

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS



**RESPONSE TO THE SENATE COMMUNITY AFFAIRS REFERENCE
COMMITTEE INQUIRY INTO MEDICAL COMPLAINTS**

NOVEMBER 2016

About the Royal Australasian College of Surgeons

The Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand. RACS is a not-for-profit organisation that represents more than 7000 surgeons and 1300 surgical trainees and International Medical Graduates (IMGs). It also supports healthcare and surgical education in the Asia-Pacific region and is a substantial funder of surgical research.

RACS provides training in nine surgical specialties, cardiothoracic surgery, general surgery, neurosurgery, orthopaedic surgery, otolaryngology head and neck surgery, paediatric surgery, plastic and reconstructive surgery, urology and vascular surgery. The College plays an active role in the setting of standards of surgical care, the training of surgeons and their participation in continuing medical education throughout their lifetime of surgical practice.

As part of our commitment to standards and professionalism RACS strives to take informed and principled positions on issues associated with the delivery of health services. RACS takes very seriously the subject of this inquiry and acknowledges that there is no doubt that bullying and harassment occurs in the surgical workplace. Over the past eighteen months in particular, our College has dedicated considerable resources to ensuring a comprehensive response to this issue.

Every individual has the right to a healthy workplace. Discrimination, bullying and sexual harassment (DBSH) demeans individuals and prevents them from reaching their true potential. Sadly, it is also the cause of a great loss of invaluable talent from the health sector. This insidious and unprofessional conduct cannot be tolerated. We welcome the opportunity to participate in this inquiry, to share our experiences, and to assist in any way we can.

Background

Media reports profiling DBSH by surgeons were first published in late 2014. The reports, which continued throughout 2015, were distressing and highlighted the serious adverse impact it can have on the lives of individuals. While we acknowledge that as a College, we have made mistakes in dealing with such matters in the past, the media reports helped galvanise RACS, and led to decisive action.

In March 2015, RACS appointed an Expert Advisory Group (EAG) to look into the prevalence of DBSH in the practice of surgery and to understand the extent of the problem in Australia and New Zealand. While the EAG was resourced and supported by RACS, it was independent of the College with a panel of esteemed experts in varying fields including human rights, law, police, government and medicine.

Before developing its final report on how to address DBSH, the EAG first had to develop an understanding of the extent of the problem. In order to ascertain this information, the EAG adopted a multi-pronged approach. The wide-ranging consultation and engagement campaign included;

- An **independent prevalence survey** of all RACS Fellows, Trainees and IMGs. The survey was conducted by Best Practice Australia.
- A series of **online forum where** RACS Fellows, Trainees and IMGs were invited to participate in four independently facilitated and confidential sessions, and discuss ideas about how to prevent and address DBSH in the profession.
- Another independent provider was contracted to collect **personal stories** from people who had experienced discrimination, bullying and sexual harassment but did

not wish to make a formal complaint. Themes and issues from the stories provided are published in a report of this research.

- The EAG sent an **organisational survey** to more than 300 hospitals and employers to learn about their approaches to preventing and addressing discrimination, bullying and sexual harassment.

All of these information collection methods were used to guide the final EAG report and recommendations. Throughout the process RACS committed to ensuring full transparency and that the results from all of these methods would be made publically available on our website. For more detailed information, please see each of the links below;

- [Independent Prevalence Survey](#)
- [Online facilitated discussions](#)
- [Personal accounts of bullying, discrimination and sexual harassment](#)
- [Organisational Culture and Solutions Survey](#)

The research found that:

- 49% of Fellows, Trainees and IMGs report being subjected to discrimination, bullying or sexual harassment (DBSH)
- 54% of trainees and 45% of Fellows less than 10 years post-fellowship report being subjected to bullying
- 71% of hospitals reported DBSH in their hospital in the last five years, with bullying the most frequently reported issue
- 39% of Fellows, Trainees and IMGs report bullying, 18% report discrimination, 19% report workplace harassment and 7% sexual harassment
- the problems exist across all surgical specialties and
- senior surgeons and surgical consultants are reported as the primary source of these problems.

Despite these unacceptable behaviours being prohibited by workplace laws and in some cases a criminal offence; we know that DBSH occurs in many workplace environments. In regards to the health system, and in particular surgery - trainees, IMGs and female staff are identified as the most likely targets. Proceduralists are particularly likely to offend. Some offenders unwittingly reproduce behaviours they have learned from role models of previous generations. Others are more deliberate or determined perpetrators, often with a reputation for misbehaviour that frequently goes unchecked.

Observers who are aware of such behaviour may be co-victims or co-perpetrators, or both. Hospitals and professional associations sometimes foster a culture of abuse through covert sanctions against complainers, or by providing tacit approval by failing to act or by discouraging change. There is little doubt of the perception among trainees and junior medical doctors that complaining can damage a career. Therefore, the underreporting of unacceptable behaviours is prevalent across the entire health sector. Despite explicit professional values being taught, these seem to be overlooked, and there is a perceived disconnect between organisations' stated values and their responses in individual cases of unacceptable behaviour.

Regarding barriers, whether real or perceived to reporting of DBSH, the EAG Report found:

- There is a sense that there are no consequences for perpetrators. No action is seen to be taken even against those about whom allegations have been proven.
- That fear about the impact on career or training of making a complaint effectively stops people from reporting complaints or speaking out. Hierarchy and power are central issues.

- People report not speaking out (about bullying or conditions or the behaviour of others) for fear of being seen as weak or unsuitable for surgery; concerns about marginalisation; and being denied workplace opportunities, including in theatre. They report making a complaint as ‘career suicide’ and fear being ‘black-balled’ in areas such as selection, references, job recommendations, appointment processes, and career path.
- There is a lack of any mechanism to raise – and address – concerns or issues early, which means they either escalate into formal complaints or are not addressed at all.
- Legalistic approaches commonly in place for complaints management narrow the focus of investigations, fail to address the real issues and focus on the individual not the issue. This approach can polarise the parties, fail to deal with root causes and rely for resolution on individuals exposing themselves to significant risk of reprisal.
- Despite their legal obligations, hospitals are reported to be reluctant to take action on badly behaved surgeons for a range of reasons, including potential financial and operational consequences; potential negative impacts on hospital performance and reputation; and skill gaps in executive leadership.

The EAG provided its final report to RACS in September 2015, which outlined that the College needed to do much more to prevent and address DBSH in surgery. The College accepted in full the 42 recommendations in the report and RACS President, Professor David Watters, made an unreserved public apology to anybody who had suffered from DBSH in the practice of surgery.

A copy of the final EAG report is available [here](#)

In November 2015 RACS launched an [Action plan in response to the EAG Recommendations](#). The plan details a comprehensive, multi-year program of work designed to promote respect, counter discrimination, bullying and sexual harassment in the practice of surgery, and improve patient safety. RACS will be reporting publicly each year on what has been done, and what has been achieved.

What is RACS doing?

There is no doubt that of all the medical colleges, RACS is leading the work on countering DBSH and changing the culture.

In brief the RACS Action Plan focusses on three key areas of work described below:

1. Cultural change & leadership “Take a stand”

The area of cultural change and leadership as the first pillar of the Action Plan is supported by engagement and collaboration.

This includes discussions with all health jurisdictions and many hospitals to look at areas where we can support each other and work together to improve the culture in medicine. RACS is encouraging employers to base their responses to DBSH on the Vanderbilt Principles¹, which have shown to be successful in the hospital setting.

These discussions can lead to more formal commitment being shown by jurisdictions and hospitals to work with RACS on improving the culture in the health sector through the signing

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

of Memorandums of Understanding (Appendix 1) or Letters of Intent. RACS has signed a few now with several others in discussion (Appendix 2). These MoUs signal a commitment to the employees including trainees and surgeons that we are committed to working together in areas of education, safe training environments, improving diversity and flexible training options, the sharing of information to better handle complaints and co-branding to reinforce this commitment.

Another important partner in this are the medical schools (universities), postgraduate medical councils and other medical colleges, and various discussions with these individuals groups is ongoing, with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) having just signed an MoU regarding exchange of educational resources, support for supervisors and agreement to collaborate and co-brand where possible.

The glue that holds all this together is the Campaign “Let’s Operate with Respect.” It provides the visibility and cohesion to the Action Plan in order to support cultural change.

The Let’s Operating with Respect campaign in hospitals was launched at the RACS Annual Scientific Congress in May this year which brought together 2000 surgeons. The campaign makes a visible connection between these projects and activities. It is focused on surgeons and their profession. It aims to bring together the different parts of the Action Plan, raise awareness of these problems in surgical practice and what the College is doing about them, and support cultural change.

WHAT IS IN THE CAMPAIGN?

- **About respect:** A section of the RACS website with information about the Action Plan, the campaign, the work of the EAG and progress reports.
- **Resources and tools:** On the membership side of this section of the website, is a series of resources and tools that can be used to help build respect and improve patient safety in surgery. There are presentation templates for members to use when giving lectures or talks; presentations with content on the Action Plan and the campaign to raise awareness or update colleagues about this work. There are fact sheets and definitions of unacceptable behaviours. Bandanas and surgical caps are also being printed to spread the key message.
- **Posters:** These contain quotes and statements, made by surgeons supporting the campaign. They can be downloaded from the website and used in tearooms and the surgical workplace to start conversations and raise awareness.
- **Stories and audio:** Surgeons are putting their faces and names to this campaign, through words, audio, video and on social media. This campaign is by surgeons, for surgeons.

2. *Surgical education “Principles of respect, transparency and professionalism”*

In terms of meeting the education goals of the Action Plan, specific training about what DBSH is and its impact is covered through a new e-Learning Module “operate with respect.” This was put together by surgeons and medical educators and is not only an excellent tool for increasing awareness and self-reflection, but is also useful to be shown and discussed in team settings. The e-learning module is mandatory for all Fellows, Trainees accepted into surgical training and IMGs. The module aims to improve knowledge and understanding of DBSH to be able to recognise unacceptable behaviours when they occur and also recognise the adverse impact of these behaviours on individual and team performance and patient safety.

RACS is expanding on the e-learning module by developing a one day face to face course. This will help attendees gain skills in having the sometimes difficult conversations to call behaviour out and to better support a safe learning and operating environment. It will be launched at the RACS ASC in May 2017 and will be mandatory for members of training boards, supervisors and assessors and those on RACS education committees.

The Expert Advisory Group urged the College to better support supervisors, to help strengthen their teaching skills and understanding of adult education methods. As a result, the College Council has resourced the Foundation Skills for Surgical Educators (FSSE) course so that all surgical supervisors can complete it promptly. Completing the FSSE is now a requirement for all Fellows who have contact with surgical trainees.

RACS is also developing a **diversity plan**, which is looking broadly at multiple issues to improve access to surgical training. This is broader than gender, including the promotion of surgery to all cultural and linguistically diverse groups as well as indigenous peoples. The aim is to ensure the College is more reflective and representative of the broader Australian community.

The development of a **mental health plan** is also a key activity with recent agreement by Council to approve a number of actions as first steps to better supporting the mental and physical health of the surgical workforce. They include training on personal resilience and how to deal with work day stresses, promotion of 'do you have a GP?' program, and promotion of the RACS Support Program and its evaluation.

The provision of the RACS Support Program (through Converge), is available free of charge to all RACS Fellows, Trainees and IMGs across Australia and New Zealand.

3. Complaints management “Fair, timely, transparent”

RACS has developed a new comprehensive complaints management system with dedicated expertise and centralised recording. New specialised resources (both psychological and legal) have been procured enabling the College to respond much more effectively. Clear processes are being developed with a new policy and user guide now available to members and the public, see:

[Complaints Policy](#)
[Complaints User Guide](#)

The roles of the Medical Board of Australia, the Australian Health Practitioners Regulation Agency and other relevant organisations in managing investigations into professional conduct

The oversight for health professions is often complex and difficult to distinguish. Varying entities are involved including medical colleges, health departments, hospitals and regulators including the Medical Board and AHPRA. There is a clear lack of coordination between these bodies and a strong requirement for better communication.

There is a time and place for the Medical Board and AHPRA to investigate professional conduct. However, the entities at the coal face of the issue are best placed to deal expeditiously with complaints and then make notification to AHPRA.

One of the key findings from the EAG was that the responsibility to end a culture of bullying and harassment does not reside with any one individual or entity. Employers, hospitals,

governments, health professional and industrial associations, universities, regulators and other partners in the health sector must all commit to sustained action. There is no room for bystanders. While each of these groups can and should develop individual solutions, at the core of the issue is a need for cooperation and collaboration across the health sector.

The operation of the Health Practitioners Regulation National Law Act 2009 (the National Law), particularly as it relates to the complaints handling process;

Each entity has a role to play throughout the complaints management process. Too often the complex system of complaints management has meant, whether it be intentional or unintentional, that the appropriate information is not shared. Additionally, concerns regarding a practitioner's competence are often not passed on to the regulator, due to a reluctance to breach an individual's right to practice. While RACS respects individual liberties, it is imperative that they are not prioritised ahead of the fundamental responsibility of protecting patient safety.

For its part in the process AHPRA must endeavour to maintain ongoing communications with the relevant parties, and also commit to improving the timeliness of its complaints management process. The average time taken by AHPRA to investigate and close a straightforward complaint is nine to 12 months according to their website. In many circumstances, complaints lodged can even take years to resolve. Such a scenario is unacceptable and places an unnecessary amount of stress upon all individuals involved in the process.

We appreciate that the complexities of certain cases may contribute to the length of time taken to resolve complaints; however, AHPRA must look at non-legalistic processes to provide quicker outcomes of complaints in less than six months. A review of processes and commitment to timeframes to resolve a significant number of complaints in less than six months would serve in the best interests of all.

The benefits of 'benchmarking' complaints about complication rates of particular medical practitioners against complication rates for the same procedure against other similarly qualified and experienced medical practitioners when assessing complaints;

RACS welcomes the publication of surgical outcome data, and every effort must be made to ensure that what is published is reliable, and is in a format that facilitates interpretation by those for whom it is intended. The best way to achieve this is to; fund audits and registries, use agreed definitions for disease, procedures and outcomes, and ensure that everyone is able to understand, interpret and value the reports.

Audit processes are enhanced when they are conducted in an open and transparent manner, and publication is encouraged. RACS has a longstanding history of advocating for a comprehensive system of audit, evaluation and peer review. This includes many established processes that are used to monitor and enhance performance, with the ultimate goal of allowing for reflection and improving the quality of care for patients. Further information on the College's activity in this area can be found [here](#).

It must be noted that there is also no such thing as a zero complication rate. The surgeon who "has never seen a complication" has not done enough operating. Managing complications can be challenging and how we respond to complications provides also an opportunity to reflect and learn. It is for this reason that those funding healthcare need to factor in a complication rate, including unplanned readmissions and returns to theatre for the procedures and treatments they cover.

Although surgical outcome are inherently linked to the surgeon and procedure, there are many other aspects of care that outcome measures, including the contributions of different cadres of health worker in the treating team, and the quality of the facilities and resources available. Surgical outcomes are also determined by the pathophysiology of the patient (their comorbidities) and stage of disease.

RACS certainly supports the public release of outcomes based data on surgical performance at a team, institutional or national level but there are caveats. The reports need to be valid, reliable and trustworthy so that surgeons and patients can be confident that reports accurately reflect the standards of health care.

RACS does not recommend the release of reports on individual surgeon performance as there is so much dependence on surgical teams and institutional support in the delivery of surgical care.

RACS welcomes the opportunity to provide this submission and to have been part of the college panel at the 2 November 2016 hearing. We would be very pleased to be able to provide further information as required.