Society Training Boards and RACS committees including external, non-surgical representatives	Fellows, trainees and IMGs feel safer and less at risk of unacceptable behaviours and more confident to speak up about unacceptable behaviours The membership of RACS reflects the diversity of the general community	
RACS Diversity Plan published and communicated Conduct cultural competency training promoting awareness of Aboriginal and Torres Strait Islander, and Maori culture	Targets established for the involvement of female surgeons in leadership positions, such as on Training Boards and as examiners System of monitoring, reporting and acting on the rates of application, selection and attrition Cultural competence training programs conducted	RACS Diversity and Inclusion Plan developed and disseminated Diversity principles are communicated to RACS employees, partners, selection and training bodies and the whole surgical profession Barriers to provision and uptake of flexible training options are identified Diversity opportunities are communicated to Trainees Regular review of monitoring data on the rates of application, selection and attrition to identify barriers for women, Aboriginal and Torres Strait Islanders, Maori, and people from other diverse cultural backgrounds in surgical training and RACS committees	Trainees are aware of opportunities for flexible training and more confident to seek these out Increase in flexible options for surgical training (eg part time placements) Review of training program and selection process to address identified barriers The applicant field for surgical training is increasingly diverse	More women and culturally diverse surgeons, trainees, IMGs and Fellows remain in surgical training Reduced barriers based on gender or culture for entry to or progression within the surgical profession RACS becomes the industry leader in facilitation and promotion of flexible training opportunities	

Cultural Change and Leadership					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Conduct communication, awareness raising and capacity building activities to increase recognition of and skills in managing unacceptable behaviours	*Let's operate with respect* campaign, posters, blogs, newsletter articles, promoting training courses, events, presentations, speakers, commentators, research	Fellows, Trainees and IMGs can recognise unacceptable and reportable behaviours in themselves and others Fellows, Trainees and IMGs understand the need to address unacceptable behaviours in themselves and others Fellows, Trainees and IMGs understand the need to demonstrate professional behaviours Open discussion of what constitutes 'respectful' and 'unacceptable' behaviour	Fellows, Trainees and IMGs have the confidence to address unacceptable behaviours Fellows Trainees and IMGs have the required skills to speak up about unacceptable behaviours Fellows, Trainees and IMGs observed engaging in unacceptable behaviours receive constructive feedback	Fellows, Trainees and IMGs take appropriate action to address unacceptable behaviours in themselves and others Fellows, Trainees, IMGs and patients perceive a fair and safe surgical workplace People who work with surgeons perceive improvement in teamwork, collaboration and communication	
Develop and progress implementation of models for collaboration with hospitals, governments and universities in Australia and New Zealand on programs to incorporate respectful behaviours Lead and create partnerships within the health sector in Australia and New Zealand to improve management of unacceptable behaviours	Recognition of common goals, roles and responsibilities with partner organisations MOUs with collaborating orgs Established partnerships	Increased cooperation / collaboration with hospitals, governments and employers about prevention and management of unacceptable behaviours Increased communication and sharing of knowledge on respectful behaviours across organisations and within the profession Active engagement of the RACS Surgical Directors Section and STANZCommittees and Boards Established agreements, MOUs and SOIs with partner organisations	Development of joint or aligned processes for cultural change programs Development of joint or aligned processes for complaints management and sanctions Organisations employing or training surgeons collaborate to improve standards of behaviour and training Government policies in Australia and New Zealand consistent with the goals of this Action Plan Alignment and information sharing with MOU partners (within the law) about complaints management	MOU partner organisations, where surgeons work, align policies, practices and management of unacceptable behaviours with the principles of the Vanderbilt model Hospitals and other employers of surgeons, who are MOU partner organisations, actively support RACS initiatives in building a respectful culture Successful pilot models and strategies are progressively shared with and promoted to other hospitals and employers Hospitals and other employers of surgeons, who are MOU partner organisations, effectively implement and actively monitor respectful behaviour policies and action plans	

Cultural Change and Leadership					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Advocate for integration of respectful behaviour training into medical training	Dialogue with universities about respectful behaviour training	Medical schools incorporate respectful behaviour training and its links to patient safety as part of the curriculum	SET-1 Trainees begin their surgical training with knowledge and skills about respectful behaviour	Acceptance across SET Trainees of the relationship between patient safety and respectful behaviour RACS is recognised as a leader in promoting respectful behaviour in surgical practice	
Monitor, evaluate and continuously improve the *About respect* program of work	Evaluation framework developed Planned evaluations conducted Repeat DBSH prevalence surveys every five years Publication of annual reports and activities reports	RACS systematically gathers data to measure the effectiveness and impact of the Action Plan Data analysis leads to understanding of program effectiveness and identifies areas for improvement / refinement Pilot programs are evaluated RACS' activities in building a culture of respect are transparently reported to members Data gathered to monitor FTI's understanding of the need for and importance of the Action Plan	The Action Plan is adapted and improved as part of continuous improvement activities and response to progress and the changing context Learning from Pilot programs is used to extend successful models to other locations Learning from pilot programs is used to inform FTIs of the need for and importance of the Action Plan	A culture of continuous improvement is reinforced within RACS Fellows, Trainees and IMGs are aware of the Action Plan and support its requirements and achievements	
Ensure appropriate governance and oversight of the Action Plan	Regular reports within RACS to Council, CEO and management	Transparent and accountable processes in place to oversight the implementation of the Action Plan	Action plan principles are embedded in the RACS strategic plan thus becoming normal business	All RACS activities incorporate respectful behaviours as a matter of course Respectful behaviours are normalised across the surgical profession	

Surgical Education					A culture of respect in surgical practice and education
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	
Establish training in respectful behaviours as a mandatory component of continuing professional development and in Surgical Education and Training (SET) Provide face to face advanced training (OWR) in respectful behaviours to all members of Training Boards and other major committees of RACS, including surgical, IMG and research supervisors/assessors Conduct training on respectful behaviours and provision of constructive feedback for Fellows, trainees, IMGs, Training Boards and RACS Committees Develop advanced feedback module for surgical educators Develop Surgical Leadership Program for surgeons Improve FSSE course to include training in respectful behaviours and provision of constructive feedback for Fellows involved in surgical education	Mandated training via e-learning module (Operating with Respect) for all Fellows, IMGs and Trainees on identifying, preventing and taking action on unacceptable behaviours and on building a respectful culture Face to face OWR course is mandated for surgical supervisors and trainers, IMG assessors, Training Boards and RACS Committees. Advanced feedback module piloted Surgical Leadership course developed Train the trainer courses for OWR trainers Mandated FSSE course for all surgical supervisors and trainers and IMG assessors includes training in providing respectful and constructive feedback to trainees	Fellows, IMGs and Trainees recognise unacceptable behaviours in themselves and others and increase their understanding of respectful behaviours Fellows, IMGs and Trainees appreciate that professional behaviours are a determinant of patient safety Surgical educators and IMG assessors gain skills in identifying and addressing unacceptable behaviours Surgical educators and IMG assessors understand their professional obligations regarding respectful behaviours Surgical educators and IMG assessors increase their knowledge of how to provide respectful, constructive and effective feedback to trainees Surgeons have access to leadership training Increased capacity to deliver the OWR course to a broader audience Feedback from Trainees and IMGs indicates that surgeons are becoming better educators Continuous monitoring of FSSE, specifically on outcomes relating to provision of feedback	Fellows, IMGs and Trainees gain skills in identifying and addressing unacceptable behaviours More people feel confident in speaking up about unacceptable behaviours Surgical educators and IMG assessors provide respectful, constructive and effective educational feedback to trainees, in line with new policies Fellows in leadership positions accept that they have a responsibility for addressing unacceptable behaviours by regulating their own behaviours and modulating the behaviour of others Advanced feedback module is accessible to surgical educators Faculty members feel adequately prepared to teach the OWR and FSSE courses Course participants perceive the courses as credible and high quality	Integration of respectful behaviours within surgical education is normalised Training in respectful behaviours becomes normalised and embedded in all training curricula Trainees recognise the values underpinning RACS surgical education Increased retention of trainees Decreased attrition of trainees due to unacceptable behaviours Surgical leaders model respectful behaviours and advocate for these behaviours in the workplace Respectful and constructive feedback is normalised Trainees seek out and value feedback from their supervisors	

Surgical Education					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Revise accreditation standards for surgical education posts to include respectful behaviours	Agreed accreditation standards across all Training Boards Agreed safe and confidential pathways for communicating training concerns to Specialist Training Boards and RACS	New standard for respectful behaviour is included in the accreditation guidelines Accreditation of training posts in hospitals includes respectful behaviours Safe and confidential pathways for identifying and addressing concerns about behaviours in educational posts are developed, defined and communicated Model for conducting bi-annual reviews of training posts is developed	RACS, Training Boards and hospitals understand their roles and responsibilities in addressing behavioural issues Trainees are aware of processes for raising concerns about behaviours Bi annual review of training posts conducted and de-identified results published RACSTA survey shows improvement of educational experience against the accreditation standards	Responsibilities between hospitals and RACS are aligned and consistent All surgical education posts demonstrate respectful behaviour standards and agreed complaints resolution processes Trainees feel safe and confident to raise concerns RACS acts on the findings of surgical education surveys	
Establish a process for independent review of training rotations for SET	Agreed model for RACS-led independent reviews of training rotations	Development of criteria to trigger a review Specialist Training Boards support the training rotation review process Pilot methodology established	Process for independent review of training posts established Independent reviews of training rotations conducted Learnings from pilots inform model development and improvement Improved review model implemented	Agreed and sustainable model achieved Stakeholders are confident in the review methodology The training environment is optimised Trainee satisfaction with SET improves Trainee attrition reduces	
Establish a process for independent review of IMG training rotations	Agreed model for IMG reviews	Development of criteria to trigger a review Pilot methodology established Reassessment process is standardised and transparent	Process for independent review of IMG training posts established Independent reviews of IMG training rotations conducted Learnings from pilots inform model development and improvement Improved review model implemented	Agreed and sustainable model achieved Stakeholders are confident in the review methodology The training environment is optimised IMGs are confident in the system IMG attrition reduces	

Surgical Education					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Ensure independent review of SET selection processes to support diversity of surgical trainees	SET selection panels modified to include external, non-medical panel members	Selection weightings are revised Selection interviewers are trained Consistent selection principles are applied across selection panels	An industry approach to knowledge, skills and attributes is implemented SJTs are piloted Template referee reports are developed and introduced	Selection into SET is transparent and consistent Reduced SET attrition rates	
Ensure the surgical education training (SET) program includes a focus on building resilience and managing stress	Evidence-informed resources, self-assessment tools, are identified and made available Accreditation standards for evidence-informed external courses are agreed Courses, tools in building resilience and managing stress/ personal wellbeing developed and made compulsory within SET program. Resilience and managing wellbeing is integrated into the SET program	External courses and tools are identified and appropriately accredited Trainees have access to appropriate courses and tools to gain skills and awareness about building resilience	Trainees are aware of the importance of resilience to support their own wellness Trainees gain skills and awareness of methods to build resilience	Trainees consistently demonstrate more resilience in maintaining professional behaviour Resilience becomes part of surgical training and feedback Resilience and stress management are recognised as a necessary component of surgical skills	

Surgical Education					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	
Develop respectful behaviour standards for all surgeons involved in education and supervision of research Provide underperforming supervisors with a remedial education plan to improve skills	Explicit standards developed for all surgeons involved in education and supervision of research Standards promoted to Fellows Formal assessment process against standards is established Processes established for individual coaching to support behaviour change	Fellows are aware of and understand how to comply with the standards of professional behaviour Standards for surgical supervisors incorporate respectful behaviours	Fellows have the skills to remain professional and respectful when under stress Fellows access individual coaching Underperforming supervisors are identified in a formal assessment process Underperforming supervisors participate in educational programs and individual coaching for behavioural change	Fellows comply with identified standards of behaviour Individuals who do not meet the standards are managed appropriately, including through individual support for behavioural change as needed Underperforming supervisors show improvement after support and intervention from the Boards and RACS RACS recognises that some surgeons are not suited to supervision and leadership	**A culture of respect in surgical practice and education**
Review selection criteria for all supervisors to include training as educators including respectful behaviours Provide underperforming supervisors with a remedial education plan to improve skills	Defined standards for heads of departments, supervisors and other senior positions, include demonstration of leadership regarding respectful behaviours New selection criteria for all supervisors (including training as educators, understanding respectful behaviours and dealing with concerns of unprofessional behaviour) Within two years Training Boards review all supervisors to ensure that underperforming supervisors are being provided with remedial education plan to improve skills Educational, coaching and support programs established for underperforming supervisors	Leadership positions are increasingly filled by people who demonstrate respectful behaviours Supervisory positions increasingly filled by people who demonstrate respectful behaviours	Leaders comply with and are accountable to identified standards of behaviour Supervisors comply with and are accountable to identified standards of behaviour Underperforming supervisors are identified in a formal assessment process (through Trainee feedback/multi-source feedback (MSF)/complaints mechanisms) Underperforming supervisors participate in educational programs and individual coaching for behavioural change	Appointments to hospital leadership positions have regard to the RACS standards Underperforming supervisors show improvement after support and intervention from the Boards and RACS	

Surgical Education					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Advocate for integration of respectful behaviour training into pre-vocational training	Dialogue about respectful behaviour training with pre-vocational medical councils, hospitals and networks	J-Docs program administrators recognise the importance of respectful behaviours as part of surgical practice	Pre-vocational training incorporates respectful behaviours and its links to patient safety as part of the curriculum SET-1 Trainees begin their surgical training with knowledge and skills about respectful behaviour	Acceptance across SET Trainees of the relationship between patient safety and respectful behaviour RACS is recognised as a leader in promoting respectful behaviour in surgical practice	
Develop policies, procedures and systems for introduction of Multi source feedback (MSF)	Clear criteria developed and in place for the successful introduction of MSF inclusive of respectful behaviours MSF introduced in reviews of all Trainees, supervisors, surgical department heads Systems established to ensure feedback is recorded, acknowledged and used to improve quality A program for Trainees to engage constructively with feedback is developed	Pilot activities are conducted to define the most appropriate model of MSF for surgical education and training Post-Pilot review by Training Boards of all pilot supervisors to ensure they are using MSF	Learnings from pilot inform development of MSF model for upscaling across the profession Adequate resources provided to support implementation of MSF Supervisors across the surgical profession begin to participate in training about MSF Supervisors understand how to provide constructive feedback using MSF	MSF is implemented across the profession Supervisors provide constructive feedback to trainees through MSF Trainees engage constructively with MSF feedback MSF is evaluated and adapted for continuous improvement of the program MSF is the standard approach for reviews of all trainees, supervisors, surgical department heads	

Surgical Education					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Review IMG assessment process Ensure cultural awareness is incorporated into assessment and management of IMGs Review composition of IMG committee	Composition of IMG assessment panels reviewed Training on unconscious bias provided to IMG supervisors An independent review process is established for all Trainees and IMGs placed on probation to ensure all cultural issues are being addressed IMG Committee membership is diverse and includes representatives external to RACS Dedicated ongoing support for IMGs provided	Increased independent oversight of IMG assessment Position established for a Clinical Director IMG Assessment and Support IMG assessment panels are composed of more diverse people, including people external to RACS Clear, culturally sensitive criteria are developed for assessment of IMGs IMGs on probation are provided with constructive and culturally effective feedback for improvement	Cultural issues are addressed when reviewing trainees and IMGs Process for mitigating unconscious bias established in IMG assessment Implementation of the 2 Day Work-based Assessment approach	IMG assessment meets AMC accreditation standards for cultural competence	
Explore and understand the percentage of women choosing surgery as a career	Research methodology developed Research findings / insights available to inform future work	Research undertaken to explore and understand barriers for women in choosing surgery as a career Research undertaken into reasons for leaving surgical training	Key barriers to participation and completion of surgical training are understood and addressed	More women participate in and complete surgical training	
Advocate for and facilitate flexible training opportunities for surgical training	CBME principles support flexible training	RACS engages with jurisdictions to advocate for provision of flexible training Training regulations and accreditation standards appropriately reflect the provision of flexible training	Trainees access flexible training options	Flexible training for all surgical trainees is destigmatised and seen as acceptable	

Complaints Management					
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	**A culture of respect in surgical practice and education**
Develop effective, fair and timely complaint mechanisms that are consistent with best practice Establish a framework of accountability for taking, and reporting on, the actions and outcomes arising from complaints to participants in the process Conduct communication and awareness raising activities about complaints procedures and available support Work in partnership with hospitals and other health sector organisations to develop a commonly understood approach to sanctions, including mechanisms for identifying, preventing and eliminating illegal and inappropriate behaviour and reporting surgeons as needed	Revised RACS Code of Conduct and sanctions policy Introduction of centralised lodgement, assessment, co-ordination and ongoing oversight of complaints across all specialities of the College, including complaints about surgical practice, education and behaviour. Clear and straightforward information about complaints management is accessible centrally Provide external expert mediation for complaints where required Provide support for investigations, when mediation fails Oversight by independent review including the appointment of an external reviewer Communication to all stakeholders about the changes to the policy and about the process	Fellows, trainees and IMGs are aware of avenues for making complaints about unacceptable behaviour Development and implementation of supports for people experiencing unacceptable behaviour Complaints confidentiality is strengthened Complaints management is centralised within RACS External reviewer appointed to review College processes and make recommendations where processes not followed or are inadequate	Fellows, trainees and IMGs are aware of supports for people experiencing unacceptable behaviour Fellows, trainees and IMGs experiencing unacceptable behaviour have improved access to support Fellows, trainees and IMGs are more confident to make complaints Recommendations from external review of complaints management are implemented for program improvement Improved feedback from surgeons and complainants about the RACS complaints process. Surgeons subject to a complaint learn from the process and change their behaviour External stakeholders are aware of the revised policy and process	Workplace culture supports the effective and timely reporting and management of unacceptable behaviour Calling out unacceptable behaviour is normalised in the surgical workplace Reduced recidivism regarding unacceptable behaviours	

Complaints Management					A culture of respect in surgical practice and education
Activities	**Outputs**	**Short-term Outcomes**	**Intermediate outcomes**	**Long-term outcomes**	
Establish a Peer Support program for respondents and complainants	Promotion of Peer Support program to Fellows, Trainees and IMGs Supports for behavioural change provided	Complainants and respondents receive peer support throughout the process	Fellows, Trainees and IMGs who are the subject of a complaint are supported to change their behaviour Fellows, Trainees and IMGs who have received peer support perceive it as a useful intervention	Fellows, trainees and IMGs have increased confidence and trust that the complaints process has been fair	
Monitor complaint issues/trends, resolution rates and user satisfaction to inform continuous improvement and improve the quality and effectiveness of complaint mechanisms and make further interventions as needed.	All complaints received are effectively recorded and monitored Data about complaints is recorded centrally and reported regularly User satisfaction is regularly monitored and reviewed	Consistent with privacy and confidentiality principles, complaints and their outcomes are publicly reported including Activities reports, Annual report User satisfaction measures or indicators are introduced	User satisfaction data informs process improvements User satisfaction data is published	User satisfaction in the complaints process continues to increase Continuous improvement is incorporated into the complaints process	

Attachment 3: Building Respect Program Evaluation Framework

Questions	Indicators	Data Source
PHASE 2: 2020 • Measure whether program implementation (delivery of policy framework to underpin respectful behaviours; education initiatives; complaints management process); governance and oversight are proceeding as intended. • Measure whether short-term outcomes (awareness of standards of respectful behaviour and approaches to address unacceptable behaviours; key partnerships formed; better educator skills; focus of surgical education on principles of respect, transparency and professionalism) are being achieved as intended. • Identify program strengths, what is working well, barriers to progress. • Make recommendations on areas for program adjustment or improvement, based on findings.		
KEQ 1: Has the Action Plan been implemented as intended to date?		
1.1 Have the program elements been delivered according to the plan to date?	% Milestones developed and delivered against annual workplans % D and I Plan delivered to target D&I Plan integrated into RACS strategic plan Perceptions of RACS staff, Exec, Councillors of implementation progress	Annual BR workplans Building Respect progress reports D&I targets and workplans D&I reports RACS Strategic Plan Terms of reference of RACS Boards and Committees Key informant interviews
1.2 Are the program elements reaching the intended audiences?	Attendance at events/courses or digital substitutes % completion rates for training courses Evidence of engagement with partners	Education attendance and completion reports Changed COVID plan Partner engagement data
1.3 What are the reactions of the program's target audiences to the program activities?	FTI perceptions of/attitudes to the Action Plan activities (Training, messaging, Diversity Plan etc) Perceptions of program target partners of the Action Plan activities (MOU, information sharing)	Evaluation survey Key Informant Interviews

Questions	Indicators	Data Source
1.4 What are the barriers/enablers for program implementation?	Perceptions of RACS staff, FTIs, potential program partners about program barriers/enablers	Evaluation survey Key Informant Interviews Building Respect reports
1.5 Have there been any unintended consequences, positive or negative, of program activity?	Perceptions of program staff, RACS, FTIs, program partners	Evaluation survey Key Informant Interviews Building Respect reports Publications (Media and professional reports)
KEQ 2: Is program governance and oversight effectively supporting delivery of the Action Plan?		
2.1 Is the program appropriately resourced?	Perceptions of Councillors, Exec and program staff	Key Informant Interviews
2.2 Is program progress being appropriately monitored?	Perceptions of Councillors, Exec and program staff Evidence of monitoring and review against milestones Monitoring of application, selection and attrition trends Evidence of monitoring of complaints, including perceptions of users Evidence of identification of career barriers to women, and people of Aboriginal and Torres Strait Islander or Maori background Evidence of identification of barriers to implementation of flexible training Pilot methodology for independent reviews of training rotations for IMGs and SET processes implemented	Building Respect workplans and reports D&I reports Key Informant Interviews Council/CEO reports
2.3 Are adjustments being made to the program in light of emerging data trends and/or practical barriers?	Evidence of program amendment in response to evaluations, recommendations of external reviews, emerging trends and issues Perceptions of Councillors, Exec and program staff	Building Respect reports External review reports RACS response to external reviews/evaluations Key Informant Interviews
2.4 Is RACS reporting transparently to members and the public about progress towards building a culture of respect?	Annual public reporting on program activity Reporting of trends in complaints and outcomes FTI and partner perception of transparency re BR program	Annual and activities reports Building Respect reports RACSTA Survey Evaluation survey Key Informant Interviews

Questions	Indicators	Data Source
KEQ 3: To what extent has awareness of the standards for respectful behaviour increased across the surgical profession?		
3.1 Can Fellows, Trainees and International Medical Graduates identify unacceptable behaviours?	% FTIs, surgical educators and IMG supervisors who recognise unacceptable and reportable behaviour in themselves and others Perception of Training Board and RACS Committee members on what constitutes unacceptable and reportable behaviour Perception of program partners on what constitutes unacceptable and reportable behaviour % FTIs, surgical supervisors, IMG supervisors aware of concept of unconscious bias	Evaluation survey Key Informant Interviews
3.2 Can Fellows, Trainees and International Medical Graduates identify what constitutes respectful behaviours?	% Fellows, Trainees and IMGs, surgical educators and IMG supervisors aware of the expected standard of professional behaviour % Fellows, Trainees and IMGs, surgical educators and IMG supervisors aware of how to comply with expected standards of professional behaviour % Fellows, Trainees and IMGs, surgical educators and IMG supervisors and partners aware of RACS' diversity goals Surgical educators and IMG supervisors' self-perception of how to provide respectful and constructive feedback to trainees	Evaluation survey Key Informant Interviews
3.3 Have attitudes towards unacceptable behaviours changed across the surgical profession?	Perception of FTIs on whether respectful behaviours have entered open discussion % FTIs and surgical educators, IMG supervisors, Training Board and RACS Committee members and partners who recognise the need to address unacceptable behaviours in themselves and others % FTIs and surgical educators and IMG supervisors who recognise the need to demonstrate professional behaviours % FTIs and surgical educators and IMG supervisors who recognise the need for and importance of the Building Respect Action Plan FTI perceptions of whether supervisory and leadership positions are increasingly filled by people who demonstrate respectful behaviours	Evaluation survey Key Informant Interviews Usage statistics for support App for OWR Utilisation of low level intervention conversations- key informant interviews

KEQ 4: To what extent are RACS processes to manage unacceptable behaviour working as intended?		
4.1 Has RACS provided information about mechanisms, supports and pathways to address unacceptable behaviours to Fellows, Trainees and International Medical Graduates?	Evidence of implementation and dissemination of complaints mechanisms, supports, pathways for addressing unacceptable behaviours Evidence that the RACS complaints user feedback process is actively operating Evidence of dissemination of information about potential outcomes of complaints	Messaging in newsletter, website, letters, user guide RESPECT webpage Building Respect reports External complaints review report
4.2 Are Fellows, Trainees and International Medical Graduates aware of avenues to address unacceptable behaviours?	Awareness of FTIs of complaints mechanisms, supports, pathways for addressing unacceptable behaviours (informal, hospital, RACS and regulatory pathways) Perception of availability of information about complaints management Perceptions/awareness of target audience of updated RACS complaints process	Evaluation survey Key Informant Interviews
4.3 Is the RACS complaints management process appropriate, transparent and fair?	External review findings re compliance and process FTI perceptions of confidentiality, safety and fairness	External review of RACS complaints process Evaluation Survey Key informant interviews Results of Medical Training Survey

Questions	Indicators	Data Source
KEQ 5: To what extent have relationships of trust, confidence and cooperation on Discrimination, Bullying, Sexual Harassment issues supported progress towards RACS Action Plan goals?		
5.1 Have partnerships with employers, health departments, university medical schools and others recognised common goals, roles and responsibilities?	Evidence of development of mechanisms to facilitate DBSH and complaints information sharing Evidence of dialogue with university medical schools University curricula include appropriate respectful behaviour and its links to patient safety Respectful behaviour module incorporated into prerequisites for surgical training Perceptions of RACS staff and external partners of barriers and enablers for partnership	University curricula Reports from regions Prerequisite documents Key Informant Interviews (Judy, John, External partners)
5.2 Have internal partners (eg Specialty Training Boards and Specialty Societies) committed to the RACS Action Plan vision?	Increased engagement by RACS STBS and Committees with Action Plan principles New committee members complete required training Action Plan values and principles reflected in TOR and supporting plans and documentation	Key Informant Interviews New supervisor standards New RACS competencies
KEQ 6: To what extent has surgical education incorporated the principles of respect, transparency and professionalism?		
6.1 Have surgical educators gained skills in providing respectful and constructive feedback to trainees?	Trainees and Fellows perceptions of surgical educator skills	RACSTA Survey Evaluation survey Key Informant Interviews Cultural competency pillar
6.2 Are surgical educators delivering feedback to trainees in a more timely, constructive and respectful manner?	Trainees and Fellows perceptions of surgical educator skills	RACSTA Survey Evaluation survey Key Informant Interviews 2020 MTS results – in Feb 2021 will be able to see RACS against national benchmarks

Attachment 4: Stakeholder Engagement Plan

Objective
To hear and understand the breadth and depth of views of Fellows, Trainees, SIMGs, RACS staff, Councillors and external stakeholders on issues relating to the scope of the evaluation.

Approach
A mixed methods approach is best practice. For this evaluation we have designed the following:

1. QUAL → 2. QUANT → 3. QUAL

1. The first step was to conduct 12 open ended interviews with a range of representative stakeholders to identify the issues and experiences from their perspective. Representatives were purposively sampled from each stakeholder type: Fellows, Trainees, SIMGs, staff, Councillors, and external stakeholders for their ability to provide insights and stories of their experience. This allowed us to ensure all further data collection was based on issues grounded in the real experience of stakeholders and not from the assumptions of the evaluator. Data from this step of the process has been presented in qualitative form, as themes.

2. Analysis of the themes and issues supported development of an online evaluation survey which was sent out to all females, all Trainees and SIMGs and a randomly selected sample of male Fellows, a total of 4780 people. This provided the breadth of information about the issues, i.e. it answers the question '*what is happening*'. This approach also ensures broad range of Fellows, Trainees and SIMGs have been given the opportunity to have a voice in the evaluation, whilst minimising survey fatigue where possible. Data from this step of the process has been presented in quantitative form, as graphs and tables.

3. Once the evaluation survey was analysed, we had a broad understanding of the views on particular issues. This provided an insight into areas where further exploration may be needed, to gain an answer to the question '*why is this happening?*' For this step of the process, 44 interviews were conducted (via zoom) with randomly selected Fellows, Trainees, SIMGs, and Councillors, and purposively selected RACS staff and Executives, and external stakeholders. We used stratified random sampling, to ensure a representative mix of gender and location across all groups, and that selection was not biased. But it is important to note that this was a qualitative exercise, to gain deep dive insights into the issues highlighted by the survey. Data from this step of the process was presented in qualitative form, as themes.

4. After the data were analysed, further engagement occurred through validation meetings with members of the Project Reference Group, and feedback was incorporated into the final findings and recommendations. Findings were also presented to RACS Council, Building Respect Implementation Group and the EAG.

5. Findings were disseminated via publication of the evaluation report; by presentations to the EAG, Council and BSET; and via a podcast interview with the evaluator.

Attachment 5: Evaluation Survey Questions

RACS Action Plan: *Building Respect, Improving Patient Safety*: Phase 2 Evaluation Survey

Thank you for taking part in this short survey.

This survey is part of an evaluation of our work to build respect in surgery. Your feedback will check that our work is on track and starting to make a difference. It will also make sure what we do next is relevant and effective.

This survey will take between X and Y minutes to complete.

Please take a few minutes to give us your feedback. It will make a difference to what we do next.

Questions?
If you have any questions about this survey, please contact the evaluator, Ruth Friedman at ruth@thethreadconsulting.com.au

Privacy and confidentiality
Your answers are strictly confidential. The information gathered from this survey will not be identifiable. We will aggregate the results and use the information to improve our work. The final report will be made available to all Fellows, Trainees and SIMGs of the College.

You can raise a concern about bullying, sexual harassment, discrimination or harassment by calling the RACS Complaints and Feedback office for a confidential discussion: 1800 892 491(Australia) or 0800 787 470 (New Zealand).

Please do NOT report or cite a specific concern about bullying, sexual harassment, discrimination or harassment in this survey. This survey cannot respond or assist you.

More information about RACS Feedback and Complaints process is detailed here https://www.surgeons.org/about-racs/feedback-and-complaints

Confidential support

The RACS Support Program, provided by Converge International, offers confidential support to RACS members and their families, at no cost. To access this service, please identify yourself as a Fellow, Trainee or SIMG of RACS.

Telephone: 1300 687 327 Australia or 0800 666 367 New Zealand

Email eap@convergeintl.com.au

Appointments available from 8.30am – 6.30pm Mon-Fri (excluding public holidays)
24/7 emergency telephone counselling is available.

This survey will close on Monday 22nd March 2021.

Demographics

My age
Under 30
30-40
41-50
51-60
61-70
71+

My location
New Zealand
Australia

I describe my gender as
Male
Female
In another way

My status with RACS (Please tick one)
Fellow < 10 years
Fellow > 10 years
Surgical Trainee
Specialist International Medical Graduate

My involvement with RACS (Please tick all that apply)
Not involved
RACS Committee member
Specialty Training Board member
RACS Councillor
Surgical supervisor
Surgical trainer
SIMG assessor
Other

My specialty
Cardiothoracic Surgery
General Surgery
Neurosurgery
Orthopaedic Surgery
Otolaryngology Head and Neck Surgery
Paediatric Surgery
Plastic and Reconstructive Surgery
Urology
Vascular Surgery

Thinking about <u>your views on RACS' work</u> to build a culture of respect in surgery, how strongly do you agree or disagree with the following?
(1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know)

I support RACS' commitment to building respect in surgery.
I support RACS' leadership on this issue.
I support RACS' work to increase indigenous representation in surgery.
I support RACS' work to increase gender diversity in surgery.
I support RACS' work to increase flexible training opportunities in surgery.
Improving surgical education is an important way to address unacceptable behaviours in surgery.
It is important for RACS to keep working with others to address unacceptable behaviours in surgery.
The **<u>frequency</u>** of communications from RACS to the Fellowship about respectful behaviours has been appropriate.
The **<u>content</u>** of the messages from RACS about respectful behaviours has been appropriate.
Work to build a culture of respect continues to be relevant.

Thinking about <u>the way RACS reports on its work</u> to build respect in surgery, how strongly do you agree or disagree with the following?
(1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know)

I receive enough information from RACS about progress towards building a culture of respect across surgery.
I receive relevant information from RACS about progress towards building a culture of respect across surgery.

Knowledge, attitude and behaviour

Thinking about <u>what you know</u> about respectful behaviour, how strongly do you agree or disagree with the following?
(1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know)

I know how to comply with the RACS Surgical Competence and Performance Guide in relation to respectful behaviour.
I know how to provide constructive feedback to my team, peers and Trainees.
When receiving feedback, I can recognise the difference between difficult feedback and unacceptable behaviour.
I can recognise unacceptable behaviour **in others**.
I can recognise unacceptable behaviour **in myself**.
I know what to do to address unacceptable behaviour **when I see it**.
I know what to do to address unacceptable behaviour **when I experience it.**
I am aware that my personal biases could influence my behaviour.
I am aware of RACS' diversity goals.
I support RACS' diversity goals.
I am aware of the connection between my behaviour and patient safety.

Thinking about how you feel about respectful behaviour, how strongly do you agree or disagree with the following?
(1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know)

I feel confident to call out unacceptable behaviours in colleagues and peers.
I accept the need to demonstrate respectful behaviours.
I support increasing flexible training opportunities in surgery.
I support increasing indigenous representation in surgery.
I support greater gender diversity in surgery.
I recognise the need to address unacceptable behaviours **in my colleagues and peers.**
I recognise the need to address unacceptable behaviours **in myself.**
I feel confident about giving feedback to my peers, Trainees or SIMGs.

Thinking about your general perceptions about how people around you behave in the workplace, how strongly do you agree or disagree with the following?
(1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know)

My colleagues comply with the RACS Surgical Competence and Performance Guide in relation to respectful behaviour.
My colleagues provide constructive feedback to their team, peers and Trainees.
When receiving feedback, my colleagues recognise the difference between difficult feedback and unacceptable behaviour.
My colleagues address unacceptable behaviour **when they see it**.
My colleagues address unacceptable behaviour **when they experience it.**
My colleagues demonstrate support for RACS' diversity goals.
My peers demonstrate respectful behaviours.
Supervisors and leaders in my workplace demonstrate respectful behaviours.
People in leadership positions at RACS demonstrate respectful behaviours.
Surgical educators provide respectful, timely and constructive feedback to Trainees.

Thinking about what has changed in your main workplace over the last five years, how strongly do you agree or disagree with the following?
(1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know)

My workplace has introduced training on respectful behaviours.
My workplace has a complaints process for raising concerns about unacceptable behaviours.
My workplace provides flexible working arrangements.
My workplace encourages greater indigenous representation.
My workplace encourages greater gender diversity.

Please describe any major changes in the culture, positive or negative, that you have seen in the workplace, RACS or in the surgical profession over the last five years.

Thinking about lodging a complaint about discrimination, bullying and sexual harassment, how strongly do you agree or disagree with the following?
(1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree; 6 = NA/Don't know)

I know where to find information to help me lodge a complaint.
I know where to find information to help me access support.
I know how to lodge a complaint through RACS, my workplace or another agency.
I am aware of the RACS Support Program provided by Converge International.
I am aware of RACS' revised feedback and complaints process.
I would feel safe raising a concern with RACS.
I would feel safe raising a concern with my workplace.
I would feel safe lodging a complaint through RACS.
I would feel safe lodging a complaint through my workplace.
The RACS feedback and complaints process is confidential.
The RACS feedback and complaints process is transparent.
The RACS feedback and complaints process is fair.

Reflecting on the issues canvassed in this survey, what is the most useful thing RACS could do to build a culture of respect in surgery?

Thank you for your time. Your responses will help RACS build a culture of respect.

Attachment 6: Semi-structured Interview Questions

Fellows, Trainees and Specialist International Medical Graduates (FTS)

Thank you for your time. This interview is part of the evaluation for the Building Respect Action Plan evaluation. The findings from this interview will help inform the evaluation findings.

All your answers will be confidential, only I will know who has been interviewed. The resulting themes will be analysed, collated, and presented in de-identified form. If I quote you, it will be referenced as from a Fellow, SIMG or Trainee.

The final report and its recommendations will inform the next phase of the Building Respect Action Plan. Your contribution will help the College decide what to do next.

Role
Please describe your role and interaction with the College.

KEQ 1 Diversity
What do you see as the challenges to increasing diversity across the surgical profession? (women, indigenous peoples)
What do you see as the challenges to increasing flexible training opportunities across the surgical profession?

KEQ 1 and 5
What do you think of the way the program has been implemented so far?
What do you see as the major successes of the Action Plan?
What are the major challenges for implementing the Plan?
How can they be addressed?
What, if anything, has helped with implementation?
Have there been any unintended consequences from the program? (Thinking about education programs, policies, cultural barriers, complaints, diversity)

KEQ 2
Do you feel adequately informed about RACS' progress in changing the culture?

KEQ 3 Outcomes: Awareness, attitude, behaviour
Do you think FTS have learned what unacceptable/ respectful behaviour looks like in themselves and others?
Does this translate into any changes in behaviour or attitudes in the workplace/or the profession? Training, culture, awareness, feeling safe, likelihood of raising issues, calling it out
Eg. Are you seeing a change in the type of behaviour reported as bullying?
How does this compare with/impact on other disciplines?

KEQ 4 Complaints
People are reporting that they do not feel safe/confident to make a complaint through the RACS/hospital process. They are not supported. Is that your experience?
What would 'support' look like in practice?
What are the systemic barriers for making a notification? Ie Multiple complaints processes, If supervisors are deemed the 'bully' but they are also the assessor.
What practical measures could RACS take to increase confidence in the complaints process in the workplace?
… And for the RACS process?

KEQ 6 Outcomes: Educator skills
Over the last four years, do you think surgical educators have gained skills in providing respectful and constructive feedback to surgical trainees?
Can you give examples?
Have you seen an increase in supervisors and leaders demonstrating respectful behaviours?

RACS CEO, Executive, staff and Councillors

Thankyou for your time. This interview is part of the evaluation for the Building Respect Action Plan evaluation. The findings from this interview will help inform the survey which will go out to FTI, in addition to the evaluation findings.
All your answers will be collated and presented in de-identified form.

Role
Please describe your role and interaction with the College.

Action Plan activities (KEQ 1)
What do you think of the way the program has been implemented so far?
How has the Diversity and Inclusion Plan been implemented?
What do you see as the major successes of the Action Plan?
What are the major challenges for implementing the Plan?
How can they be addressed?
What, if anything, has helped with implementation?
Have there been any unintended consequences from the program? (Thinking about program partners and MOUs, education programs, policies, cultural barriers, complaints, diversity)

Diversity (KEQ 1)
What do you see as the challenges to increasing diversity across the surgical profession? (women, indigenous peoples)
What do you see as the challenges to increasing flexible training opportunities across the surgical profession?

Governance (KEQ 2)
How do you feel the program is tracking? How do you know that? Ie what reports are you getting?
Do you feel adequately informed about the progress of the Action Plan?
What decisions, if any, have been made about changes to the action plan ie in light of emerging information, monitoring or barriers?
What could be improved about the way the action plan is monitored and governed?
Do you think the action plan is appropriately resourced/structured to do this work? (BAU?)
Do you think RACS is reporting transparently to members and others about progress towards building a culture of respect?

Outcomes: Awareness, attitude, behaviour (KEQ 3)
How do you think the target audiences perceive the Action Plan activities? (MOU, information sharing, training, messaging, diversity and inclusion plan)?
Do you think FTIs understand and accept the need to behave professionally?

Outcomes: Educator skills (KEQ 6)
Over the last four years, do you think surgical educators have gained skills in providing respectful and constructive feedback to surgical trainees?
Can you give examples?

Outcomes: Partnerships (KEQ 5)
What have been the challenges in building partnerships with external bodies (universities, hospitals, health departments) to support collaborative agreements and information sharing?
What have been the challenges in building partnerships with Specialty Training Boards re the Action Plan?

Complaints (KEQ 4)
Do you think people feel safe/confident to make a complaint through the RACS process?
What needs to be done to increase confidence in the complaints process?

External partners

Thankyou for your time. This interview is part of the evaluation for the Building Respect Action Plan evaluation. The findings from this interview will help inform the survey which will go out to FTI, in addition to the evaluation findings.
All your answers will be collated and presented in de-identified form.

Relationship to RACS
Please describe your role and interaction with the College.
What do you/ your members know about the College's Building Respect Action Plan?

KEQ 1 and 5
What is your understanding of the reaction of **administration and medical staff/ your members** to the College's activities? (Education, messaging, Diversity Plan, MOUs, information sessions, information sharing re complaints etc)
What, if anything, does your organisation do to promote a more respectful culture?
How does that/could it interact with what RACS is doing?
What do you see as the major successes of RACS in changing surgical culture?
What are the major challenges for changing the culture?

Diversity (KEQ 1)
How do RACS efforts to increase diversity interact with your organisation's?
What do you see as the challenges to increasing diversity across the surgical profession? (women, indigenous peoples)
What do you see as the challenges to increasing flexible training opportunities across the surgical profession?

KEQ 5 What have been the challenges in building partnerships with RACS or other Colleges for improving the culture?
How can they be addressed?
Have there been any unintended consequences from the program? (Thinking about program partners and MOUs, education programs, policies, cultural barriers, complaints, diversity)

KEQ 2
Do you feel adequately informed about RACS' progress in changing the culture?

KEQ 3 Outcomes: Awareness, attitude, behaviour
Do you think surgeons have learned what unacceptable/ respectful behaviour looks like in themselves and others?
Does this translate into any changes in behaviour or attitudes? Is NZ more progressive overall than Australia? What contributes to this?
Eg. Are you seeing a change in the type of behaviour reported as bullying?
How does this compare with/impact on other disciplines?
Have you seen an increase in supervisors and leaders demonstrating respectful behaviours?

KEQ 4 Complaints

People are reporting that they do not feel safe/confident to make a complaint through the RACS/hospital process. They are not supported. Is that your experience?

What would 'support' look like in practice?

What are the systemic barriers for making a notification? Ie Multiple complaints processes, If supervisors are deemed the 'bully' but they are also the assessor.

Are hospital/workplace HR professionals equipped to handle these issues?

With respect to your workplace, what practical measures could RACS take to increase confidence in the complaints process?

… And for the RACS process?

People suggest consequences for bullies, or transparent reporting of outcomes. Is that feasible?

Attachment 7: Definitions and common terminology

Term	Definition
ACN	Australian College of Nursing
ACORN	Australian College of Perioperative Nurses
Action Plan	The RACS *Building Respect, Improving Patient Safety* Action Plan
AMC	Australian Medical Council
ANZCA	Australian and New Zealand College of Anaesthetists
ASC	RACS Annual Scientific Congress
BSET	Board of Surgical Education and Training
Bullying	Unreasonable and inappropriate behaviour that is repeated over time, or forms a pattern of behaviour, that places physical or mental health at risk.
CEO	Chief Executive Officer
CMO	Chief Medical Officer
College	Royal Australasian College of Surgeons
CPD	Continuing Professional Development
DBH	Discrimination, Bullying and Harassment
DBSH	Discrimination, Bullying and Sexual Harassment
Discrimination	Treating a person less favourably on the basis of a legally protected attribute or personal characteristic
EAG	RACS Expert Advisory Group
EGM	Executive General Manager
Evaluation Survey	An online survey containing questions relevant to the evaluation
FSSE	Foundation Skills for Surgical Educators
FTIs	Surgical Fellows, Trainees and Specialist International Medical Graduates

Harassment	Unwanted, unwelcome or uninvited behaviour that makes a person feel humiliated, intimidated or offended based on a legally protected attribute or personal characteristic. Harassment is a form of discrimination.
IRR	Independent Rotation Review
JDocs	Surgical competency framework for junior doctors
Key Informant Interviews	Telephone or face to face interviews with representatives from a range of stakeholder groups
Members	Fellows, Trainees and Specialist International Medical Graduates
MOU	Memorandum of Understanding
MSF	Multi Source Feedback
NZNO	Perioperative Nurses College of New Zealand
OWR	Operating With Respect training course
Prevalence Survey	A survey of Fellows, Trainees and SIMGs which was conducted by RACS in 2015 and again in 2021 (see Attachment 8)
PRG	Project Reference Group (for this evaluation)
RACMA	Royal Australian College of Medical Administrators
RACS	Royal Australasian College of Surgeons
RACSTA	Royal Australasian College of Surgeons Trainees' Association
SET	Surgical Education and Training
Sexual harassment	Unwanted, unwelcome or uninvited behaviour of a sexual nature that makes a person feel humiliated, intimidated or offended.
SIMGs	Specialist International Medical Graduates
SJT	Situational Judgement Test
SOI	Statement of Intent
STANZ	State and Territory Offices of Australia and New Zealand
TOR	Terms of Reference
Unacceptable behaviours	Bullying, discrimination or sexual harassment

Attachment 8: 2021 Prevalence Survey Report

Background

In March 2015, the College established an Expert Advisory Group (EAG) to advise how to deal with discrimination, bullying and sexual harassment (DBSH) across the health sector.

In developing its report, delivered in September 2015, the EAG relied on the results of five forms of research and consultation:

- A prevalence survey to understand the extent of DBSH in the surgical profession.
- Independently conducted qualitative research (personal accounts).
- An organisational survey, independently administered.
- Submissions to an Issues Paper, based on a Background Briefing, which summarised published research on the issues uncovered.
- Independently facilitated online discussions – for College Fellows, Trainees, and Specialist International Medical Graduates.

The College responded to the EAG's recommendations with an Action Plan that includes eight goals, each with multiple actions.

Goal 5 of the Action Plan - Increase transparency, independent scrutiny and external accountability in College activities – includes an action to repeat the DBSH prevalence survey in five years (2020). The original 2015 survey was intended to inform the EAG and to provide a baseline of DBSH prevalence against which to measure progress of the Action Plan outcomes.

The second prevalence survey was carried out in May 2021. The changes between the 2015 and 2021 survey results will provide the College with insights into the impact of its Action Plan and the current DBSH landscape, which will be valuable input into the development of the strategic direction for the next period of the plan.

Comparing the 2015 and 2021 survey results

The 2021 survey was developed to allow, as much as possible, comparison with the 2015 survey. There are key differences between the two surveys which should be considered when interpreting the data:

Survey design

The 2015 survey was the first prevalence survey and asked about respondents' experiences at any time in the past. Some experiences may have been recent, others well in the past. The 2021 survey could not ask the same question without collecting data relating to the same incidents. It was also developed as a potential ongoing monitoring tool for organisational culture. As a result, the 2021 survey asked respondents about their experiences in the last 12 months. The difference in timeframes must be considered when interpreting results. The 2021 survey, with its emphasis on the preceding 12 months, can be considered a valid baseline of DBSH prevalence, against which future surveys could be

- compared. If the 2021 survey is repeated regularly then there will be greater confidence in the results when comparing one survey to its preceding survey.
- The way some questions were asked in the 2015 and 2021 surveys differs and this difference may impact the comparability of results. For example, the 2015 survey split DBSH into its component parts and asked respondents to consider each element – that is, they were asked the same question about sexual harassment, about bullying, about harassment and about discrimination. The 2015 results suggest a degree of overlap in answers, particularly in responses to questions about DBH. It is possible that some respondents were thinking about the same incidents when answering questions about bullying, about discrimination and about harassment, which could have inflated prevalence numbers.
- To reduce duplication of reporting and simplify the survey, the 2021 survey asked questions about sexual harassment, and another set of questions about DBH. Although questions from the two surveys are compared in this report, the different ways that questions were asked must be considered in drawing conclusions about differences or similarities between the two surveys.

Data source and quality

- The 2015 data used in this report was the raw data provided by the external agency which conducted the 2015 Prevalence survey. Not all of the data was available for analysis and comparison with the 2021 survey data, therefore some results are presented as 2021 only. There may also be some minor differences between what is presented here and what has been presented in the 2015 Prevalence Summary Report.

External context

- The 2021 survey was carried out in a time when the COVID-19 pandemic was underway. The pandemic has disrupted many workplaces and job roles, so the workplace context in 2021 is very different to that in 2015. The prevalence as

measured by the 2021 survey may therefore be different, in ways that are hard to predict, than it otherwise would have been had there not been a pandemic.

- Over the period 2015 to 2021, DBSH has gained prominence in the general consciousness because of a number of high-profile incidents and an increase in momentum of public response to DBSH both in Australia and internationally. The raised awareness of DBSH issues in the external environment has likely influenced the way RACS members view their own workplaces and situations and may have contributed to an increase in perceived prevalence compared to the 2015 survey (the 2021 perception of prevalence may be a truer reflection of the underlying prevalence of DBSH). Interpretation of the differences between the two surveys must therefore include consideration of the impact of changes in the external environment.

Impact of the Building Respect Action Plan

- Since 2016, the College has actively trained and informed surgeons about what constitutes unacceptable behaviour and the link with patient safety. These strong messages have been amplified by hospitals taking action to improve workplace culture with their own programs and messaging. These workplace changes must also be considered as factors which impact on individuals' increased awareness of DBSH in 2021 compared to 2015.

Interpreting the graphs

The convention used in this report is that changes or differences in results have been tested for significance at the 5% level. If a difference is said to be significant, it means there is less than a 5% chance that the difference is due to chance or random events.

When reading the graphs, it is important to note whether they are showing results for respondents, i.e. people, or whether they are about reported incidence of unacceptable behaviours, as it is possible for one person to report several incidents. Most of this report shows graphs relating to respondents, with the exception of Figures 14, 15, 16, 17 and 21which refer to reported incidence. All graphs are labelled to indicate the type of data represented.

Survey response

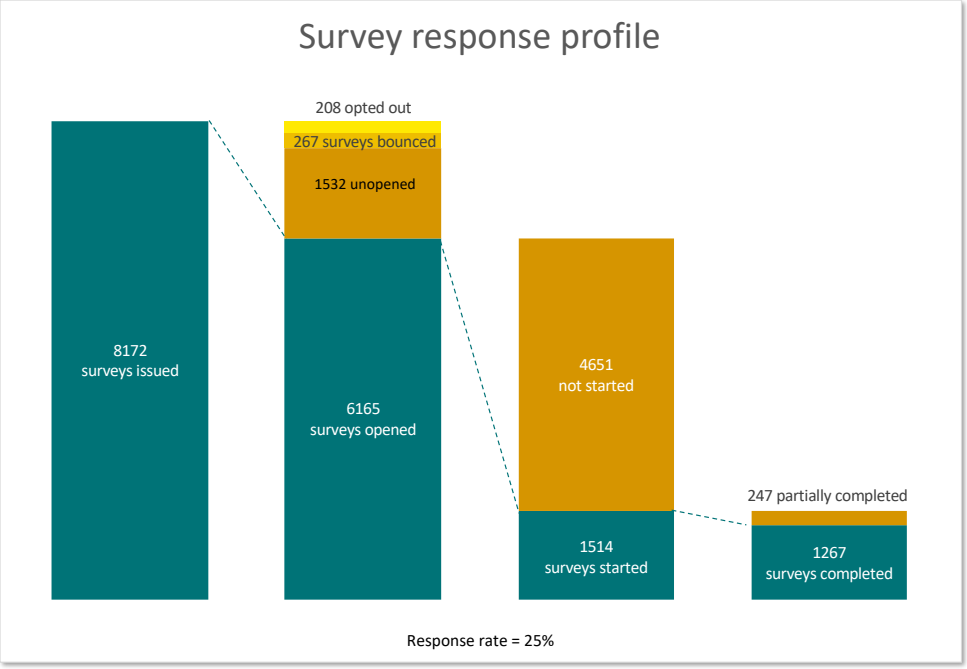
All members of RACS were invited to participate in both the 2015 and the 2021 survey. The 2015 survey involved considerable effort (eleven contacts including letters from the College President and Chair of the EAG) to persuade members to respond and resulted in a very high rate of return of 47.5%.

The 2021 survey resulted in 1514 members responding, which translates to a 25% response rate. Figure 1 shows the response profile. Of the 8172 emails sent, 267 bounced, 208 members opted out and 1532 did not open their email. Of the 6165 members who opened their email, 1514 members started the questionnaire.

The difference in response rates between 2015 and 2021 can be attributed to survey fatigue (members were asked to respond to many surveys in 2021), and the fact that the 2021 survey was statistically based, which means it focused on receiving enough responses to satisfy a margin of error of ±5% at 95% confidence[7].

The final margin of error for the whole group of respondents is ±2.3%. In other words, for whole group answers, the reader can be 95% confident that the results for the RACS membership are within ±2.3% of the survey result.

Figure 1. Response profile of 2021 prevalence survey

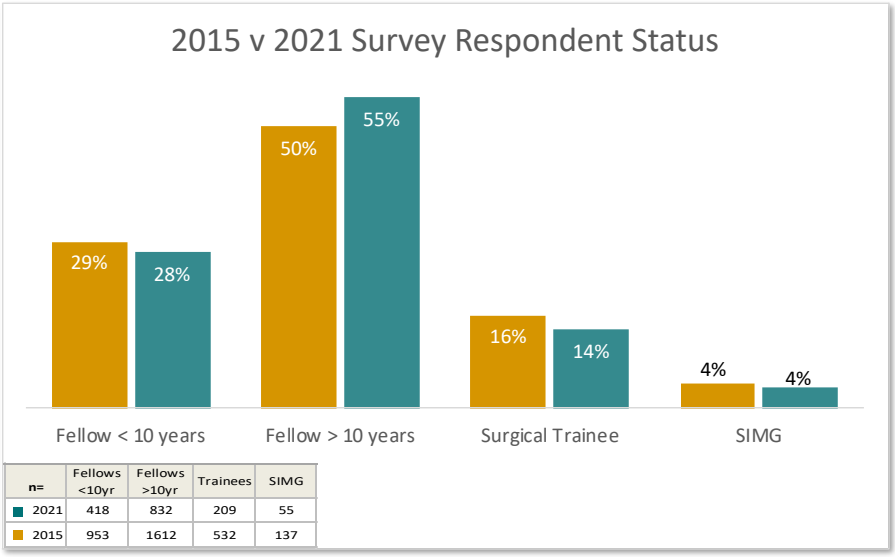


[7] A margin of error of ±5% at 95% confidence is standard for social surveys like the prevalence survey. A margin of error at 95% confidence means that the reader can be 95% confident that the result for the whole population is within ±5% of the survey result. The margin of error increases as sample size reduces, which means that the margin of error when considering, for example, just Trainees, would be larger than 5%.

The survey profiles are similar in terms of RACS status and speciality.

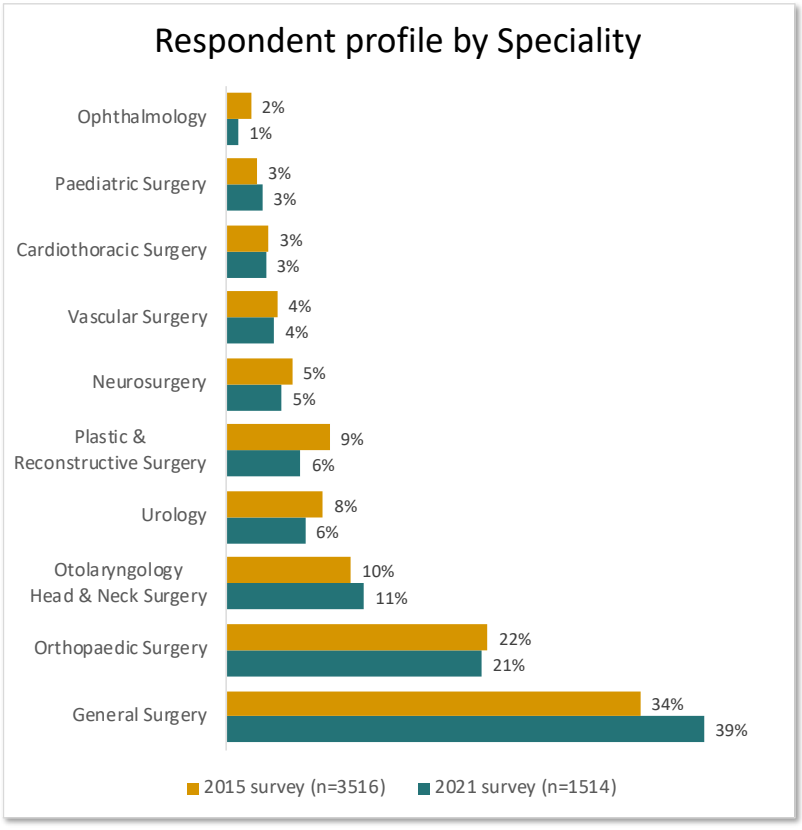
Figures 2 and 3 show that the profile of survey respondents was similar in both the 2015 and 2021 surveys.

Figure 2. Status of survey respondents



n=	Fellows <10yr	Fellows >10yr	Trainees	SIMG
2021	418	832	209	55
2015	953	1612	532	137

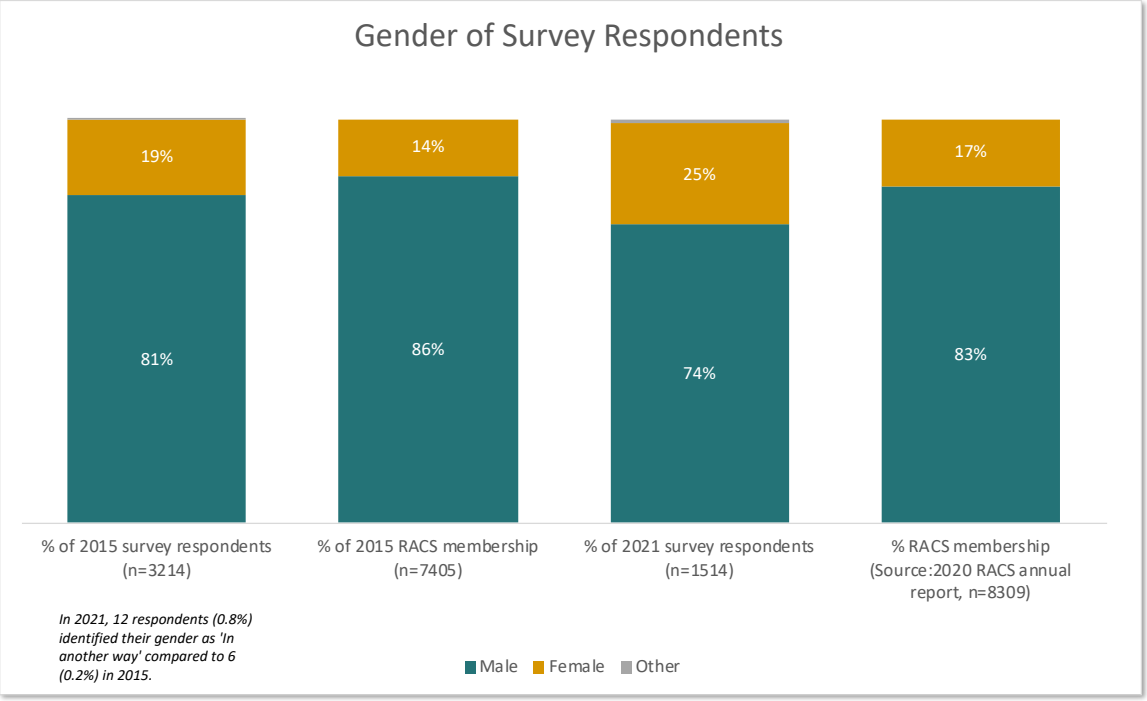
Figure 3. Specialities represented



Females responded in greater proportion in 2021 than in 2015

Figure 4 shows that females responded in greater proportion to their membership numbers in 2021 (25% to 17%) than they did in 2015 (19% to 14%). The increase is statistically significant.

Figure 4. Female members responded in greater proportion in 2021

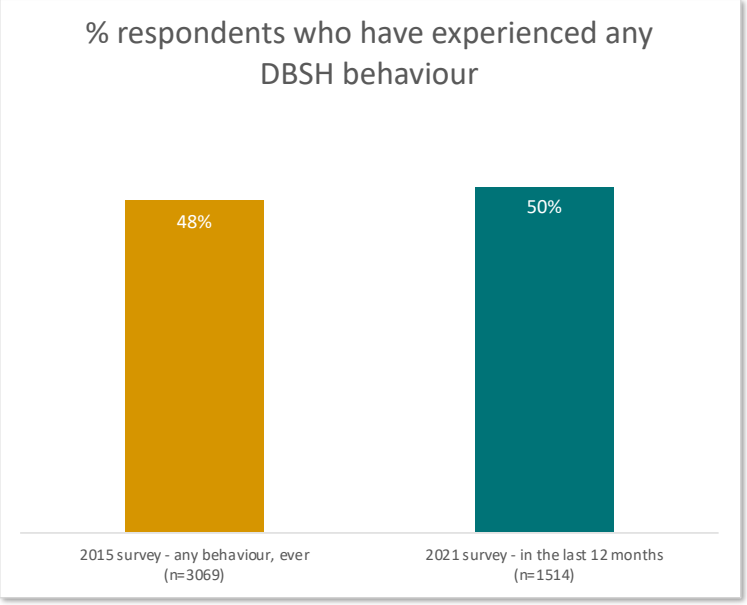


Prevalence

The overall reported prevalence of DBSH was similar in 2015 and 2021

Figure 5 shows that, in both 2015 and 2021, approximately half of the survey respondents reported experiencing some form of DBSH during the periods surveyed. (2021 results refer to the last 12 months).

Figure 5. Overall prevalence



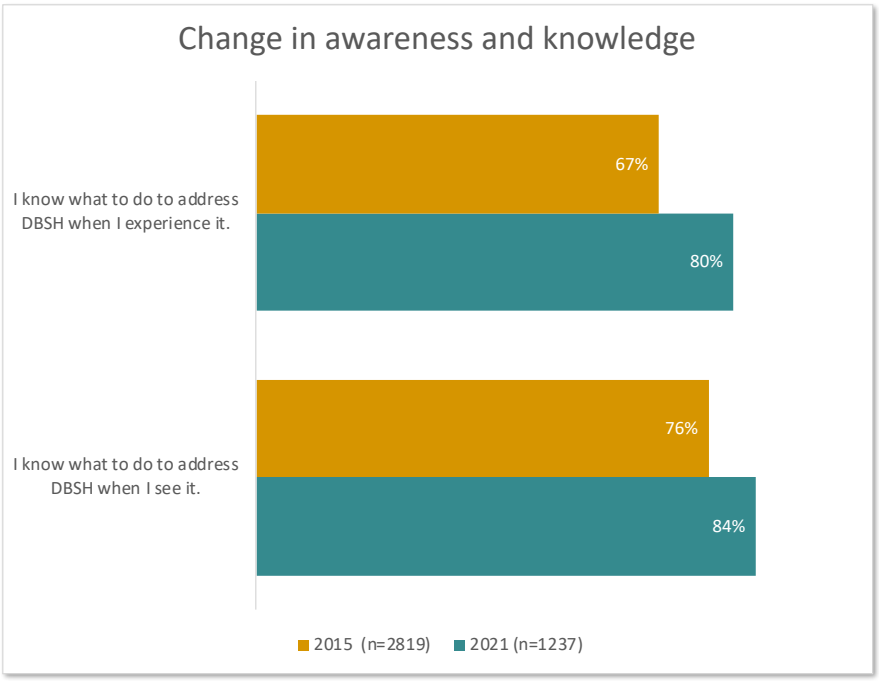
Whilst we cannot directly compare these findings for the reasons outlined above, there does not appear to have been any change in the overall prevalence results - 48% of respondents reported in 2015 that they had experienced at least one incident of DBSH while 50% of respondents reported DBSH in 2021 - the difference is not statistically significant.

At first this result is at odds with expectations. The College has undertaken considerable leading-edge work in addressing DBSH since 2015, and it is reasonable to expect that it would impact the incidence of DBSH and show a decline in prevalence from 2015 to 2021.

One explanation for the apparent lack of change is highlighted by Figure 6, which shows that since 2015 there has been a significant increase in both awareness of and knowledge about behaviours that constitute DBSH. An increase in awareness and knowledge means that members are more likely to recognise and classify a particular behaviour as unacceptable in 2021 than they were in 2015, and so the reported rate is more likely to increase or remain static than to decrease. Some observations can also be made in light of the changed environmental context. The increased normalisation of discussion regarding unprofessional conduct and patient safety may also underpin an increased predisposition to report it. A similar phenomenon occurs in crime prevention – it is well established that the more aware people are of crime related issues the more crime is reported, even when other crime statistics show a

decreasing trend.[8] It is possible that the 2015 figures may be an understatement of the level of DBSH.

Figure 6. Awareness and knowledge have increased

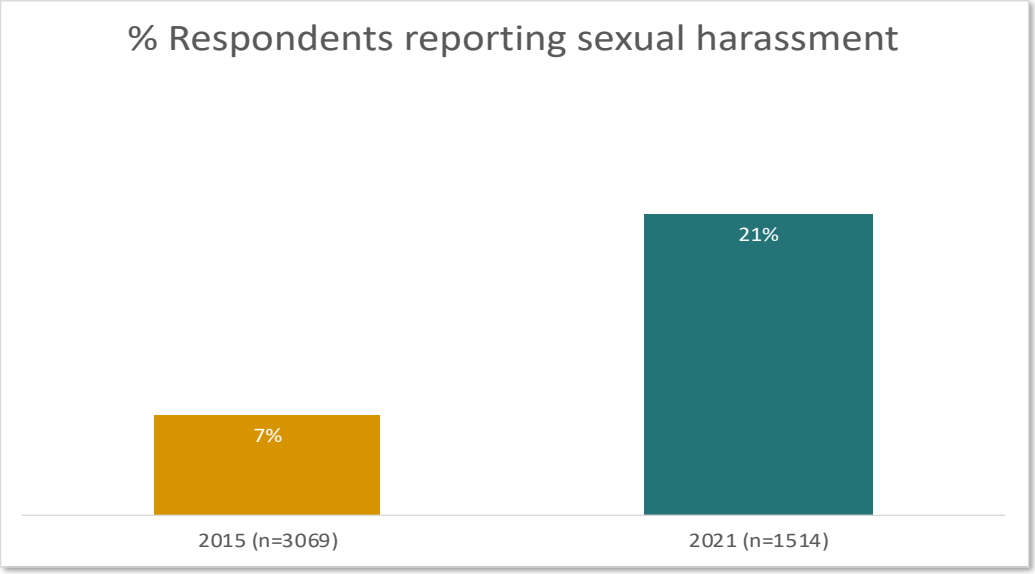


[8] Bricknell S 2008. Trends in violent crime. Trends and issues in crime and criminal justice, Australian Institute of Criminology, No. 359. https://www.aic.gov.au/sites/default/files/2020-05/tandi359.pdf

Reporting of sexual harassment has increased

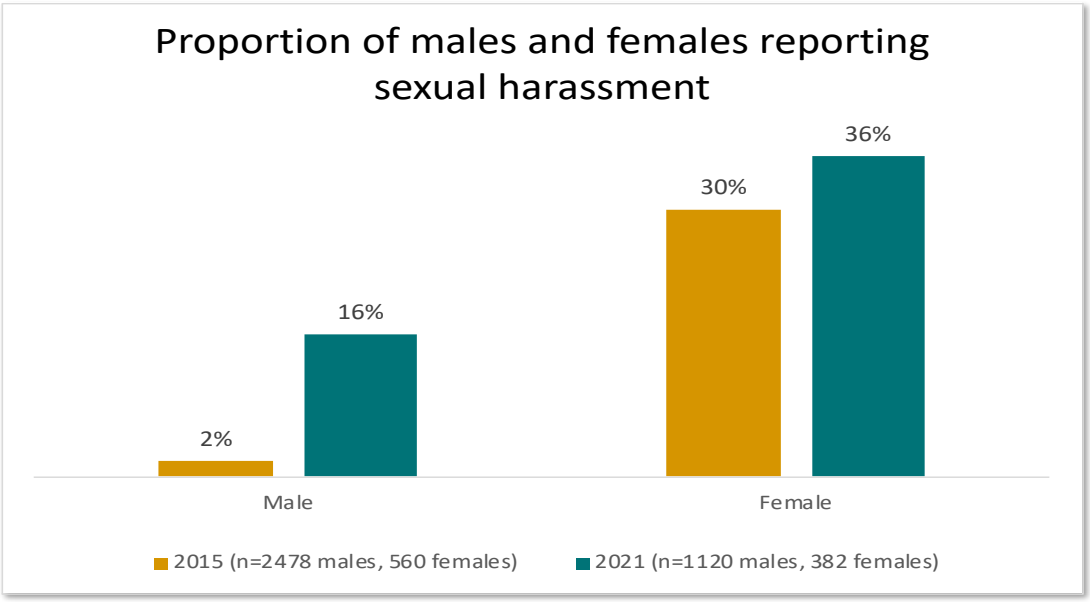
Figure 7 shows that the incidence of reported sexual harassment has increased significantly. In 2015, 7% of respondents said they had experienced sexual harassment at some time while in 2021, 21% of respondents reported they had experienced sexual harassment within the last year.

Figure 7. Reporting of sexual harassment has increased



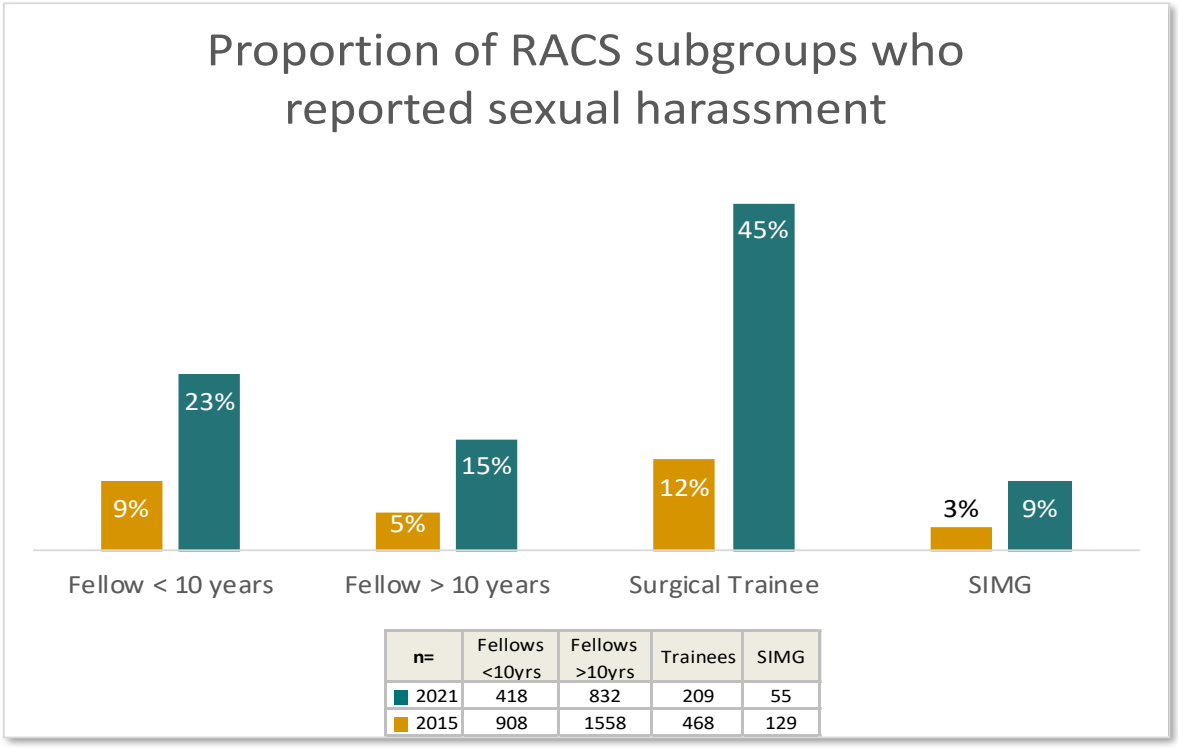
Most of the increase in reported sexual harassment in 2021 has come from reporting by males (from 2% in 2015 to 16% in 2021 of male respondents reporting incidents of sexual harassment), although the rise in females reporting sexual harassment from 30% to 36% of female respondents is also significant and females experience much higher levels of sexual harassment overall (Figure 8).

Figure 8. Males account for most of the increase in reported sexual harassment



Further analysis of the 2021 sexual harassment data (Figure 9) shows that sexual harassment increased for all subgroups, but increased the most for Trainees, from 12% of Trainee respondents in 2015 to 45% in 2021.

Figure 9. Breakdown of sexual harassment result

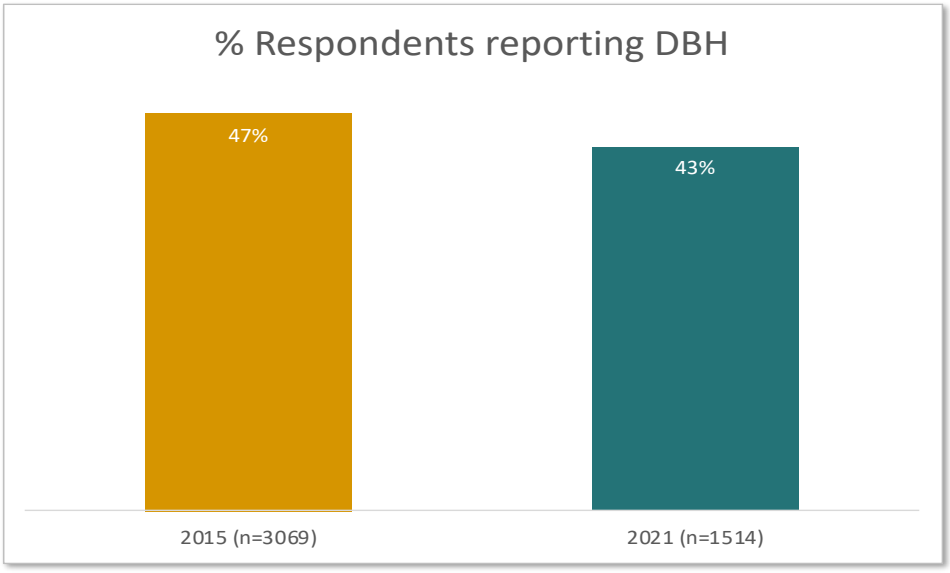


n=	Fellows <10yrs	Fellows >10yrs	Trainees	SIMG
2021	418	832	209	55
2015	908	1558	468	129

Reporting of DBH has decreased

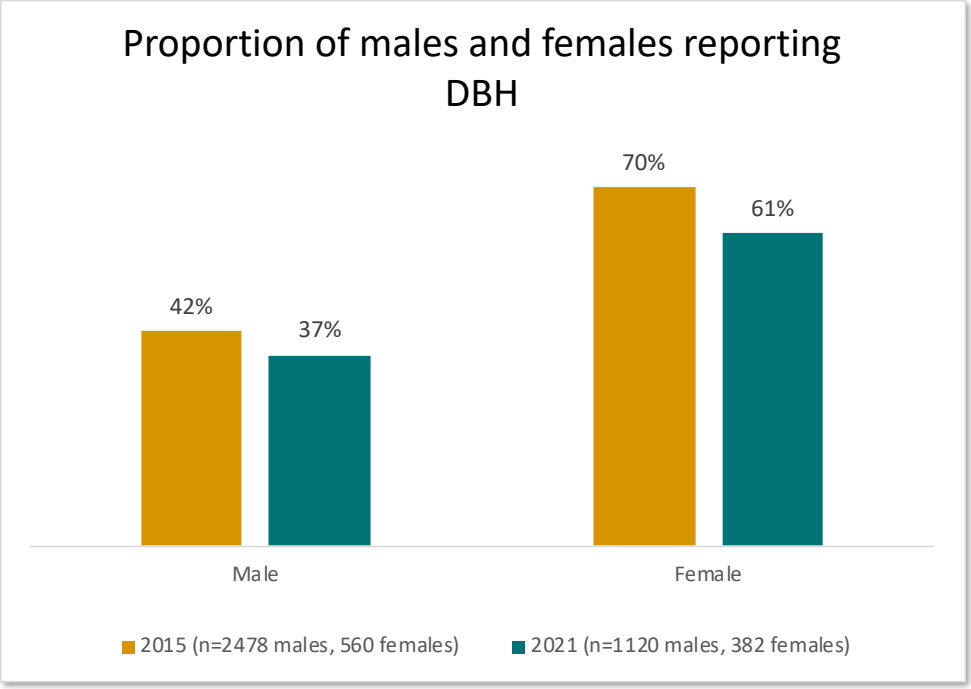
Reporting of discrimination, bullying and harassment has decreased from 47% of respondents in 2015 to 43% in 2021.

Figure 10. Reported discrimination, bullying and harassment has decreased



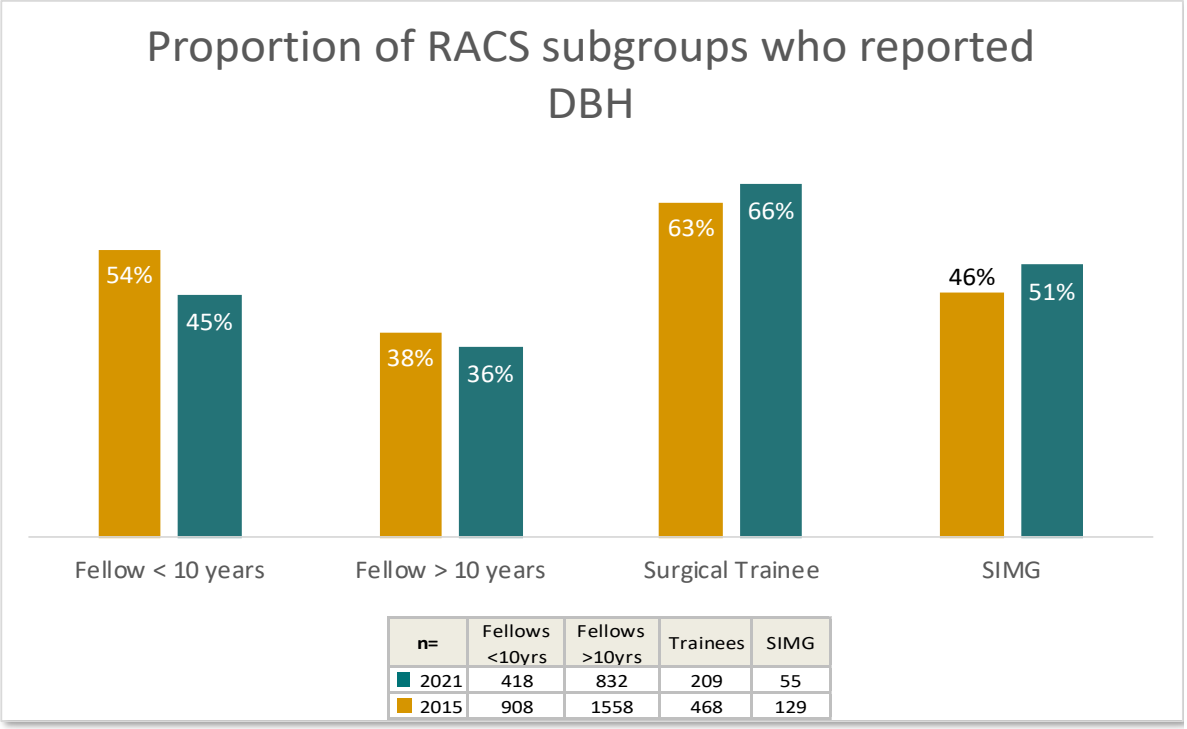
Further analysis showed a significant decrease in reports of DBH for both genders (Figure 11).

Figure 11. Decrease in DBH males and females



However, Trainees and SIMGs reported a significant increase in DBH (Figure 12).

Figure 12. Breakdown of DBH result

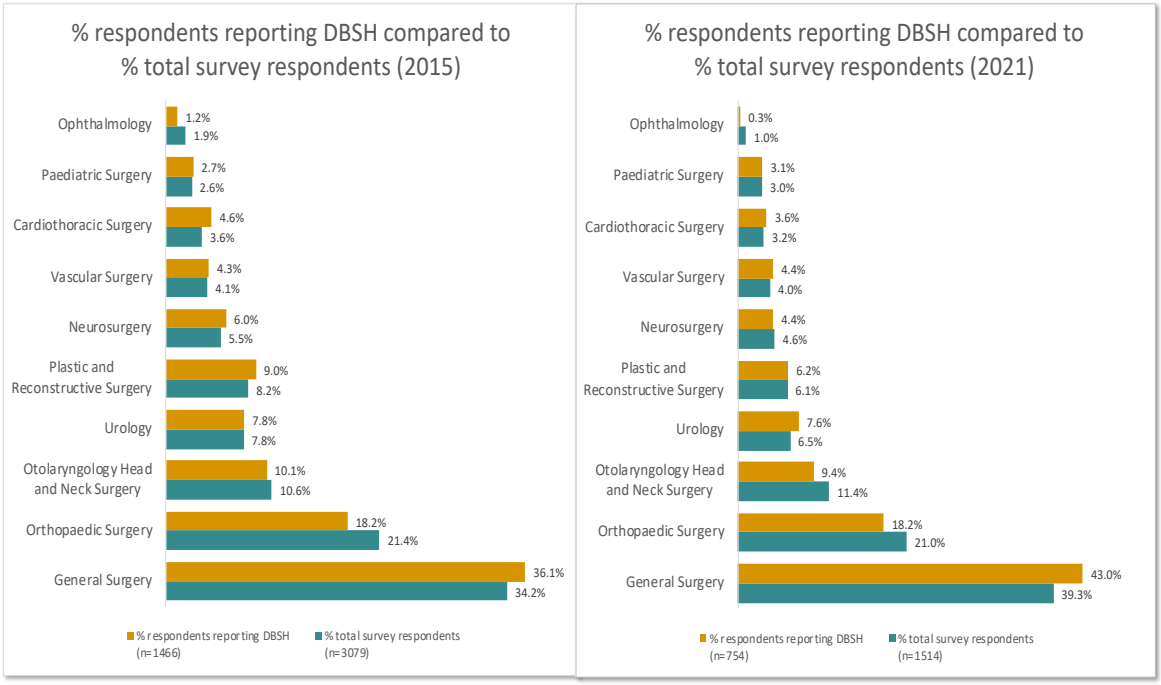


n=	Fellows <10yrs	Fellows >10yrs	Trainees	SIMG
2021	418	832	209	55
2015	908	1558	468	129

Prevalence was analysed by speciality (Figure 13). The 2015 results are shown on the left, the 2021 results on the right. In both graphs the orange bars show respondents who experienced DBSH as a percentage of overall DBSH reported in the survey. The green bars show the percent of survey respondents in each speciality.

If the prevalence of DBSH were similar across specialities, then the orange bars (% DBSH reported) would be approximately the same as the green bars (% survey respondents).

Figure 13. Prevalence within each speciality



The results show that although General Surgery made up 39% of survey respondents, 43% of people who reported experiencing DBSH were from General Surgery, a larger proportion than would be expected.

In contrast, Orthopaedic Surgery makes up 21% of survey respondents but only contributes 18% of reported DBSH. Otolaryngology Head and Neck Surgery is also different to General Surgery, with a lower reporting of DBSH (9%) than expected compared to its proportion of survey respondents (11%).

Insights into DBSH

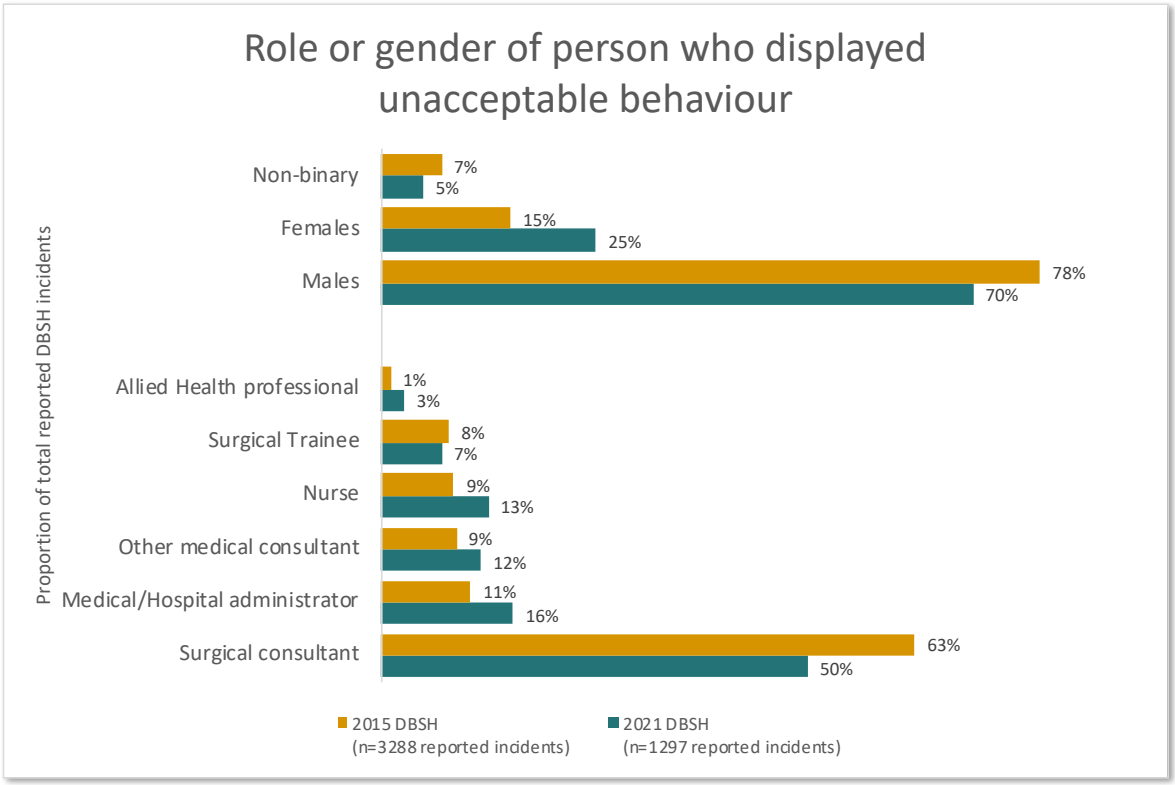
Surgical consultants have significantly reduced their DBSH behaviours

The percentage of surgical consultants who displayed DBSH behaviours reduced from 63% in 2015 to 50% in 2021, a significant result. Surgical Trainees also showed a small decrease in DBSH behaviours. This is in marked contrast to all other subgroups, which showed an increase (Figure 14).

The proportion of males displaying DBSH behaviours has also significantly reduced from 78% of DBSH incidents in 2015 to 70% in 2021. This is in contrast to females, who were reported as displaying more unacceptable behaviours in 2021 (25% of incidents) than in 2015 (15% of incidents). The increase in female DBSH behaviours was found across all roles (surgical consultants, nurses, allied health and hospital administrators).

It is likely that this decrease in unacceptable behaviours within surgery can be attributed to the Building Respect activities conducted by the College. The increase in reporting of other groups may be due to the increased awareness of unacceptable behaviours within the surgical profession.

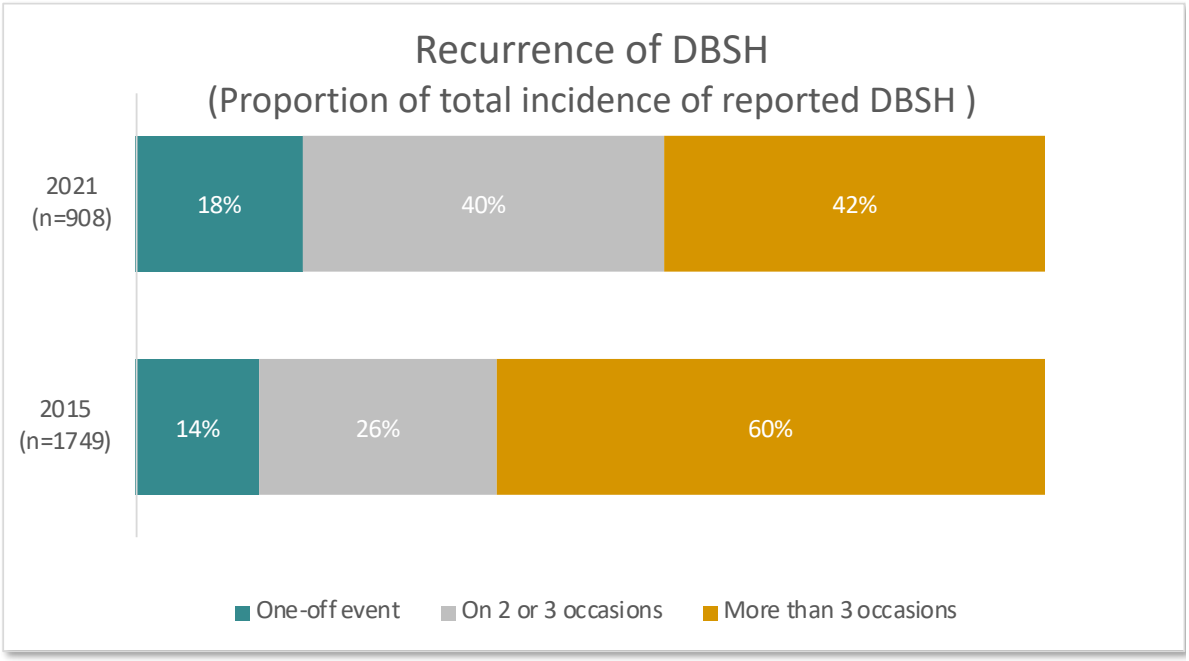
Figure 14. Display of DBSH behaviours by role and gender



Recurrence of DBSH has changed

The proportion of DBSH that occurs on more than 3 occasions, which is likely to represent ongoing sustained DBSH behaviour, has decreased from 60% to 42% (Figure 15). This result should be interpreted with caution, as the time span for 2021 was only the preceding 12 months, compared to 2015, when the period was open ended. Repeating the prevalence survey annually will give a better indication of what is happening regarding recurrence of DBSH.

Figure 15. Recurrence of DBSH

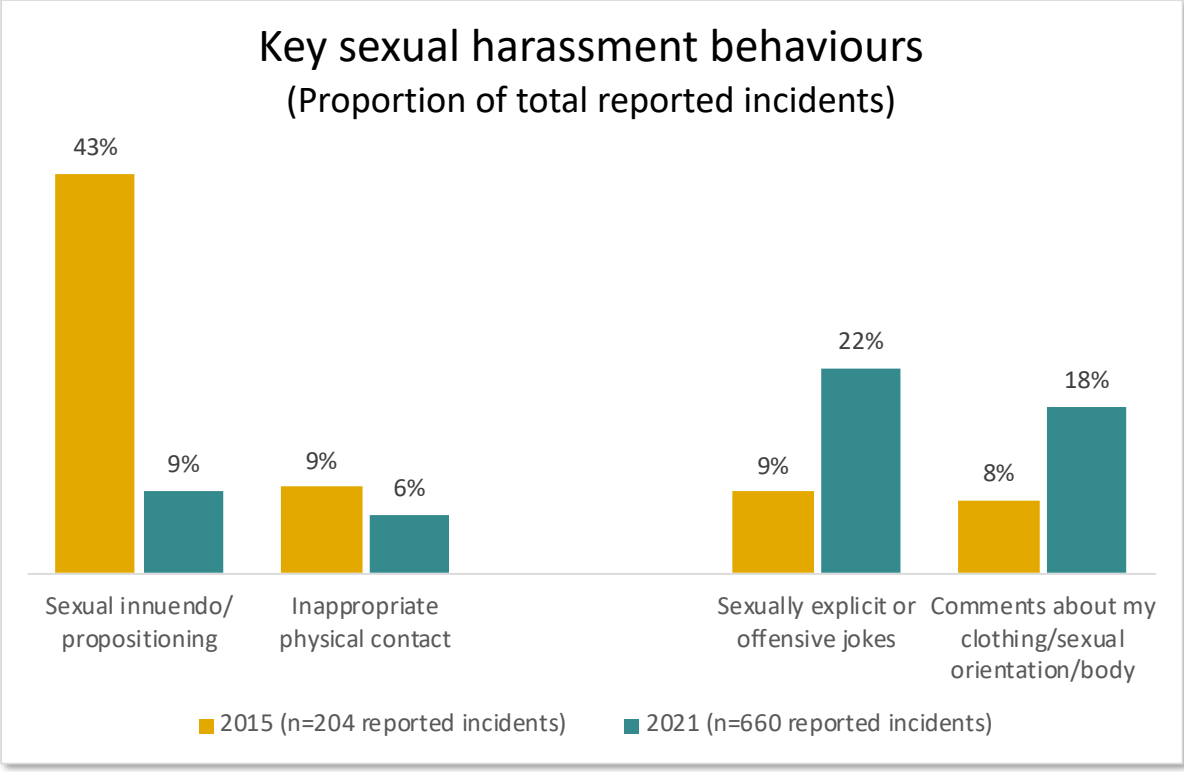


The nature of DBSH behaviours has changed

It has been suggested that, as attitudes change, people change to less obvious unacceptable behaviours that are less easily labelled as unacceptable. Interviewees and survey respondents referred to this as DBSH moving '*underground*'.

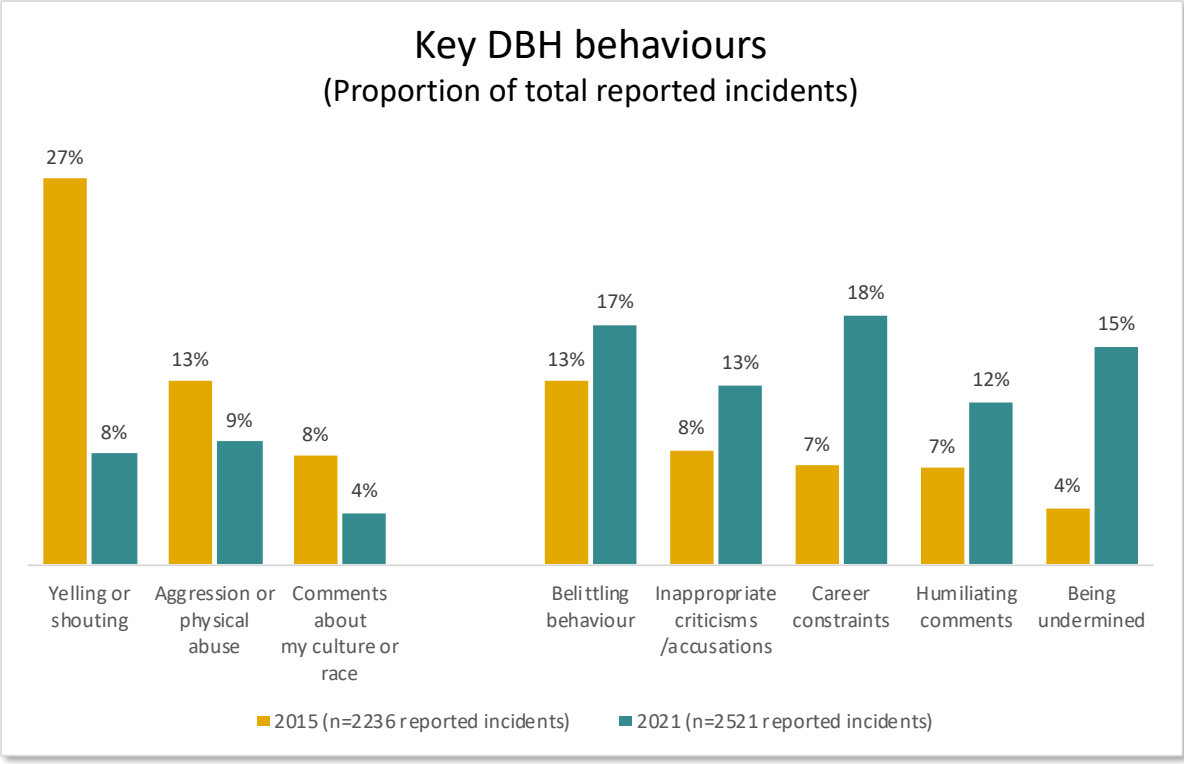
For example, the prevalence of more overt types of behaviour such as propositioning and inappropriate physical contact reduced from 2015 to 2021 (Figure 16), while the less obvious forms of sexual harassment such as offensive jokes and comments about clothing increased.

Figure 16. Reported sexual harassment behaviours have changed in nature



The nature of reported DBH behaviours is also becoming less overt. For example (Figure 17), yelling or shouting reduced from 27% of reported incidents in 2015 to 8% in 2021; aggression or physical abuse reduced from 13% in 2015 to 9% in 2021, while being undermined rose from 4% in 2015 to 15% in 2021.

Figure 17. Reported DBH behaviours have changed in nature

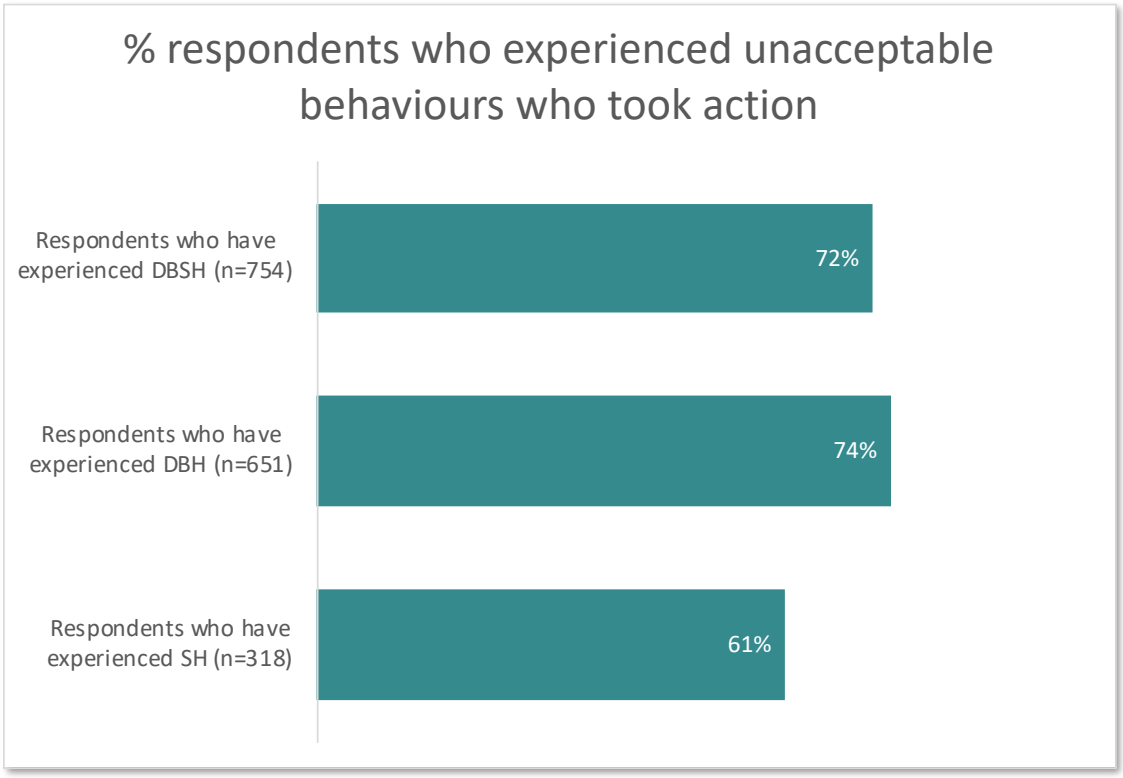


Responding to DBSH incidents

People are taking action about DBSH

Overall, 72% of people who experienced DBSH in 2021 took some form of action. A larger proportion of people took action about DBH than for sexual harassment. (Figure 18).

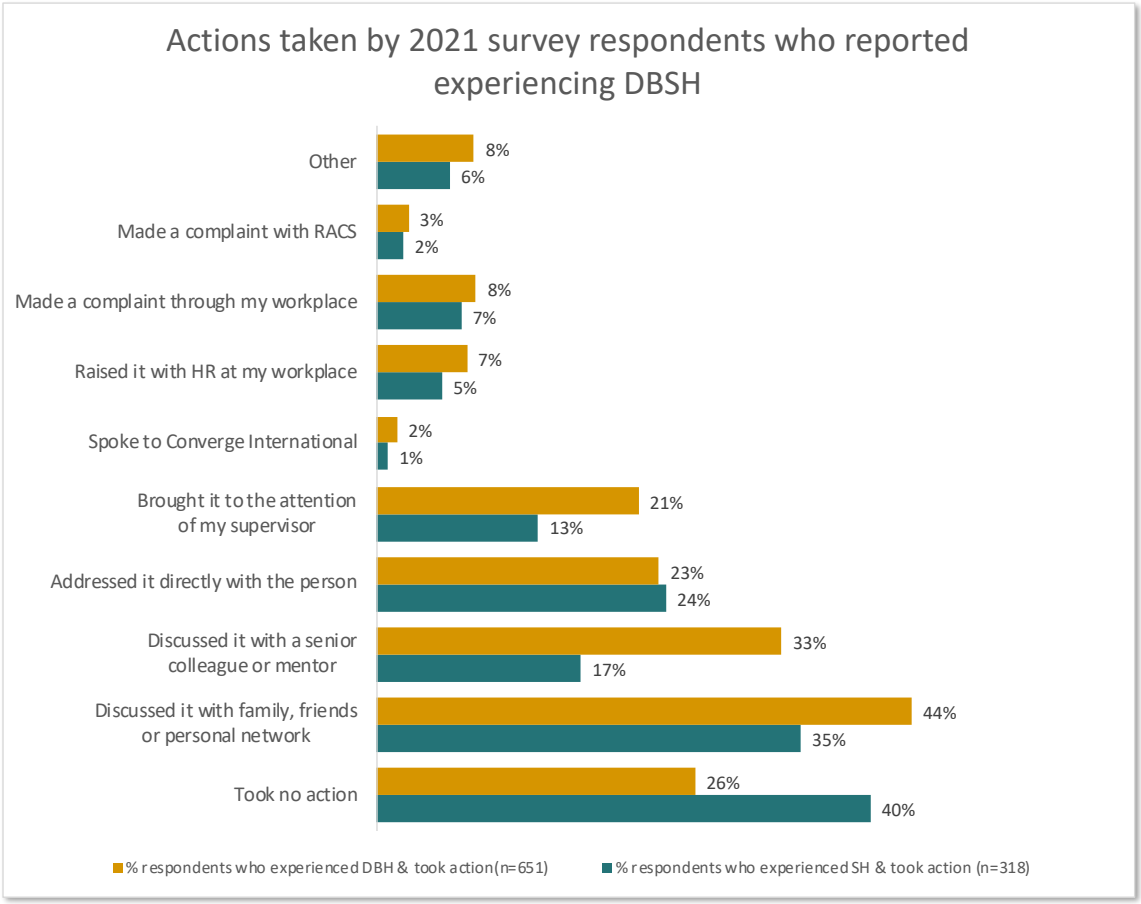
Figure 18. Percent of people who took action in 2021



People are taking multiple actions in response to DBSH

People are taking multiple actions. Figure 19 shows the actions that 2021 survey respondents took in response to unacceptable behaviours. More people took no action about sexual harassment (40%) than about DBH (26%).

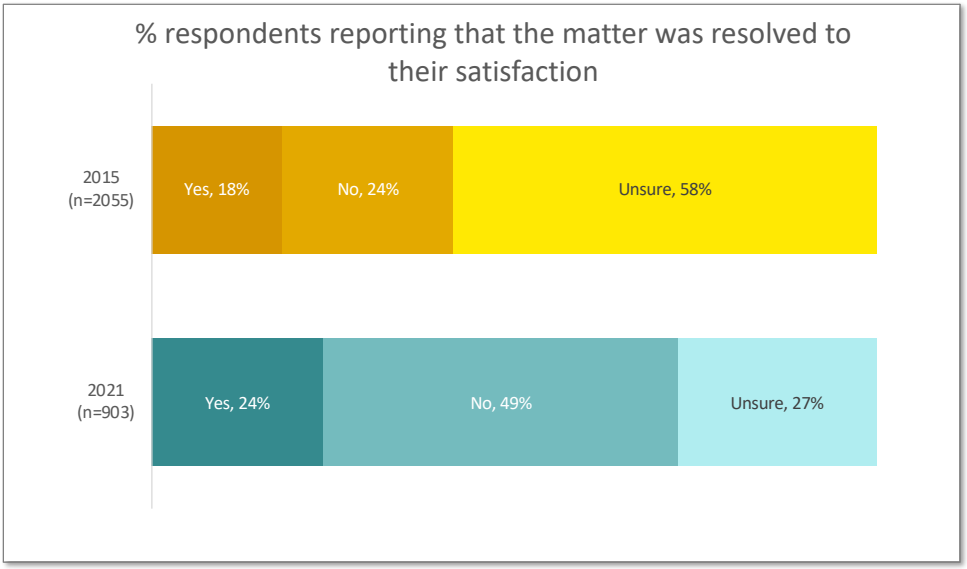
Figure 19. Response to experiencing unacceptable behaviours



More matters are being resolved

Figure 20 shows that there has been a slight but significant increase since 2015 in the proportion of DBSH matters that are resolved to the satisfaction of the complainant (18% to 24%). However there remains a large proportion that are not resolved to the satisfaction of the complainant.

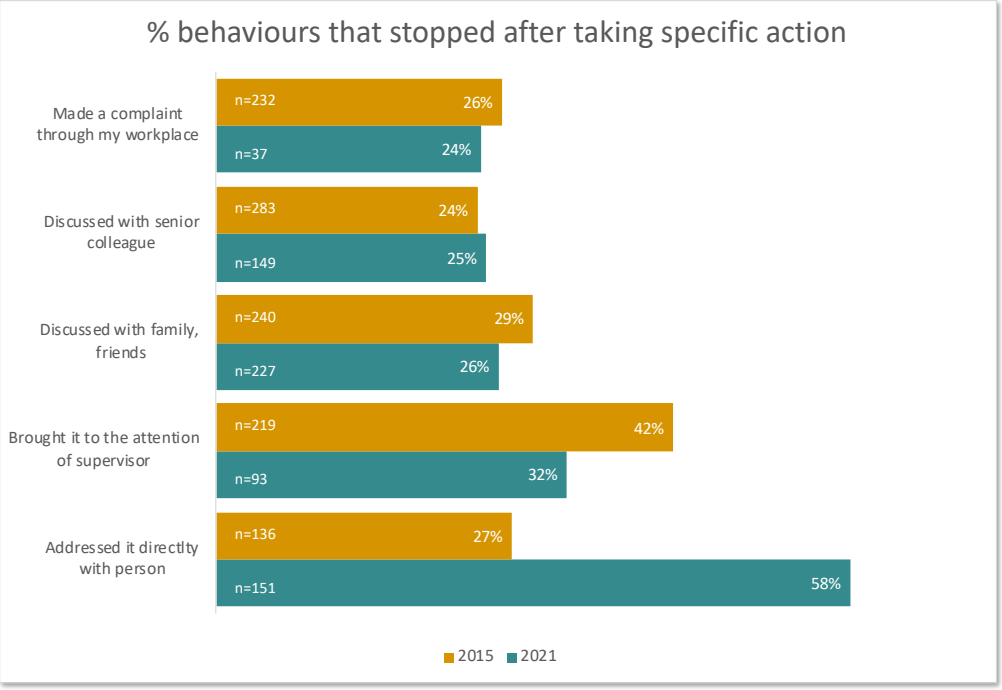
Figure 20. Resolution of DBSH matters



Raising it directly with the person is the most effective response in 2021

Addressing unacceptable behaviour directly with the person was the most effective response in 2021, improving significantly since 2015. Of the 151 people who addressed an unacceptable behaviour directly with the person, 58% reported that the behaviour stopped. This is likely due to RACS' focus on training and promotion, which has begun to normalise these discussions. The differences between the years in the other actions in Figure 21 are not significant.

Figure 21. Percentage of behaviours that stopped after taking specific actions



Survey respondents were asked about two other specific actions - making a complaint to RACS and Speaking to Converge International (only in 2021). The number of people who took these actions and reported their effectiveness is very small, which means it is not possible to provide meaningful comparisons to the other actions, so these are not shown in Figure 21.

Many factors influenced people's decisions to act in response to experiencing DBSH; the top three in each year were:

Table 1. Top three reasons that influenced decision to respond to DBSH when experiencing it

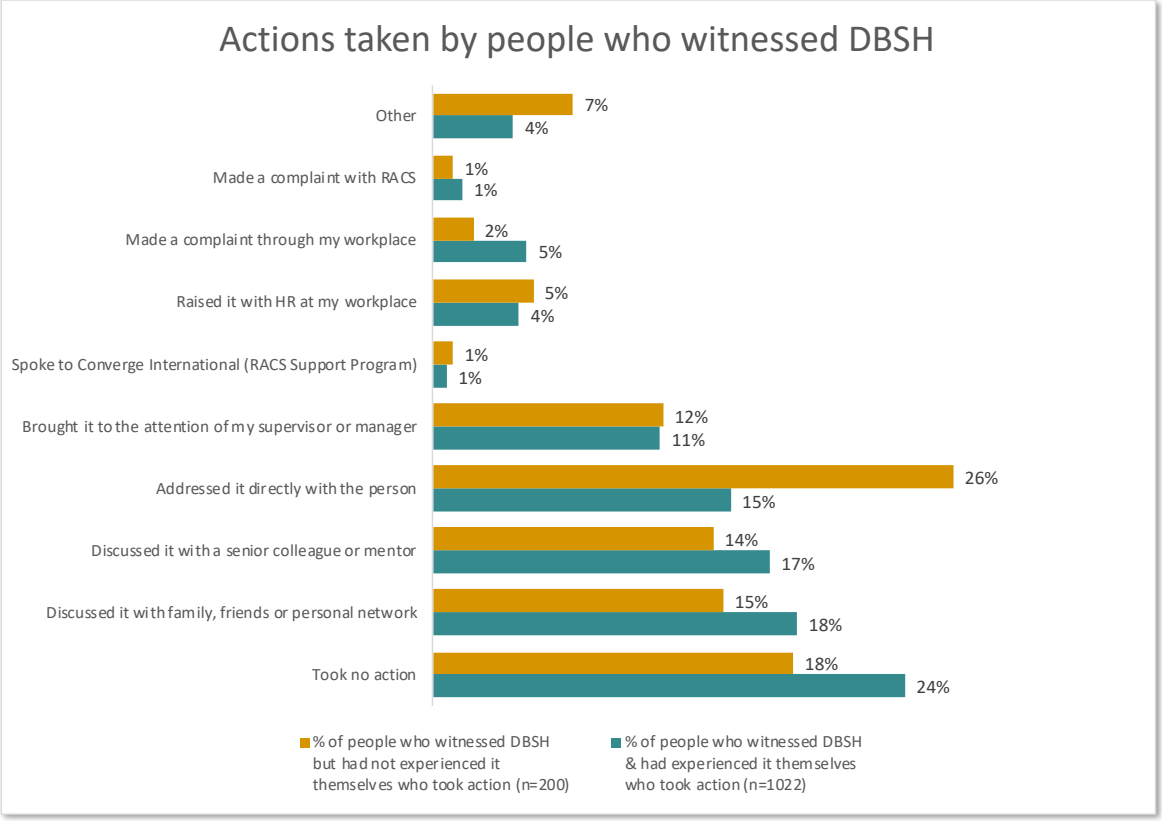
2015	2021
Effect on my future career options (21%)	Fear of making the situation worse (17%)
The stress associated with making a complaint (14%)	Possible damage to my reputation (14%)
Potential for victimisation (14%)	Effect on my future career options (13%)

Witnessing DBSH

In 2021, 51% of respondents witnessed at least one incident of DBSH. Of those people who witnessed DBSH, 81% had also experienced DBSH. The response of people who witnessed DBSH varied depending on whether they had experienced DBSH themselves (Figure 22). For example:

- People who had experienced DBSH, were less likely to take action, when witnessing it (24% took no action), compared to people who had not experienced DBSH (18% took no action).
- Only 15% of people who had experienced DBSH addressed an unacceptable behaviour they had witnessed directly with the person, compared to 26% of respondents who had not experienced DBSH.

Figure 22. Response to witnessed DBSH



Further analysis shows that the top three factors that influenced how people responded when they witnessed DBSH are:

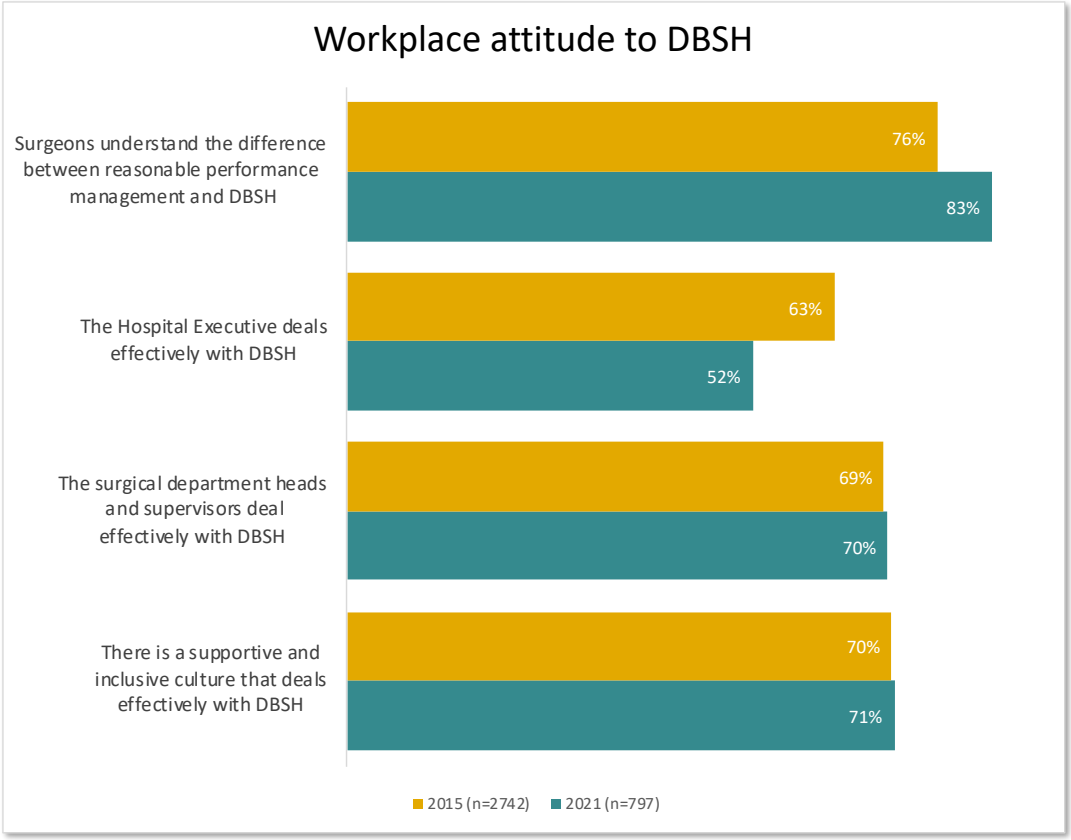
Table 2. Top three reasons that influenced decision to respond to DBSH when witnessing it in 2021

People who witnessed DBSH and <u>had</u> experienced it themselves	**People who witnessed DBSH but <u>had not</u> experienced it themselves**
Fear of making the situation worse (14%)	I knew what to do because of my knowledge gained through education programs (13%)
Possible damage to my reputation (11%)	Fear of making the situation worse (12%)
Effect on my future career options (10%)	Effect on the victim's future career option (10%)

Workplace culture

In 2021, 71% of respondents rated their workplace culture as supportive and inclusive (Figure 23), similar to the 2015 result of 70%. There has been a significant 7% increase in surgeons' rating of their own understanding of the difference between performance management and DBSH. However, the effectiveness with which Hospital Executives are perceived to deal with DBSH slipped from 63% in 2015 to 52% in 2021.

Figure 23. Workplace attitude to DBSH



Further analysis into the 2021 Hospital Executive results show a striking difference between the perceptions of people who had experienced DBSH and those who had not, with 28% of members who had experienced DBSH agreeing with the statement compared to 78% who had not experienced DBSH.

Respondents are more aware of workplace actions to deal with DBSH than in 2015.

Although awareness could be improved, overall, respondents in 2021 are more aware than they were in 2015 of workplace actions to address DBSH. For example:

- 41% are aware of workplace training in DBSH compared to 21% in 2015
- 38% are aware of a designated contact person for DBSH compared to 26% in 2015

This increase in awareness may also reflect actions taken by workplaces since 2015 to conduct training in respectful behaviours and introduce improved notification systems.

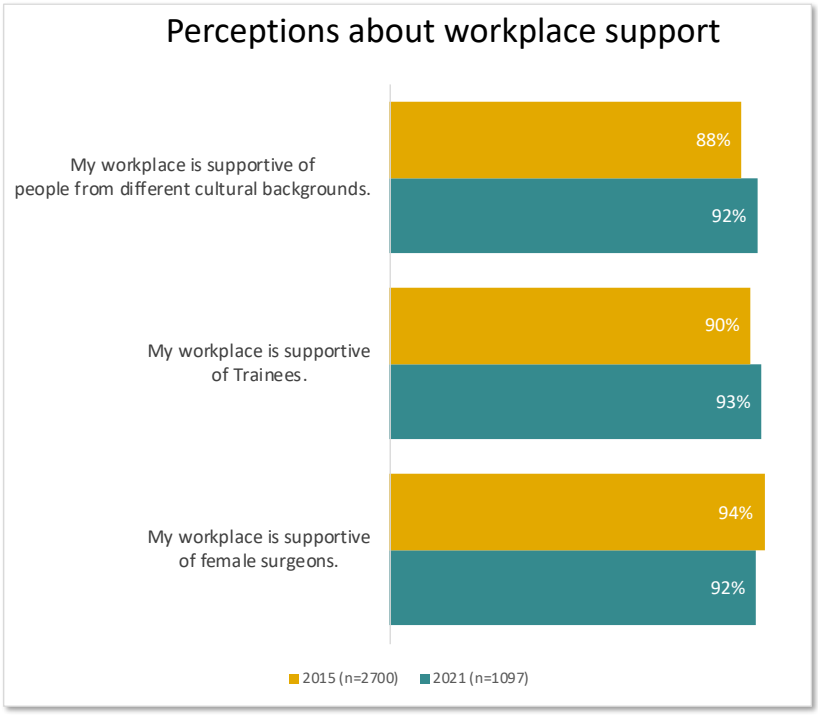
Institutional support

Respondents were asked about the level of support that the more vulnerable groups, such as Trainees, female surgeons, and people from different cultural backgrounds, receive from these institutions: 1) their workplace, 2) RACS; and 3) their Speciality Society.

Workplace support

Overall, as shown in Figure 24, a large majority of members agree that their workplace is supportive of female surgeons, Trainees, and people from different cultural backgrounds. The results have also improved since 2015 except for support for female surgeons which, although still high, has decreased slightly but significantly since 2015, possibly reflecting the larger proportion of female respondents in the 2021 survey. Although the changes since 2015 are small for the three questions, they are all statistically significant.

Figure 24. Perceptions about workplace support



Although the overall results are very high, they also vary depending on the respondent group. For example:

- Although 92% of overall respondents agreed that their workplace is supportive of female surgeons, only 76% of females agreed, compared to 97% of male Fellows.
- While 93% of overall respondents agreed that workplaces support Trainees, only 79% of Trainees agreed.
- And while 92% of overall respondents agreed that workplaces are supportive of people from different cultural backgrounds, only 57% of female SIMGs and 85% of male SIMGs agreed.

Overall, while a large number of people agreed that workplaces are supportive, the high value represents people who are not in the respective subgroups and who do not experience the same degree of DBSH as these more vulnerable groups, indicating markedly different experiences between the different subgroups.

Requests for flexible working or training arrangements

Respondents were asked about flexible working arrangements. In 2015 respondents were asked whether they had ever made a request to their employer to accommodate their responsibilities as a parent or carer. 21% indicated they had, and 74% said it had been partially or fully approved.

In 2021 respondents were asked whether, in the last 12 months, they had asked their employer for flexible working or training arrangements. 11% indicated they had, and 72% said it had been partially or fully approved.

Caution should be used in comparing the 2015 to 2021 results because a) the questions are subtly different – 2015 refers to parenting leave, 2021 to flexible working arrangements which is broader; and b) 2015 refers to a timeframe of 'ever' while 2021 refers to the last 12 months.

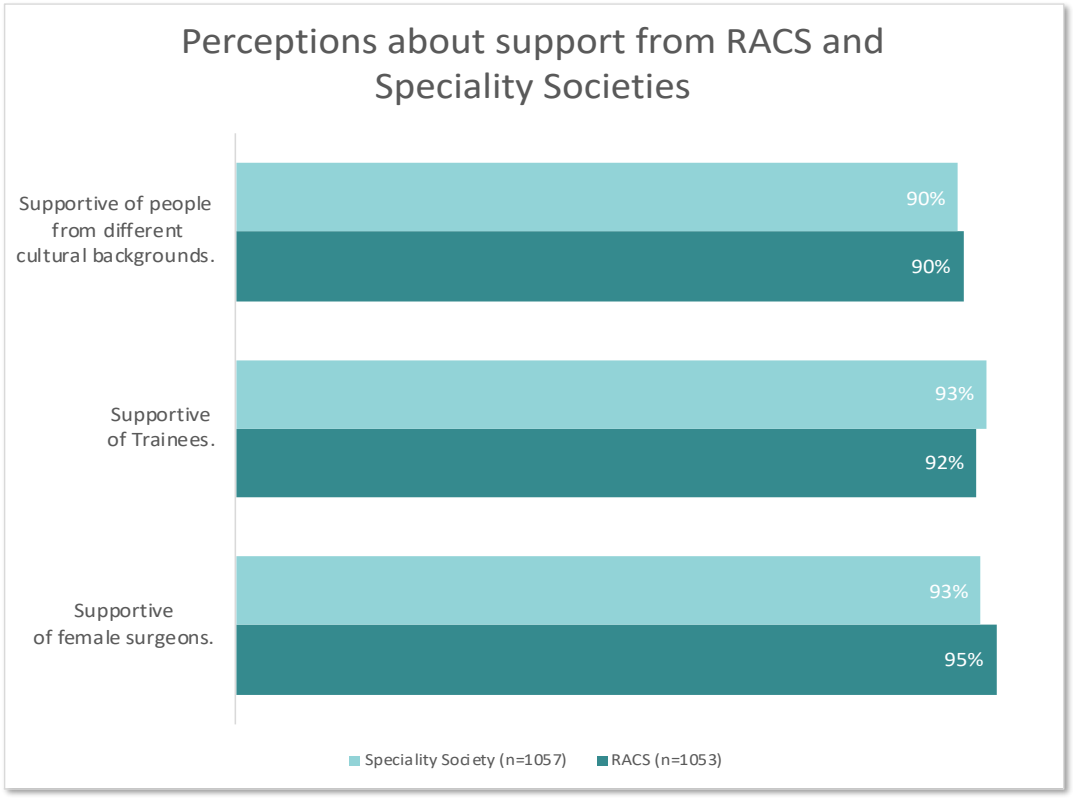
Further analysis of the 2021 result shows that, of the 137 or 11% of respondents who said they had asked for flexible working arrangements:

- 76 (55%) were male Fellows
- 33 (24%) were female Fellows
- 12 (9%) were male Trainees or SIMGs
- 14 (10%) were female Trainees or SIMGs

Support from RACS and Speciality Societies

Figure 25 shows a high level of agreement that RACS and their Speciality Societies are supportive of female surgeons, Trainees, and people from different cultural backgrounds. The differences between RACS and Speciality Societies are not statistically significant. Similarly to the workplace results, the level of agreement is lower for the minority groups than it is for Fellows. For example, 97% of male Fellows agreed that RACS is supportive of female surgeons compared to 87% of female fellows, and 91% of Trainees and SIMGs.

Figure 25. Perceptions about support from RACS and Speciality Societies



Respondent suggestions

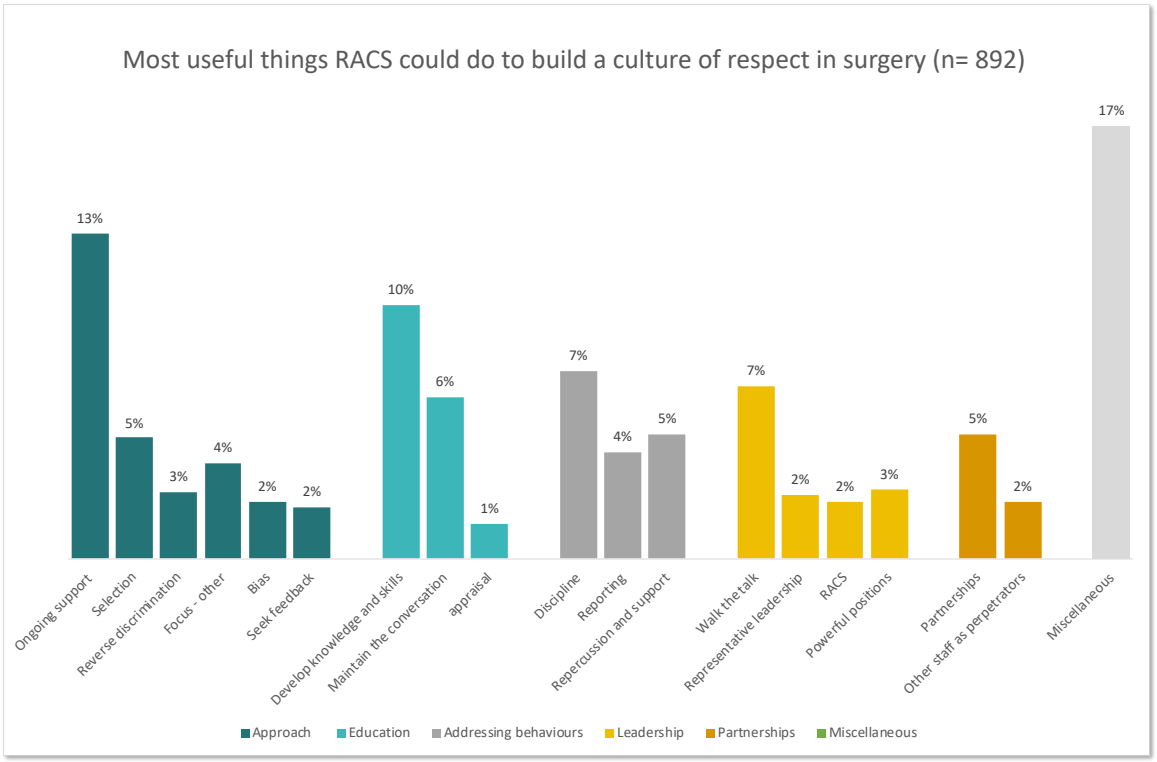
As a final question in the 2021 prevalence survey, respondents were asked an open-ended question to identify their views on potential next steps for RACS in reviewing the Action Plan. By the nature of the question, comments were generally suggestions for improvement, or critical, however positive comments have been included where relevant to ensure a balanced representation of the views put forward.

Reflecting on the issues canvassed in this survey, what is the most useful thing RACS could do to build a culture of respect in surgery?

A total of 807 people, or 53% of survey respondents, provided feedback. Many comments focused on similar topics or themes, the main ones being:

- The Approach the Building Respect Action Plan has taken.
- Education and awareness raising
- Addressing unacceptable behaviours and disciplinary action
- Leadership
- Working with partner organisations
- Miscellaneous comments

Figure 26. Percent of total comments received by theme and sub-theme



Theme 1: Approach

249 comments, or 28% of the total, made suggestions or comments about the approach the Action Plan is taking.

There is strong support for the Action Plan

13% of the total comments were in support of the approach and basically suggest it should continue as is. Typical comments included:

> *'RACS has put a great programme in place, and by making this a consistent and clear message it will set the new rules of engagement for surgeons in the workplace.'*
>
> *'Think the College is on the right track.'*
>
> *'I think RACS is doing a great job already, the message and culture is appropriate, but individuals may be letting the majority down.'*
>
> *'Continue to promote diversity, gender equality and respectful behaviour. I don't think you can change the cranky misogynist men in charge, but you can start to make them look like dinosaurs so younger surgeons don't copy.'*

Approach to Selection

42 comments (5% of total) were about selection. A number of comments within this sub-theme were about merit versus quota. Typical comments included:

> *Keep promoting diversity, but not at the expense of white males. Promote merit.*
>
> *Do not apply a reverse discrimination policy. Positions should be based on merit not gender, ethnicity, or sexual orientation.*
>
> *Appoint and employ people based on their experience and skill not whether they are male or female. There is a strong drive to employ females which is discriminatory against males. There is discrimination against the international medical graduate.*
>
> *Stop giving extra to females and treat all surgeons and trainees as equal irrespective of gender. The cup has overflowed. Back to merit not gender.*
>
> *As a female surgeon I believe that surgeons should be treated equally on their performance and not related to their sex. This survey ignores males and they certainly could get harassed as well. A bit sexist!!*

A minority of comments supported the idea of quotas:

> *Build on the concept of "If you can't see it you can't be it". Gender quotas across all speciality training programs will enable a culture/ gender change and encourage a more diverse work force.*

Quotas for women and culturally diverse people on all RACS committee and boards, enforced. Refusal to allocate CPD for conferences that do not meet set criteria for a proportion of women on the Speakers list.

Other comments about selection offered advice about the selection process:

Must follow proper procedure when jobs are given, unfortunately lot of nepotism exists. Proper interview process must happen, and interview boards should be fair and follow equal opportunity guidelines.

Entirely remove the influence and role consultants have on selection of trainees, references and appointment of future consultant roles.

Have a more transparent and objective process to select trainees. Have equal representation of gender and cultural representations on selection committees. Things have moved on over the last decade or so but the old system of selecting trainees particularly in general surgery was clearly discriminatory based on gender and possibly culture.

Choose future surgeons (trainees) based on the most rigorous of assessments with regards to possession of empathy, care and humanity, and not simply intellectual or surgical capability....and ensure gender equity.

Be careful in choosing registrar training supervisors. In the past year I have experienced 1 female surgeon who directly and deliberately undermined my training, not judging me by the same standards as my male colleagues. In a different metropolitan hospital, I am currently working with a male surgeon who has treated me with aggression and disrespect on a weekly basis for 3 months. I do not believe it is gender related. Thankfully, he is not my training supervisor and is recognised as being "difficult" but nothing is done to address this.

Profile trainees to identify the likelihood of hidden agenda, bias, self interest and bullying/ abusive tendencies in addition to the current assessments obtain similar profiles from fellows and put them into support group to assess their personal issues.

Claims that the Approach has resulted in reverse discrimination

23 comments (3% of total) suggested the Action Plan has resulted in discrimination against males. Typical comments include:

The worst bullying in surgery can unfortunately be by older female surgeons on younger female surgeons-that is where the focus needs to be.

Realise and understand that women are equally capable of bullying, intimidation, and sexual harassment. If RACS focuses on typical male / female gender stereotypes, then female bullying and harassment will continue unchecked and unabated.

Stop victimising everyone else surrounding doctors and provide the surgeons with support. The balance has been altered to the point anyone can complain about us for no reason and we have been left with no supports, as it looks like it is always our fault. RACS is out there supporting anyone else to complain

about our behaviour, rather than protecting us from others' behaviour (nurses, admin, physios, patients) which has become more aggressive and is always unreported and dismissed.

I feel the pendulum has swung the other way, the sensitivity about female equality in the work place is going too far.

People are now terrified of saying/doing the wrong thing. We have gone too far the other way.

Ensure that respect goes all ways, not just towards 'woke' minorities.

Hear both sides. Do not discriminate. Pro female is also anti male. Pro colour is also anti white. So all are forms of discrimination.

Currently, reverse bullying happening from some of the trainees towards trainers and supervisors. If they are of different gender then those trainees wont even hesitate to give it a sexual hint. Trainees (a reasonable proportion of them but not all) no longer want to be trained, they want to spend time and get their FRACS. They don't consider getting trained only want to get the alphabets and shortcuts. I know some female trainees actively having relations with supervisors and getting bolder about bullying others and even destroying the opponents career. The bullying and harassment allegations are so powerful tool that even some of the consultants support their trainees to level them against other consultants. This sort of sponsored "reverse bulling" is very dangerous and it will make trainees to stop training the future surgeons.

The Approach should address unconscious and systemic bias

20 comments, or 2% of the total, argue that the Approach to Building Respect needs to tackle bias, in particular institutional or systemic bias. Comments included:

The identification of unconscious bias and the understanding of disrespectful conversations including what was previously thought to be playful banter when there is a power imbalance. Improving diversity strategy to include gender identification and cultural diversity.

Stop giving male surgeons a separate title of " Mr" and tossing female surgeons in with the trainees as "Dr". Terrible hypocrisy.

Increased recognition of subtle unconscious bias and discrimination particularly against women that has a cumulative long term harmful impact on women's careers and wellbeing. As women we experience this almost on a daily basis and there has been very little improvement in this area due to a lack of acknowledgement of the issue.

Promote awareness of institutional bias and how to address it.

Educate male surgeons on the impact of unconscious gender bias on female surgeons and trainees.

The Approach should build in greater feedback

18 comments, or 2% of the total, recommended the College seek greater feedback from members to better understand their issues. Comments included:

> *Ask victims and minority groups (anonymous response) what they think should change and how. Their perception is often different and educational and reveals unperceived attitudes and behaviour. Watch filmed meetings without sound and observe body language.*

> *Have a survey of all trainees and ask them if they have experienced these issues from their consultants at each of the hospitals in previous 12 months, then feed that back to each hospital dept so that dept can look at itself. Keeping it to 2 -3 terms and entire department gives a bit of anonymity but enough narrow focus on specific hospital departments for the members to review themselves.*

> *Talk to trainees frankly in confidence regarding their workplace culture. I have only become aware of certain hospitals notoriety regarding bullying behaviour by listening to trainees experience.*

> *End of rotation/term deidentified individual surgeon feedback so that it can be pointed out when particular surgeons are engaging in inappropriate recurrent behaviours that are not appropriate. Needs to be reviewed externally to hospital as some on board/RACS committee are those causing the behaviours.*

> *Continue to survey responses like this --identify any areas of concern or places --instigate discussions with those in the workplace where issues identified.*

Other suggestions regarding RACS' Approach

Another 33 comments touched on a variety of topics connected to the Approach. Typical comments were about flexible working arrangements:

> *Allow women maternity leave without harassment and stress. Make it clear to young trainees that they will be supported and not expected to work dangerous hours.*

> *Continue to support female surgeons particularly those wanting to have families as well as a career.*

> *Better options for interrupting or part time training for new parents especially.*

> *Female trainees still suffer when they take time out for pregnancy - they are treated as if they failed the attachment and the assessment form classifies the attachment as "unsatisfactory" - a separate category of assessment is needed.*

Some comments focused on what they saw as a limited definition of diversity:

> *There is a real concern among the fellowship from ethnic backgrounds other than Maori/pi/aboriginal/white that the college is promoting indigenous cultures at the expense of indo/Asian cultures, and that this is yet another*

example of white privilege. Would be good to promote equity regardless of culture rather than pick a handful of cultures that fit the local appetites. The last survey clearly showed that IMGs experienced higher levels of DBSH than almost any other group, they have received little to no focus from RACS compared with female and indigenous groups. This can only be interpreted as implicit racism.

Beware that diversity does not end with gender. All behaviours should be reflected

Diversify the term 'culture' There are many cultures not just the indigenous and non indigenous. Each culture has its own place. Stating and promoting only 2 cultures is hypocritical.

Several comments referenced the Vanderbilt model:

Mandated training courses and advocating for a nationwide Vanderbilt type process for feedback to surgeons who fail to recognise their behaviours.

More widespread adoption of the Vanderbilt model. Natural justice about outcomes when a behaviour issue is raised (feedback to the person who reported about the outcomes) More disciplinary action including termination of employment when surgeons repeatedly behave poorly. Active efforts to recruit and support indigenous and Pacifica junior doctors to become surgeons. Support of female trainees in training and employment of female consultants in training hospitals.

Have an anon helpline where people could voice issues without fear of recrimination, almost like a Vanderbilt situation.

Other comments included:

Outline a constitution of behaviour for surgeons.

Define below the line behaviours for professionalism so that in the work place there is a standard to hold individuals to account.

Bring the focus back to the patient. The culture has shifted ridiculously to focus on the staff - they are not the important ones in the equation. As Shem said in The House of God " Always remember the patient is the one with the disease."

Develop a senior mentoring program.

Focus on a culture of resilience alongside respect. We cannot expect everyone to behave perfectly in a high pressured environment.

Emphasise bystander involvement. Surgical news article on the Human Rights Act 1993 (NZ).

Theme 2: Education

156 comments, or 17% of the total, made suggestions or comments about education. The three main sub-themes included developing knowledge and awareness, raising awareness through ongoing conversation and promotion and, very specifically, education in the appraisal process.

Developing knowledge and skills

88 comments, or 10% of the total, focused on developing knowledge and skills in recognising and responding to DBSH. Typical comments included:

> *Keep training and wait for the old guard to retire especially those in charge in hospitals. Push for change in state contracts that have better options for part time work. More online courses for females (and some males) that have trouble getting to capital cities on weekends for college courses/CPD/conferences.*
>
> *Increased opportunities for flexible training.*
>
> *Continue to give mandatory education. Need also to pressure /lobby hospitals to take more decisive action such as terminating long term bullies.*
>
> *Encourage education at the medical student level and junior doctor level. Take disciplinary action when there is a breach in attitude. Hospital administrators too need to be educated.*

Maintain the conversation

56 comments, or 6% of the total, related to maintaining the conversation and keeping it in everyone's consciousness. Comments included:

> *Keep talking about it- the more available the knowledge about a culture of respect, the better we will follow the culture.*
>
> *Keep raising the issue. Maybe some video vignettes of documented cases to serve as examples?*
>
> *Keep respect in the general conversation so it is not forgotten.*
>
> *Advertise more widely how to recognise and who to report to if feel experienced workplace issues.*
>
> *Continue to reinforce the message and raise the issue in meetings, citing examples where it has happened and how it has been resolved and also having more diverse heads of departments/training as role models.*
>
> *Keep it at the front of everyone's mind. The new policy is a help too.*
>
> *Report on actions taken when examples arise, obviously deidentified.*

Improve appraisal skills

12 comments (1%) focused specifically on the need to develop better appraisal skills – both in the giving and receiving of performance feedback:

> *I think RACS is doing as good a job as it can. The distinction between effective feedback and bullying remains unclear in my mind and I don't see a simple solution to that problem.*

> *The other tough issue is the balance of fair criticism and appraisal of trainees vs unfair comment or destructive comment. Not always easy when there is a person overly sensitive or deliberately covering for poor performance. Needs more work or protection for all. Trainees need protection from "whim" but we see trainees that are not well suited and tact and consensus is needed for them.*

> *Trainees also need ongoing education about boundaries between acceptable 'feedback' and harassment.*

> *Ensure that all evaluation and assessment processes are COMPLETELY TOTALLY OBJECTIVE. No assessment or evaluation or selection of trainees or potential trainee applicants, none of the processes can have any element of subjectivity, such that a situation whereby a person gets an edge over someone else because certain surgeons "like" him or her more than someone else, and hence gives a higher score. ALL evaluations MUST be OBJECTIVE with totally absolutely no room for subjectivity or favouritism which can undermine another more qualified applicant.*

> *Need to support surgeons to provide effective feedback. I have directly supervised >20 SET trainees. I was accused of bullying after providing two episodes of structured feedback to a SET trainee regarding punctuality and leave approval. These two feedback entries in part contributed to the trainee failing a term. once it was apparent that they had failed the term the trainee took out bullying proceedings against myself and another surgeon, as a strategy to overturn the term failure. I am really concerned that this is an avenue that trainees will pursue to counteract corrective feedback. The process took almost 6 months to resolve and the findings were in our favour and no bullying was substantiated. Going through this process makes me not want to have a SET trainee ever again.*

Theme 3: Addressing behaviours

148 comments, or 16% of the total, provided feedback about addressing unacceptable behaviours. Three sub-themes emerged: discipline or action taken in response to incidents of unacceptable behaviour, reporting unacceptable behaviours, and repercussions and support.

Discipline

65 comments, or 7% of the total comments, were about disciplining the alleged perpetrators. The sentiment around discipline was very strong with a number of people calling for zero tolerance. A large number of respondents also pointed out that many perpetrators hold influential positions and that these people should be a focus, even if politically difficult, since they are such strong influencers of culture. Typical comments included:

> *Address systemic bullying behaviour by the senior members of RACS and specialty societies. Consider seeking anonymous feedback for surgeons taking leadership positions within RACS and specialty societies.*
>
> *Actually prosecute the perpetrators and NOT the complainant. The whole process is a complete and utter farce.*
>
> *There is a small number of surgeons that continue to bully and harass. The RACS needs to take a firm approach in dealing with such individuals. Ongoing education and compulsory CME in this domain is required for all fellows and trainees.*
>
> *No tolerance for repeated offenders with enforced (not threatened) punitive measures. Audit of departments and enforced punitive measures for high risk (repeated) offenders.*
>
> *Prosecute the perpetrators, clamp down hard on those engaged in bad behaviour.*
>
> *Take stronger action against surgeons who are found to have engaged in misconduct. Remove FRACS title from those extreme breeches of guidelines or repeat offenders.*
>
> *Provide some repercussions and pathways of consequence, materially, for repeat offenders who continue behaving poorly via a strike system.*
>
> *Boot out the serial offenders. Everyone knows who they are, but we are powerless to act.*
>
> *Revoke the Fellowship of Fellows who persist in displaying disrespectful behaviour.*
>
> *RACS needs to act on the EAG recommendations put in place in 2015 by acting more severely on Fellows found guilty for bad or inappropriate behaviour - including removing their Fellowship.*
>
> *Act on reported bad behaviour Don't just say it-do it.*

Continue education programs. Remove fellowships if poor behaviour is severe and repetitive despite intervention.

Have a low tolerance for poor behaviour, which carries consequences such as being suspended from operating until remediation courses are completed.

Culture of zero tolerance works very effectively. In my experience the bully was an individual in 2 different terms but the bystander effect of others witnessing and doing nothing about it, just because "they didn't want to feel awkward". It was harder to go through it when everyone telling me they are noticing it & it's not cool but no one was telling him to stop or he suffered no consequences of it or my exposure to him was not reduced. They didn't do anything because I'm a trainee and will change position in 6-12 months but they had to continue work with him. The senior surgeons, and particularly those in training board deal with the situation where trainees are bullied very poorly. We basically told to never complain and fly under the radar. The level of aggression and the way they come after the trainee who feedback is very ganglike and scary. It only involves a handful of individuals. Majority of the consultants are great but generally feel helpless to help us and fail to stand up when they see bad behaviour.

Reporting of unacceptable behaviour

Many of the reporting comments were aimed at what people saw as inaction by the College in response to complaints of unacceptable behaviours. These comments reflect a lack of understanding of the College's authority and remit to take action about complaints. Comments included:

Take action immediately and effectively as soon as an issue is brought to its notice without worrying about its consequences to the College itself.

Better dealing with complaints received with being open minded and not safe guarding the interests of the college.

Address peer bullying i.e. between consultants, and DO SOMETHING ABOUT IT when a complaint is made.

Improve at responding to and resolving complaints. Improvement is about timeliness. Admittedly RACS is usually not the employer but has struggled in this area on some occasions.

Keep trying and improve the complaint mechanism. Currently it lets everyone down.

When a complaint is lodged regarding harassment or bullying, take it seriously and do a proper investigation. As the overarching surgical body, do not be yourself bullied by powerful subspecialty groups who may be more concerned about litigation, protection of the reputation of that specialty group or powerful individuals, or more concerned about the potential cost of "losing a case" rather than seeking to do the right thing for a vulnerable individual. Please recognize that surgery still has a long way to go in addressing these issues but what has been done is a welcome start.

Provide an effective system for reporting and addressing bullying behaviour. Address systemic bullying behaviour by the senior members of RACS and specialty societies.

A couple of comments suggested a reporting process that was not as formal as making a complaint:

Provide an "intermediate" avenue to highlight poor behaviour which was available through the college but was not too "high level" or threatening. Some means by which one surgeon can indicate to another surgeon that their behaviour is unacceptable, without there being significant subsequent ramifications. It would need to be fed back to the surgeon against whom the complaint had been made, and noted in case of frequent such complaints, but should not adversely affect the individual in order to allow them to reflect and change practice.

Encourage the practice of openly talking to people concerned when they experience or see bullying etc. there should be a tier of response and not immediately formally complaining. A @metoo culture is as harmful as a culture of silence.

Repercussion and support

46 comments, or 5% of the total, related to concerns about repercussions when a complaint is made and support of the complainant. Lack of confidentiality was also a common theme:

As idyllic as it would be to have a repercussion free reporting system for harassment and bullying, the reality is that whistle-blowers get gossiped about and form the basis (usually through other "valid reasons") for exclusion from training and future career options.

We had a bad issue of bullying and sexual harassment within our department two years ago. The orthopaedic SMOs supported the bullied and harassed RMOs and nurses and dealt with our offending colleague with little or no support from DHB management or our professional body. The eventual outcome was fudged by the DHB who appeared to be more worried about being sued in the employment court than protecting vulnerable staff members. If faced with the same issue again I would have little faith in the systems currently used to try and resolve these issues. As stated, I think fear of legal consequences makes employers fearful of confronting bullies.

I wanted to report bad behaviour I was subjected to. I discussed with supervisors in my college. In the end I was given the advice that if I make a complaint I will be labelled as a weak and whiny female, and it will damage my career. I don't want my comments shared at any board level etc because they are too identifying, and I fear repercussions still. The biggest thing to help is that when people speak up, they should be believed and supported. If someone reports issues, there should be follow up support.

Make it actually possible to make a complaint without destroying your own career. Even if you are correct and everyone believes the complainant - their

career is completely f#@&d and everyone knows them as a whistle-blower / trouble maker. It isn't worth making a complaint unless you already have a safe consultant position somewhere and can make a complaint from a position of power. Otherwise, it's just career suicide.*

Most surgeons, trainees do NOT report behaviours such as bullying / harassment because there is the perception (correct or not) that the whistleblower is not protected, "calling out " is stressful, cannot occur (if it is "your boss"who is doing your end of term assessment thus influencing your surgical career path, and whistle blowers are labelled as "trouble makers" instead of advocates for patient care and staff safety. In rural and regional Australia, in a tight job market, (eg 1 public hospital / perhaps only 1 private) even prior to Covid - why would health workers speak up/ call it out / for patient safety or staff safety only to be stood down or labelled a trouble maker ?

If making a report means compromising one's career, nobody will come forward unless the behaviour is so unbearable they would rather risk their career than have it continue. My surgical career has been destroyed because I made complaints about bullying and sexual harassment. While the training board allowed me to leave my post, they assigned me to new posts that then refused to hire me based on "compulsory references" from the people I had accused of bullying and sexual harassment rendering me unemployable. The board was likely aware of this likelihood as they warned me I was subject to employment checks, meaning they likely set me up for that situation knowing I would be unemployed/unemployable for over a year, and expecting I would quit the training program. I have told the training board specifically about other serious instances of bullying and to my knowledge no action was ever taken. The hospital refused to investigate the matter. The only way to address this issue is to make the training board accountable in some way for the conditions the trainees are forced to endure, and to make reporting events a non-lethal event.

If a trainee or a junior surgeon makes a complaint his future in the specialty closes. The seniors close ranks and make sure that the person is not selected for any future positions. Therefore the victim suffers in silence and leave the position without disclosing the reasons. The RACS support for the victims is only in theory.

Feedback and complaints process via online anonymous portal available to all including nursing staff.

If there is no way for a complainant to remain truly anonymous there will never be a way for victims to complain or escalate concerns in surgery. It will always affect the victim's reputation.

The subspecialty colleges treat accusations as allegations and relies upon the hospital to make a finding, leaving the trainee with no support. Much of the behaviour is committed in private and without witnesses. Even when witness names are provided, the subspecialty college are not proactive in contacting such people to help establish facts. Situations of sexual harassment and bullying are always complex as it is so closely linked to potential blowback and

retribution upon the person forwarding the complaint. In the majority of cases, the victim is the junior to a whole team of consultants, all of which involve complex interpersonal, private and public working relationships, with varying levels of personal gain. There cannot be an effective complaints process when it is run by the subspecialty organisation that has an interest in protecting its own reputation and their own members. "Measures" taken to investigate "allegations" made by the trainee are half hearted and ineffective. There must be an impartial and third-party organisation unrelated to the surgical fraternity, that will have more interest in seeking the truth of the matter to pursue fairness and justice. In this situation, trainees will have more faith in forwarding a complaint and how it is managed. Known bullies among the consultants will be more mindful of their behaviour when they know that they are accountable to an organisation other than their own, which focusses on such despicable behaviours.

Oh, so many things! RACS is trying to address the problem by forming committees and having cup of coffee conversations when the problems that trainees are dealing with wrt. bullying / harassment are serious and emotionally exhausting. With all due respect, a cup of coffee is not going to sort out the trauma of being bullied in theatre or being yelled at for a decision. First and foremost, the complaints process needs to be more heavily weighted in favour of the trainees. I think that there is a fear that "frivolous" complaints will be made by underperforming trainee to "pay back" consultants. This whole notion is frankly laughable - as if trainees have nothing better to do than to come up with stupid complaints. There needs to be an ANONYMOUS way to take complaints. Even at present, the end of term survey is IDENTIFIABLE and I am afraid to fill it out - the only reason that I filled this survey out is that I have been guaranteed this response is NOT IDENTIFIABLE. To fix the problem, RACS should TRULY care about trainees - which is not what they do at the moment. They are a board that charges thousands of dollars each year but they really have no power. I don't know the name of a single person at RACS who I think that I could call. Say we are bullied. The bully has IMMENSE power over the trainee. So even if they complain, the bullies are friends with the other bosses, the bullies complain about us, see my earlier comments re: cup of coffee, we are traumatised and our performance suffers, and then ultimately, we are made to feel like it is all our fault. RACS - no teeth in this process until too late! If you want to help, have an anonymous way of reporting CONTEMPORANEOUSLY. If you have the SAME REPEAT OFFENDER named by multiple trainees, for god's sake, do NOT let them supervise trainees. Remove them from the supervisors. Do not let them have accredited registrars. Complain to the registrar. Do something instead of pretending things are all rosy. As for representation, RACS still has a whole bunch of white males with rich people problems that are running the show. This is a plea to the minorities & the females at the table. Be allies. Do not side with the bros as usual. You made it to the table. Be there for people that experience sexual harassment. Recent political events should be a teacher to you - Quis custodiet ipsos custodes - RACS can only be great at anti bullying efforts if RACS chooses to side itself with the trainees and not the trainers; and at the moment, apart from pretending like you do, you do not actually care. Have a mentor or someone; or a supervisor of training that will

actually learn about the trainees. We are all going through so much together - yet the SET supervisor position is literally forced upon people who don't necessarily want it. Why not have an independent person who can remain confidential help trainees and also keep track of aggression etc. And also there is too much power given to people in the name of references, jobs etc....and I know personally in one instance that a sexually harassing surgeon was actually on the anti-bullying board in the hospital & this was known by the other consultants on the unit till things went too far. Anyway, I have written a lot. I am not hopeful things will change. I want to be optimistic but really what I am doing is getting through training and hoping that I can at least break the chain in myself being to others what others were to me. The weight of history is sadly not on my side, but I can only try.

Theme 4: Leadership

126 comments, or 14% of the total, were about leadership. Within this theme, the majority of comments used the term 'walk the talk' to sum up their mostly negative observations that people in senior positions say the right things about building respect but don't do the right things. The other sub-themes include comments about the extent to which the College's leadership represents the diversity of its members, specific comments about the RACS leadership, and some responses about the influence of people who hold powerful positions.

Walk-the-talk

60 (7%) leadership comments focused on the difference between what the College's leaders say and what they do or, in other words, the extent to which they are walking-the-talk. Typical comments include:

Walk the talk! I have recently observed disrespectful behaviour from those at the highest levels of RACS governance.

Stop the lip service and take real meaningful measures. Allow women maternity leave without harassment and stress. Make it clear to young trainees that they will be supported and not expected to work dangerous hours.

Take action, not just say the right words. I was accused of bullying where it wasn't made clear of how and why. The accuser immediately had the RACS on his side and 'many discussions' were made even before I was notified. I wanted to formalise the complaint but was told not to. This is obviously because I am a person of an ethnic background and felt silenced instead of initiating an investigation. Diversity and inclusivity seem to apply mostly to indigenous groups, not to the other many immigrants who have dedicated their lives to the service.

It's all just lip service, ticking boxes the heads of Department and the more senior / older members set the tone and this is just perpetuated by the younger appointees who are just clones. They know their behaviour is wrong and they don't care or think it is funny. RACS contributes to discrimination of IMG by singling them out and not recognising experience and training appropriately.

Local trainees happy to get education and training from the IMG but then when pass exam happy to abuse them.

Based on my own reporting and complaints about harassment and discrimination to RACS, as well as my experience as a trainee and surgical supervisor and former head of department, I can state from my own personal experience that RACS talks the talk but doesn't walk the walk. RACS has all the policies and documents and definitions in place but is absolutely toothless and ineffective in taking any real action when a complaint is made. RACS is just involved in a box-checking or ticking exercise that looks good and achieves no real change. There is an underlying covert current of indelible racism in Australia and throughout RACS Australian Fellows against IMG's. It's unspoken but ever-present. RACS will never ruffle feathers and make tangible stands. Its words, words, and more words and prettier websites and advertising. You build a culture by setting an example. You cannot set a standard when you don't enforce it when a complaint is made and RACS makes conciliatory excuses for lack of action. Get rid of the geriatric deadwood and the older generation who will promise to change at RACS but will never change because either they are not able to or really don't want to. Culture change is very hard and challenging and we need fearless and courageous leadership to set an example, not just an example of the past leadership desperately attempting what they are not capable of.

Pay more than lip service to actual abuse. The college talks a good game, but Has no spine or desire to deal with abusers, or actually protect trainees.

Actually do something about the problem rather than just pretend to care. One on one feedback and reviews and assessments of units is paramount. RACS seems to be all about the show rather than actively working to eliminate these behaviours and attitudes.

Representative leadership

22 comments (2%) expressed the view that the current leadership in surgery is not reflective of the diversity of the membership. Comments included:

Stop choosing misogynist racist private school educated old men as your 'champions of change.'

Continue to promote female surgeons in visible roles within the RACS - this is being done to great effect already.

Promote diversity/change. The heads of department are still predominantly entitled white males from private schools. They surround themselves with their own kind and exclude everyone else. Discrimination and bullying will not change until the people in power change. Now they have simply become better at hiding their sentiments and in many ways it's even harder for women.

Continue to involve people of both genders and all races in positions of responsibility.

Be more inclusive of different cultures races and genders in the College of surgeons in positions of power and administration.

I honestly don't know anymore. More diversity in leadership (age, gender, ethnicity) would be a start since overwhelmingly, the leadership in surgery in societies, heads of department, hospitals, colleges etc are so often the people who are part of the problem.

Increase the diversity in college leadership and executive roles.

RACS should show representation from all backgrounds in the leadership positions.

Change the people in charge. The College is dominated by white men from capital cities. There is no insight.

Leadership comments about RACS

Within the theme of leadership, 2% of comments related directly to RACS, a few were positive, but most were negative:

Sack the entire college and start again. The RACS doesn't seem to know or understand what its core business is anymore and is becoming increasingly irrelevant to the professional lives of surgeons and trainees.

Stop including patronizing literature / microlearning events like the 5 to thrive - picking up kids from school and making lunches / dinner is not an optional extra - unless you are used to having someone at home who 'takes care of all that'. Seriously. If a man goes to pick up the kids from school he's a star. If a woman goes to pick up the kids from school she's unreliable, like all those women who insist on having kids and family. That culture needs to change ASAP, and continuing it on the RACS website needs to stop.

Side note, but a gender issue - Please put a female bathroom in the Brisbane RACS office, the shared facility is disgusting. It is horrible being the only female surgeon in a meeting of 20 men and having to share facilities. I won't go back to the RACS office until that is addressed.

RACS is a toothless tiger scared to really act on anything. The behaviour of some is awful and most folk know the offenders (one harasses reps including sending photos of genitals). By the same token there are some female surgeons who abuse the system and force themselves into faculty in meetings when they are simply not good enough to be there. Insight is crucial in that regard.

Burn RACS down and start again... Get back to focusing on clinical proficiency rather than left wing ideals.

I was bullied terribly by the RACS when I rang converge asking for help. When I complained to higher up the food chain the RACS doubled down and did nothing about my complaint. I will never ask the RACS for help again.

These questions are all about my "workplace", but the only incidence I have experienced of a man shouting and talking over me was by an employee of RACS. Maybe start with RACS itself.

Powerful positions

Another sub-theme included comments about people who behave badly being in senior positions where they influence the culture and behaviour of others. The degree of emotion evident in these comments indicates the significance of this issue. Comments include:

It's just ridiculous. Utterly ridiculous. You guys in the college have no idea. The main perpetrators of bullying in my previous public hospital were the exact same people in charge of the anti-bullying campaign in the department. In fact, the registrars had the poster in the reg room as a joke: the poster had the photo of the main culprit declaring that bullying was unacceptable. What a f$#%@g joke. My partner was subject to a torrent of verbal and sexual innuendo abuse in theatre by a senior vascular consultant only last month. That f@#$r continues to be a total bastard every day. And no one has a f@$#g clue how to report it. Because here is the problem: proving this problem is impossible. It's he said v she said. The only thing that is clearly and unequivocally documented is the fact that the recipient of the abuse reported it. And as such, because the crime can't be proved, all everyone ever knows is such and such accused such and such of harassment. You guys sit in your ivory tower and continue with your paperwork. F@#%g joke.

The problem is that all of the above is a process of box ticking. Some of the worst perpetrators are the people in prominent places in the hierarchy. The practice of bullying is endemic in Australia/New Zealand. Many of the worst perpetrators sit on the major committees of the college. These are the sad facts.

I'm not sure. Powerful people are powerful. I cannot complain about them because they own everybody in the hospital and my voice can't do anything except making my situation worse! So I decided to be quite!

RACS has a major problem in that the worst bullies occupy positions of power within the organisation. In our specialty the chairman of the board and the recent president of the society are both notorious bullies. One of the two is also an examiner and also intimidates and bullies candidates in the fellowship exam, which currently has a pass rate of 25%. It is difficult to address bullying while the organisation is one of the major perpetrators of bullying.

Get rid of all the bullies that run the college and the anti-bullying campaigns. Foster and nurture a culture of respect by embodying it rather than having notorious bulllies tell the rest of us how we shouldn't be bullies.

Simply at a loss. I don't see anything that has changed since I experienced and highlighted my own personal discrimination 20 years ago, and which continues to this day. Although to be fair I'm in the twilight of my career and have given

up caring. Could have been so different. But when you have individuals at the very top of RACS committing the offences there's little hope.

its hopeless because the worst offenders are in administration.

Don't have bullies become the face of the college anti bullying campaign.

Preventing supervisor of training from misusing their position especially when a trainee do external rotation and the receiving hospital supervisor abuse his position for advantage of his own private work and don't care about supporting trainees and their unsafe working hours. It is abuse of power and assessment.

There has been a lot done to raise awareness of gender and race discrimination in surgery. The RACS' efforts have been, I feel, heartfelt and thoughtful. The problem is that we are dealing with mostly older surgeons with deeply ingrained attitudes who dismiss these efforts as 'woke' and 'jumping on the bandwagon'. These are often people in powerful positions who pay lip service to the ideals without carrying through.

Theme 5: Partnerships

63 (7%) of comments related to other organisations, mainly workplaces. Two sub-themes emerged, the first being the need for RACS to work with other organisations because RACS' members work in environments that RACS does not control or influence; the second sub-theme is that some perpetrators of unacceptable behaviour are not RACS members and change in this group can only occur with the collaboration of workplaces.

Partnerships

43 comments (5%) related to the fact that hospitals and workplaces have their own culture, and that the surgeon is just one of many who influence that culture. A number of commenters recognised that RACS is leading the way with respect and recommended that RACS work with other organisations to help them progress in the area of diversity and respect. Typical comments include:

The surgeons' workplace has other categories of people as well (specially the public hospitals). The place is run by managers and HR depts - neither of these classes of people are members of any professional organisation. Their ethical standards and standards of workplace behaviour are therefore appalling. Somehow, the RACS's standard should be applicable to these classes of workers as well to have any real impact. The HR in my hospital has a particularly nasty reputation in the way it deals with complaints about bullying. Please help!!

The RACS is fine. Hospital administration and power affected heads of department are the problems.

RACS needs to engage directly with health administrators and lead the discussion. Other areas of hospital are not as engaged as RACS.

It would be useful for RACS to provide some guidelines to private hospitals who are more likely to turn a blind eye to bullying from surgeons towards staff in order to keep the surgeons happy.

Have more control on private hospitals by giving or withdrawal of the college support to such institutions

Ensure that the hospitals where surgeons work also have the infrastructure to support the work being done in relation to discrimination by the RACS. This is not just about stopping bullying or sexual or racial discrimination. Most surgeons agree this is totally inappropriate and most surgeons do not practice these. The other issue that is almost never talked about, but which has become a bigger threat in the hospital system is the weaponizing of anti-bullying procedures by surgeons who are being called out for their professional or clinical behaviour. Unless there is a cross agreement from the hospitals, with the hospital administrators support then the RACS work will be ineffective.

Help hospitals and institutions develop and apply effective mechanisms for dealing with these behaviours. The current measures still leave whistle blowers open to criticism and further harassment whilst the perpetrators often get away with it. Work is needed with the AMA to establish clear and enforceable guidelines. Brigham and women's hospital Boston is a good example of this.

Improve meaningful collaboration with Hospitals and State Health when "issues" arise Push for hospital wide use of OWR and Peer feedback programs.

Do more workplace inspections and random confidential interviews with staff.

Work with places of employment to ensure RACS values are reflected in the workplace, and BHD are addressed in the workplace.

Continue to promote education about the issues, with direct links to our employers. Our hospital executive teams need to improve their education about options for discussion within the workplace, and referral points. RACS has led the way on this, but our employers are behind and the ability of RACS to exert influence is limited.

There are limits to what RACS itself can do and it has done what it can. Hospital HR departments have to do the leg work when this behaviour occurs.

RACS to work with the territory government/ health authority to impose recommendations /effective investigation process to identify and to take appropriate disciplinary action against these people. Unfortunately, many issues are not investigated properly due to bias. I believe the investigation process itself has bias on decisions, depending on the person who is being investigated.

Other staff as perpetrators

20 respondents (2%) made the point that unacceptable behaviours are often made by other staff who are not RACS members. Typical comments include:

> *I have no issue with what the college is doing to improve behaviours among surgeons, fellows of the college and it's trainees. My personal experience is we don't do enough to address bad behaviours from our nursing colleagues from whom I have seen the majority of bad behaviours in theatre. This is a form of ingrained territorialism and is often well timed when the consultant is not there. The policies to 'create and maintain a positive collegiate working environment' in theatre ultimately fails when there is only one side doing all the work.*

> *From my observation the major problem is abusive behaviour from nurses and other non-surgical specialties towards trainees/ registrars.*

> *For me the biggest issue in surgery as female trainee at the moment is the differential treatment of female surgeons/registrars by (predominantly female) nursing staff. This may be out of RACS scope to address but it is a significant issue. "power moves" of senior nurses belittling (predominantly) female registrars and the perception that female surgeons are being "demanding" or "bitchy" when making identical requests as male surgeons is really doing my head in.*

> *Focus less on Surgeon behaviour. I feel all the messaging from RACS has been on surgeons being the instigators of bullying as a result of an assumed power imbalance. This is not true in my experience. Nurses due to their numbers carry enormous influence particularly in the private settings. I have found the RACS campaigns painting surgeons as instigators of abuse most unhelpful. Having high expectations (not unrealistic nor unfair) is important in surgery. The culture RACS has implied has made making any criticism of performance in the operating theatre or wards near impossible. Patients rightly have high expectations. It is our responsibility to meet those expectations. Most nurses are amazing and incredible to work with, but some are not focused on best outcomes and cry bullying any time there is any negative feedback irrespective of how sensitively that is handled. The vast, vast majority of surgeons in 2021 are not bullies. I'd like to see that messaging should come from RACS.*

> *Most of the issues/bullying encountered by trainees is not directly related to the behaviour of surgeons or trainees, but the additional staff with whom we interact; administrative staff, JMO unit administration, clinic staff, nursing managers.*

> *The biggest problem is not RACS or the speciality societies but public hospital management who are poorly trained, a law unto themselves and often completely inappropriate. Hence, I quit the public system last week and am going to be much happier in full time private practice.*

> *Address the attitude of hospital administration.*

Raise voice to nurses. Nurses have given me the worst bullying (even worse than surgical consultants) and they have the power to put complaints in whereas I am told we cannot put complaints in against nurses. There need to be education to nurses and warning to them that bullying doctors in training cannot be tolerated - it is often the most difficult to deal with, as 'what can you do if nurses bully you' question is often answered with 'nothing. let it go.'

Theme 6: Miscellaneous comments

150 comments, or 17% of the total, did not fit into the other themes. Many of these comments were short one or two word statements in support of or against the Building Respect Action plan, others offered interesting suggestions. Some comments included:

Change the cycle of behaviour stemming from the premise "that's how it was when I was a trainee" - either consciously or subconsciously. Stop the tide of ego maniacs selecting ego maniacs for the future. Treat our trainees with respect and dignity that every human being deserves. Teach them, don't bully and humiliate them to learn. That's how I was trained. Luckily I had a successful career before surgery and had a strong sense of myself and my character - I didn't change to assimilate these behaviours. Not all my colleagues were the same.

Some of the problems: 1. A lot of bullying and undermining is done in private conversations and therefore is not out in the open to be addressed. 2. I rarely if ever see gender / sexuality / race / cultural based bullying and the RACS spends a lot of time on these topics which are, in my observation, of limited relevance. 3. Many of the bullying complaint and support mechanisms require the reporter to assume the role of victim which is often not what is required and discourages those who are generally happy and productive from engaging with the reporting processes and procedures. 4. Those tasked with dealing with bullies are often compromised by the fact they have to deal with these colleagues in other forums or may be a referrer or receive referrals from the bully. ie they are compromised in their ability to deal with the situation effectively.

RACS also needs to be aware , that, whilst the organisation congratulates itself on increased training of female surgeons (and this is correct - the statistics show that) - reality is the majority of NSW female trainees completing training are not successful in securing a public appointment - it is still "jobs for the boys " in spite of apparent transparent employment processes.

Not sure what the answer is for the few people out there that have a problem with it. Reporting issues is difficult because trainees worry about their own reputation and being identified by virtue of the fact that the currently occupy the posting where the problem is, therefore conceivably it is easy for the accused to figure out who is making the complaint. Most people (99% of the time) just put up with it because that is easier than fear of reprisal. I know this to

be true for many of my colleagues I've spoke to over the years. There probably needs to be more responsibility placed on the shoulders of senior surgeons who are in a position to do something about it rather than the victims who are invariably junior and perpetually in a relatively vulnerable position

At the core of all bullying and sexual harassment within surgery is power imbalance. The consultant has means to negatively impact the trainee's career and especially non-trainee registrars' prospects of securing a place on an accredited training program. For this reason, it is extremely difficult for more junior staff to take action when bullied or harassed or to speak up when experiencing poor work conditions. If RACS were somehow able to enable junior staff to act on what they see and experience without fear of reprisal, then this would drop a significant barrier to culture change. Practically speaking I don't know what this would look like and in an apprenticeship model of training that we currently have I'm not sure there is a practical solution. However, a maximally objective selection process for trainee selection would be a good start.

I know what to do when I see or experience bullying and harassment, but I will not take a step as it is more harmful to the person complaining and the system doesn't change unless you have independent parties involved, ie not raising these issues with your own supervisor. Supervisors usually have their hands tied due to other dept politics and at my last hospital was a very junior consultant anyway. Besides supervisors are always so busy, getting your forms signed off with them is enough hassle, let alone raising serious issues like above that require so much time attention and energy.

RACS can not change entrenched culture and power structures. Bullying and harassment will be tolerated by victims due to the power imbalance, career impact and stigma associated with making a complaint. Culture change will take a long time to work through the system.

Encourage younger leadership in departments and training supervisors. "The old guard" now provides the biggest barrier to culture change. That being said they also hold the important knowledge of our craft so it's an important process to get right to benefit both patients and surgeons alike.

Most bullying comes from Australian trained surgeons who belittle others because of fear for their private practices in my opinion.

Attachment 9: 2021 Prevalence Survey Questions

RACS Discrimination, bullying and sexual harassmentprevalence survey 2021

Introduction

Thank you for taking part in this important survey.

This survey aims to check the incidence of discrimination, bullying and sexual harassment in surgery. In 2015, the results of a prevalence survey inspired RACS' commitment to building respect in surgery. In 2021, as we prepare our next Action Plan, we want to know how much has changed.

This survey will take about 15 minutes to complete.

Please take a few minutes to give us your feedback. It will make a difference towhat we do next. **The survey closes on Wednesday 2nd June 2021.**

Privacy and confidentiality

It is safe and confidential to do this survey. Your answers will be anonymous. The information gathered from this survey will not be identifiable. It will be aggregated and used to improve RACS' work to build respect in surgery. An independent company, The Thread Consulting has been engaged to conduct the survey and compile the results. The final report will be made available to all Fellows, Trainees and SIMGs of the College.

If you have any concerns about this survey, please feel free to contact RuthFriedman at ruth@thethreadconsulting.com.au

Raising specific concerns

You can raise a specific concern about discrimination, bullying or sexual harassment by calling the RACS Feedback and Complaints office for a confidential discussion:
1800 892 491 (Australia) or 0800 787 470 (New Zealand)
Please do NOT report or cite a specific concern in this survey. This surveycannot respond or assist you.
More information about the RACS Feedback and Complaints process is detailed here https: /www.surgeons.org/about-racs/feedback-and-complaints

Confidential support

The RACS Support Program, provided by Converge International, offers confidential support to RACS members and their families, at no cost. To access this service, please identify yourself as a Fellow, Trainee or SIMG of RACS.

Telephone: 1300 687 327 Australia or 0800 666 367 New ZealandEmail eap@convergeintl.com.au

Appointments available from 8.30am – 6.30pm Mon - Fri (excluding public holidays)

24/7 emergency telephone counselling is available.

RACS Discrimination, bullying and sexual harassmentprevalence survey 2021

Demographics

* 1. My age

- Under 30
- 30-40
- 41-50
- 51-60
- 61-70
- 71+

* 2. My location

- New Zealand
- Australia

* 3. I describe my gender as

- Male
- Female
- In another way

* 4. My status with RACS (Please tick one)

- Fellow < 10 years
- Fellow > 10 years
- Surgical Trainee
- Specialist International Medical Graduate

* 5. My roles (Please tick all that apply)

- [ ] Non-clinical role
- [ ] Surgical consultant
- [ ] Trainee supervisor
- [ ] Surgical trainer
- [ ] SIMG assessor
- [ ] Department Head/Divisional Director
- [ ] Other

* 6. My specialty

- ○ Cardiothoracic Surgery
- ○ General Surgery
- ○ Neurosurgery
- ○ Orthopaedic Surgery
- ○ Otolaryngology Head and Neck Surgery
- ○ Ophthalmology
- ○ Paediatric Surgery
- ○ Plastic and Reconstructive Surgery
- ○ Urology
- ○ Vascular Surgery

* 7. Thinking about **your workplace**, have you **personally experienced** any of the following behaviours **in the last 12 months**? (Please tick all that apply)

- [ ] Sexual innuendo/propositioning
- [ ] Inappropriate physical contact
- [ ] Sexually explicit or offensive jokes
- [ ] Aggression or physical abuse
- [ ] Comments about my clothing/sexual orientation/body
- [ ] Unwelcome sexual flirtations/requests for dates
- [ ] Questions or insinuations about my sexual or private life
- [ ] Display of sexually suggestive material
- [ ] Demands for sexual favours
- [ ] Sexual assault
- [ ] None of the above

RACS Discrimination, bullying and sexual harassmentprevalence survey 2021

Your personal experience of sexual harassment- some details

8. Who displayed this behaviour? (Tick all that apply)

- [ ] Surgical consultant
- [ ] Other medical consultant
- [ ] Surgical Trainee
- [ ] Nurse
- [ ] Allied Health professional
- [ ] Medical/Hospital administrator

Other (please specify)

9. What was the gender of the person who displayed this behaviour?

- ○ Male
- ○ Female
- ○ Other

10. How often did this behaviour occur?

- ○ One-off event
- ○ On two or three occasions
- ○ On more than three occasions

11. In which setting did it occur? (Please tick all that apply)

- [ ] Metropolitan region
- [ ] Rural region
- [ ] Public hospital
- [ ] Private hospital

Other (please specify)

12. Where did it occur? (Please tick all that apply)

- [ ] New Zealand
- [ ] NSW
- [ ] Victoria
- [ ] Queensland
- [ ] ACT
- [ ] Tasmania
- [ ] South Australia
- [ ] Western Australia
- [ ] Northern Territory
- [ ] None of the above

13. How did you respond to this behaviour? (Please tick all that apply)

- [ ] Took no action
- [ ] Discussed it with family, friends or personal network
- [ ] Discussed it with a senior colleague or mentor
- [ ] Addressed it directly with the person
- [ ] Brought it to the attention of my supervisor or manager
- [ ] Spoke to Converge International (RACS Support Program)
- [ ] Discussed it with a lawyer or legal service
- [ ] Made a complaint through my workplace
- [ ] Made a complaint with RACS
- [ ] Other

14. Did any of the following influence your decision about how to respond to thisbehaviour? (Please tick all that apply)

- [ ] I didn't know what to do
- [ ] Effect on my future career options
- [ ] I knew what to do because of the skills I've gained through Building Respect training
- [ ] Fear of making the situation worse
- [ ] Possible damage to my reputation
- [ ] Possible damage to the reputation of the person responsible
- [ ] The RACS feedback and complaints process is too stressful
- [ ] All complaints processes are too stressful
- [ ] The RACS feedback and complaints process is not effective
- [ ] All feedback and complaints processes are not effective
- [ ] Other

15. Did you receive any support during this time? (Please tick all that apply)

- [ ] From my peers or mentors
- [ ] From my friends and family
- [ ] From my employer
- [ ] From my employer's counselling service
- [ ] From Converge International (RACS Support Program)
- [ ] I did not receive support
- [ ] Other

16. What was the outcome of your response? (Please tick all that apply)

- [ ] The behaviour continued
- [ ] The behaviour stopped
- [ ] I left my job
- [ ] I was victimised for making a complaint
- [ ] My reputation suffered
- [ ] My career was compromised
- [ ] The complaint has not yet been finalised
- [ ] The complaint was not progressed by the receiving body
- [ ] My employer made changes in the workplace to prevent this behaviour in the future
- [ ] Other

17. Has the matter been resolved to your satisfaction?

- ◯ Yes
- ◯ No
- ◯ Unsure

Your personal experience of discrimination, bullying or harassment

* 18. Thinking about **your workplace**, have you **personally experienced** any of the following behaviours **in the last 12 months?** (Please tick all that apply)

- [ ] Aggression or physical abuse
- [ ] Being denied operating lists
- [ ] Being excluded from meetings related to my role
- [ ] Being assigned meaningless tasks
- [ ] Being excluded from social events where other colleagues have been invited
- [ ] Being denied a promotion
- [ ] Being denied training opportunities
- [ ] Receiving favourable treatment because of my gender or race
- [ ] Being undermined
- [ ] Humiliating comments made about me or towards me when alone
- [ ] Humiliating comments made about me or towards me in front of others
- [ ] Inappropriate criticisms/accusations
- [ ] Belittling behaviour
- [ ] Comments about my culture or race
- [ ] Yelling or shouting
- [ ] None of the above

Your personal experience of discrimination, bullying or harassment-some details

19. Who displayed this behaviour?

- [ ] Surgical consultant
- [ ] Other medical consultant
- [ ] Surgical Trainee
- [ ] Nurse
- [ ] Allied Health professional
- [ ] Medical/Hospital administrator
- [ ] Other

20. What was the gender of the person who displayed this behaviour?

- ◯ Male
- ◯ Female
- ◯ Other

21. How often did this behaviour occur?

- ◯ One-off event
- ◯ On two or three occasions
- ◯ On more than three occasions

22. In which setting did it occur? (Please tick all that apply)

- [ ] Metropolitan region
- [ ] Rural region
- [ ] Public hospital
- [ ] Private hospital

Other (please specify)

23. Where did it occur? (Please tick all that apply)

- [ ] New Zealand
- [ ] NSW
- [ ] Victoria
- [ ] Queensland
- [ ] ACT
- [ ] Tasmania
- [ ] South Australia
- [ ] Western Australia
- [ ] Northern Territory
- [ ] None of the above

24. How did you respond to this behaviour? (Please tick all that apply)

- [ ] Took no action
- [ ] Discussed it with family, friends or personal network
- [ ] Discussed it with a senior colleague or mentor
- [ ] Addressed it directly with the person
- [ ] Brought it to the attention of my supervisor or manager
- [ ] Spoke to Converge International (RACS Support Program)
- [ ] Discussed it with a lawyer or legal service
- [ ] Made a complaint through my workplace
- [ ] Made a complaint with RACS
- [ ] Other

25. Did any of the following influence your decision on how to respond to thisbehaviour? (Please tick all that apply)

☐ I didn't know what to do

☐ Effect on my future career options ☐

Fear of making the situation worse

☐ I knew what to do because of the skills I've gained through the Building Respect training

☐ Possible damage to my reputation

☐ Possible damage to the reputation of the person responsible ☐

The RACS feedback and complaints process is too stressful ☐ All

complaints processes are too stressful

☐ The RACS feedback and complaints process is not effective ☐

All feedback and complaints processes are not effective

☐ Other

26. Did you receive any support during this time? (Please tick all that apply)

- [ ] From my peers or mentors
- [ ] From my friends and family
- [ ] From my employer
- [ ] From my employer's counselling service
- [ ] From Converge (RACS support program)
- [ ] I did not receive support
- [ ] Other

27. What was the outcome of your response? (Please tick all that apply)

- [ ] The behaviour continued
- [ ] The behaviour stopped
- [ ] I left my job
- [ ] I was victimised for making a complaint
- [ ] The complaint has not yet been finalised
- [ ] The complaint was not progressed by the receiving body
- [ ] My employer made changes to the workplace to prevent this behaviour in the future
- [ ] Other

28. Has the matter been resolved to your satisfaction?

- ( ) Yes
- ( ) No
- ( ) Unsure

* 29. Thinking about **your workplace**, have you **witnessed** any of the following behaviours **in the last 12 months?** (Please tick all that apply)

- [ ] Sexual innuendo/propositioning
- [ ] Inappropriate physical contact
- [ ] Sexually explicit or offensive jokes
- [ ] Aggression or physical abuse
- [ ] Comments about my clothing/sexual orientation/body
- [ ] Unwelcome sexual flirtations/requests for dates
- [ ] Questions or insinuations about my sexual or private life
- [ ] Display of sexually suggestive material
- [ ] Demands for sexual favours
- [ ] Sexual assault
- [ ] None of the above

Witnessing sexual harassment - some details

30. Who displayed this behaviour?

- [ ] Surgical consultant
- [ ] Other medical consultant
- [ ] Surgical Trainee
- [ ] Nurse
- [ ] Allied Health professional
- [ ] Medical/Hospital administrator
- [ ] Other

31. What was the gender of the person who displayed this behaviour?

- ○ Male
- ○ Female
- ○ Other

32. How often did this behaviour occur?

- ○ One-off event
- ○ On two or three occasions
- ○ On more than three occasions

33. In which setting did it occur? (Please tick all that apply)

- ◯ Metropolitan region
- ◯ Rural region
- ◯ Public hospital
- ◯ Private hospital

Other (please specify)

34. Where did it occur? (Please tick all that apply)

- ☐ New Zealand
- ☐ NSW
- ☐ Victoria
- ☐ Queensland
- ☐ ACT
- ☐ Tasmania
- ☐ South Australia ☐
- Western Australia ☐
- Northern Territory ☐
- None of the above

35. How did you respond to this behaviour? (Please tick all that apply)

- [ ] Took no action
- [ ] Discussed it with family, friends or personal network
- [ ] Discussed it with a senior colleague or mentor
- [ ] Addressed it directly with the person
- [ ] Brought it to the attention of my supervisor or manager
- [ ] Spoke to Converge International (RACS Support Program)
- [ ] Discussed it with a lawyer or legal service
- [ ] Made a complaint through my workplace
- [ ] Made a complaint with RACS
- [ ] Other

36. Did any of the following influence your decision about how to respond to this behaviour? (Please tick all that apply)

- [ ] I didn't know what to do
- [ ] Effect on my future career options
- [ ] Effect on the victim's future career options
- [ ] Fear of making the situation worse
- [ ] I knew what to do because of the skills I've gained through the Building Respect training
- [ ] Possible damage to my reputation
- [ ] Possible damage to the reputation of the person responsible
- [ ] Possible damage to the reputation of the victim
- [ ] The RACS feedback and complaints process is too stressful
- [ ] All complaints processes are too stressful
- [ ] The RACS feedback and complaints process is not effective
- [ ] All feedback and complaints processes are not effective
- [ ] Other

37. Did you receive any support during this time? (Please tick all that apply)

☐ From my peers or mentors ☐

From my friends and family ☐

From my employer

☐ From my employer's counselling service

☐ From Converge International (RACS Support Program) ☐ I

did not receive support

☐ Other

38. What was the outcome of your response? (Please tick all that apply)

- [ ] The behaviour continued
- [ ] The behaviour stopped
- [ ] I left my job
- [ ] I was victimised for making a complaint
- [ ] My reputation suffered
- [ ] My career was compromised
- [ ] The complaint has not yet been finalised
- [ ] The complaint was not progressed by the receiving body
- [ ] My employer made changes in the workplace to prevent this behaviour in the future
- [ ] Other

39. Has the matter been resolved to your satisfaction?

- ◯ Yes
- ◯ No
- ◯ Unsure

Witnessing discrimination, bullying or harassment

* 40. Thinking about **your workplace**, have you **witnessed** any of the following behaviours **in the last 12 months?** (Please tick all that apply)

- [ ] Aggression or physical abuse
- [ ] Being denied operating lists
- [ ] Being excluded from meetings related to my role
- [ ] Being assigned meaningless tasks
- [ ] Being excluded from social events where other colleagues have been invited
- [ ] Being denied a promotion
- [ ] Being denied training opportunities
- [ ] Receiving favourable treatment because of my gender or race
- [ ] Being undermined
- [ ] Humiliating comments made about me or towards me when alone
- [ ] Humiliating comments made about me or towards me in front of others
- [ ] Inappropriate criticisms/accusations
- [ ] Belittling behaviour
- [ ] Comments about my culture or race
- [ ] Yelling or shouting
- [ ] None of the above

Witnessing discrimination, bullying or harassment - some details

41. Who displayed this behaviour?

- [ ] Surgical consultant
- [ ] Other medical consultant
- [ ] Surgical Trainee
- [ ] Nurse
- [ ] Allied Health professional
- [ ] Medical/Hospital administrator
- [ ] Other

42. What was the gender of the person who displayed this behaviour?

- ○ Male
- ○ Female
- ○ Other

43. How often did this behaviour occur?

- ○ One-off event
- ○ On two or three occasions
- ○ On more than three occasions

44. In which setting did it occur? (Please tick all that apply)

- [ ] Metropolitan region
- [ ] Rural region
- [ ] Public hospital
- [ ] Private hospital

Other (please specify)

45. Where did it occur? (Please tick all that apply)

- [ ] New Zealand
- [ ] NSW
- [ ] Victoria
- [ ] Queensland
- [ ] ACT
- [ ] Tasmania
- [ ] South Australia
- [ ] Western Australia
- [ ] Northern Territory
- [ ] None of the above

46. How did you respond to this behaviour? (Please tick all that apply)

- [ ] Took no action
- [ ] Discussed it with family, friends or personal network
- [ ] Discussed it with a senior colleague or mentor
- [ ] Addressed it directly with the person
- [ ] Brought it to the attention of my supervisor or manager
- [ ] Spoke to Converge International (RACS Support Program)
- [ ] Discussed it with a lawyer or legal service
- [ ] Made a complaint through my workplace
- [ ] Made a complaint with RACS
- [ ] Other

47. Did any of the following influence your decision on how to respond to this behaviour? (Please tick all that apply)

- [ ] I didn't know what to do
- [ ] Effect on my future career options
- [ ] Effect on the victim's future career options
- [ ] Fear of making the situation worse
- [ ] I knew what to do because of the skills I've gained through the Building Respect training
- [ ] Possible damage to my reputation
- [ ] Possible damage to the reputation of the person responsible
- [ ] Possible damage to the reputation of the victim
- [ ] The RACS feedback and complaints process is too stressful
- [ ] All complaints processes are too stressful
- [ ] The RACS feedback and complaints process is not effective
- [ ] All feedback and complaints processes are not effective
- [ ] Other

48. Did you receive any support during this time? (Please tick all that apply)

☐ From my peers or mentors ☐

From my friends and family ☐

From my employer

☐ From my employer's counselling service ☐

From Converge (RACS support program) ☐ I

did not receive support

☐ Other

49. What was the outcome of your response? (Please tick all that apply)

- [ ] The behaviour continued
- [ ] The behaviour stopped
- [ ] I left my job
- [ ] I was victimised for making a complaint
- [ ] The complaint has not yet been finalised
- [ ] The complaint was not progressed by the receiving body
- [ ] My employer made changes to the workplace to prevent this behaviour in the future
- [ ] Other

50. Has the matter been resolved to your satisfaction?

- ◯ Yes
- ◯ No
- ◯ Unsure

Culture

* 51. Thinking about **your main workplace today**, how strongly do you agree or disagree with the following?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Don't knw/NA
There is a supportiveand inclusive culturethat deals effectivelywith discrimination, bullying and sexual harassment.	○	○	○	○	○	○
The surgical department heads and surgical supervisors deal effectively with discrimination, bullying and sexual harassment.	○	○	○	○	○	○
The Hospital Executive deals effectively with discrimination, bullying and sexual harassment.	○	○	○	○	○	○
Surgeons understand the difference between reasonable performance management/feedback measures and discrimination, bullying or sexual harassment.	○	○	○	○	○	○

* 52. Thinking about **your main workplace**, are you aware of any of the following? (Tick all that apply)

- [ ] Policy on discrimination, bullying or sexual harassment.
- [ ] Policy on equal opportunity and gender equity.
- [ ] Complaint and grievance procedure.
- [ ] Information about discrimination, bullying and sexual harassment for new employees.
- [ ] Training on equity, discrimination, bullying and sexual harassment in the workplace.
- [ ] Designated contact person for concerns about discrimination, bullying or sexual harassment in the workplace.
- [ ] Availability of flexible working arrangements.
- [ ] None of the above

* 53. **In the last 12 months**, have you asked your employer for flexible working or training arrangements?

- ◯ Yes
- ◯ No

54. If yes, what was the outcome?

- ◯ Approved
- ◯ Partially approved
- ◯ Considered but not approved
- ◯ Immediately refused
- ◯ Other
- ◯ N/A

55. Thinking about **the culture today at your workplace** how strongly do you agree or disagree with the following?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Don't know/NA
My workplace is supportive of female surgeons.	○	○	○	○	○	○
My workplace is supportive of Trainees.	○	○	○	○	○	○
My workplace is supportive of people from different cultural backgrounds.	○	○	○	○	○	○

56. Thinking about **the culture today at RACS** how strongly do you agree or disagree with the following?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Don't know/NA
RACS is supportive of female surgeons.	○	○	○	○	○	○
RACS is supportive of Trainees.	○	○	○	○	○	○
RACS is supportive of people from different cultural backgrounds.	○	○	○	○	○	○

57. Thinking about **the culture today at your Specialty Society** how strongly do you agree or disagree with the following?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Don't know/NA
My Specialty Society is supportive of female surgeons.	○	○	○	○	○	○
My Specialty Society is supportive of Trainees.	○	○	○	○	○	○
My Specialty Society is supportive of people from different cultural backgrounds.	○	○	○	○	○	○

* 58. Thinking about **what you know about discrimination, bullying and sexual harassment**, how strongly do you agree or disagree with the following?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Don't know/NA
I know what to do to address discrimination, bullying and sexual harassment **when I see it**.	○	○	○	○	○	○
I know what to do to address discrimination, bullying and sexual harassment **when I experience it**.	○	○	○	○	○	○

59. Reflecting on the issues canvassed in this survey, what is the most usefulthing RACS could do to build a culture of respect in surgery?

RACS Discrimination, bullying and sexual harassmentprevalence survey 2021

Thank you

We appreciate your time.

Your responses will help RACS build a culture of respect.