

Expert Advisory Group

on discrimination, bullying and sexual harassment
Advising the Royal Australasian College of Surgeons



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Background Briefing

Background Briefing: Research summary

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1. Introduction

This background briefing should be read with the Issues Paper on discrimination, bullying and sexual harassment published by the RACS Expert Advisory Group.

2. Executive summary

Discrimination, bullying and sexual harassment are significant and persistent problems in medical work environments.

Reducing the incidence of these inappropriate behaviours in the workplace takes continued and persistent effort across all levels of the medical system. What is required is not only a change of behaviour; it is a change of the beliefs of individuals, and a change of the culture of the group and organisation. These changes come at a cost to some people, who can be expected to resist change unless they are provided with a powerful motivation. That motivation comes from the capacity to improve safety for patients and the possibility of a more effective and comfortable work environment.

There are recurring themes identified in this research:

- Discrimination, bullying and sexual harassment in the workplace occur in many countries and many workplace environments
- In the medical working environment these behaviours continue to be endemic, despite the fact that discrimination, bullying and sexual harassment in the workplace have been legally prohibited for decades
- Trainees, medical students, and female staff and colleagues have been identified as the most likely targets or victims
- Surgeons as a group have been commonly identified as perpetrators
- Onlookers and observers can be both co-victims and co-supporters of discrimination and bullying
- Some workplaces support a 'culture of abuse' through a wide range of covert sanctions as well as disincentives for change.

3. Key findings

1. Despite the introduction of anti-discrimination laws and processes to identify and address discrimination, bullying and sexual harassment, these inappropriate behaviours continue to have a negative impact on the health workforce in every region across Australasia as well as in other countries.
2. Inappropriate behaviour, such as discrimination, bullying and sexual harassment, has a negative impact on patient safety.
3. Besides individuals who behave inappropriately, there are a number of interlinked systemic and structural characteristics that help to maintain the status quo and have the potential to reduce the impact of any attempt to implement change.
4. The culture in the surgical workforce has specific issues of its own, particularly in the area of gender discrimination.
5. In the past some attempts to implement change have been successful while others have not.
6. Many attempts to change workforce culture have focused on either/both the victim(s) and the perpetrator, but have overlooked the influence and significance of the social and emotional vested interests of observers and bystanders who contribute to maintaining a culture that accepts inappropriate behaviour.

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7. Future attempts to change the endemic 'culture of abuse' will require an integrated approach that involves individuals, each level within an institution, and across the wider health community.
8. Processes to bring about change will need to be implemented at all levels simultaneously and be visibly maintained.

Definitions

4. The legal framework

Discrimination, bullying and sexual harassment have been prohibited forms of conduct within the workplace for more than 30 years. Anti-discrimination legislation across Australasia prohibits sexual harassment and discrimination or denial of equal opportunity in the work place. It essentially imposes two levels of obligations; one on the individual not to discriminate or sexually harass another, and the other on the employer to take reasonable steps to prevent these behaviours from occurring in the workplace.

Anti-discrimination legislation makes it unlawful to treat a person unfairly because of a personal characteristic protected by law e.g. sex, pregnancy, race, age, disability. It includes both direct and indirect forms of discrimination.

- Direct discrimination occurs where a person is treated less favourably because of a personal characteristic
- Indirect discrimination can occur where a rule, policy or practice applies equally to everyone but can have a disadvantaging effect of people with a particular characteristic.

In the context of the workplace this includes when a person is refused employment, dismissed, denied a promotion or other employment-related benefits; given less favourable terms of employment or denied equal access to training opportunities; or bullied or harassed because of their personal characteristic.

Anti-discrimination legislation also prohibits sexual harassment: conduct of a sexual nature in relation to another person that occurs in circumstances when a reasonable person would have anticipated the other person would be offended, humiliated or intimidated. This prohibition extends to a spectrum of behaviours from low-level lewd comments and sexual innuendo, unwelcome sexual advances or sexual propositions to criminal conduct such as sexual assault.

More recent protections from bullying can be found in occupational health and safety laws, which impose a legal obligation on employers to maintain a safe working environment, including looking after the health and wellbeing of employees while at work by preventing bullying behaviour. Bullying is an unreasonable behaviour that creates a risk to health and safety. It is a behaviour that is repeated over time or occurs as part of a pattern of behaviour. 'Unreasonable Behaviour' is defined as behaviour that a reasonable person, having regard to all the circumstances, would expect to victimise, humiliate, undermine or threaten the person to whom the behaviour is directed.

Similarly, professional standards set for the medical profession and the College's own Code of Conduct establish obligations of ethical and professional behaviour, and require surgeons to treat colleagues with fairness and respect and eradicate bullying or harassment from the workplace.

The regulatory framework in Australia for health practitioners – the National Registration and Accreditation Scheme – includes a mandatory obligation on registered health practitioners and

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employers to report when a registered health practitioner has engaged in 'sexual misconduct in the practice of the profession'. This obligation is not restricted to breaches of patient boundaries, but also can include cases of sexual harassment and assault of colleagues. Mandatory reports must be made to the Australian Health Practitioner Regulation Agency.

5. Sexual harassment as a specific form of discrimination and/or bullying

While over the years there has been a range of different ways of defining and classifying sexual harassment,¹ it is most frequently understood as some form of gender harassment, unwanted sexual attention and/or sexual coercion by members of the opposite sex.^{2;3}

Despite the lack of clear definition, research published in 2000 indicates that across a wide range of studies in different industrialised countries, approximately 50% of all women had been subjected to some form of unwanted sexual advances in their workplace. However, less than 20% of victims were likely to report that experience.⁴ A vast majority of incidents remain unreported due to a lack of confidence that the report would help; a fear of adverse consequences; a reluctance to be viewed as a victim; the status of those who are complicit in harassment in positions of power; as well as cultural minimisation of the problem.⁵

Although there is no typical profile of a harasser or a harassed person, a number of common environmental factors have been identified. This includes a strong hierarchical structure, with a male-dominated workforce. In such work environments, in most cases, harassers were identified as people with whom the victims associated with regularly, i.e. colleagues or supervisors.⁶

More recent studies have identified that societal and cultural values that sustain hierarchical structures and conservatism increase the likelihood of sexual harassment, whereas highly valuing egalitarian ways of life and autonomy is likely to decrease the instance of sexual harassment.⁷ This model is used to explain the high prevalence of, and under-reporting of, sexual harassment in countries such as Turkey (where more than 50% of female doctors indicated that they had experienced sexual harassment at their workplace),⁸ and Japan (where more than 80% of respondents reported having experienced at least one episode of abuse or harassment during residency, and more than 50% of female respondents reported sexual harassment).⁹

6. Gender-based discrimination, particularly in surgery

Gender-based discrimination, predominantly targeting females, is enacted by both sexes and has been found to be particularly prevalent in the surgical workforce.^{10; 11} This form of discrimination has been found to have an impact on female doctors at all levels of seniority, and to be both systemic and individual.

Systemic gender-based discrimination can take a variety of forms, and while some discrimination is overt, much of the covert discrimination has more impact on female surgeons' career satisfaction.

Systemic gender-based discrimination includes:

- An 'old-boys' club' culture
- A hidden curriculum that encourages greater confidence and self-esteem in male colleagues. The following two quotations are examples of this:
 - *"Women who ask for assistance are viewed as weak, uncommitted to the department mission, too emotional"*
 - *"Surgery is particularly cruel to individuals who show weakness, self-doubt, or non-masculine communication patterns"¹²*

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- Lower salaries
- Fewer opportunities for career advancement
- Different referral patterns from other doctors
- Less personal support and/or mentoring
- Lack of senior female surgeons as role models
- Less respect, or a different level of responsiveness, from the medical team¹³
- Bias against pregnancy and/or family responsibilities.

Gender-based discrimination from individuals can include:

- Derogatory remarks
- Discouragement to select surgery as a career or to apply for positions
- Markedly greater attention and encouragement being given to male peers
- Male peers given greater opportunities to participate and learn in the operating theatre
- Double standards in expectations.

All of these experiences and observations have a significant impact on female doctors and surgeons. While there are no statistics on female doctors who choose not to pursue a career in surgery, in one study almost half of the female surgeons indicated that they had considered leaving or declining a position during their career.

Two reasons have been suggested for this ongoing gender-based discrimination. One is that gender-related issues are mainly considered to be women's issues, but cannot be resolved by women.¹⁴ The other is the numerical imbalance between male and female surgeons (in Australasia in 2014, 11% were female).¹⁵

The scope of the problem

7. Within Australasia – the medical workforce generally

A study of the Australian medical workforce conducted in 2008–2009 reported that 25% of the responding doctors had experienced persistent bullying and/or harassment in the previous 12 months, and that consultants, registrars, and other senior doctors were the most commonly reported source of the bullying (44%).⁶

In the Queensland health system between 2012 and 2014, 15,652 incidents that may be related to harassment, plus 176 sexual harassment incidents, were reported to the Occupational Health Safety Commission by workers in the health sector.¹⁶ Recognising that such incidents are usually under-reported,¹⁷ this number is indicative of workplaces where discrimination, bullying and sexual harassment is regular and persistent.

As an example of lack of consequences, despite the scope of the legal obligations, there are only two reported legal cases before health practitioner registration boards involving registered health practitioners engaging inappropriately towards colleagues. In one case, a doctor was found to have engaged in professional misconduct by sexually harassing two nurses by inappropriately touching them, attempting to kiss them and making lewd comments.¹⁸ In another case a physiotherapist was found to have sexually harassed a young female university work experience student.¹⁹ The physiotherapist was found to have inappropriately touched the student under the guise of practical training and legitimate treatment, as her training sessions were also designed to treat her back problem.

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A review of workplace bullying conducted in New Zealand, also in 2008–2009, clearly showed that workplace stress and bullying were significant issues across each of the New Zealand sectors considered in the study. In health and education the problems appeared to be structural.²⁰ The report stated that in those workplaces:

A wide range of organisational factors were associated with workplace stress and bullying risk – including ineffective leadership, resourcing problems, poor work organisation, human resources practices, and organisational strategies for the management of psychosocial hazards.

In particular in the health sector, there was a poor understanding of links between stress and bullying and that high levels of bullying continue to occur.²⁰ For example:

Several respondents stated that bullying was endemic, particularly in large organisations, while others indicated that it was an everyday occurrence.

The common view held by participants was that bullying would not be challenged and made unacceptable unless there was strong leadership present to lead the culture away from such practices.

8. Within Australasia – surgery

While acknowledging the propensity for under-reporting, research in 2013–2014 into the frequency and impact of 'bad professional behaviour' found that the highest proportion of respondents reported being confronted by bad behaviour on a monthly basis (with 34.7% by junior colleagues and 29.5% by senior colleagues). A further large proportion reported a weekly experience of bad behaviour (20.6% by junior colleagues and 15.4% by senior colleagues). Further analysis of the overall proportion of surgeons reporting that they were confronted by bad professional behaviour from a health professional colleague in the workplace more than monthly (58.3% junior colleagues and 48.4% senior colleagues), showed that there was little difference between surgical specialties, or across geographic regions. There was, however, a significant difference between the overall experiences of male (56.6% by junior colleagues and 46.0% by senior colleagues) compared to female surgeons (66.7% by junior colleagues and 60.2% by senior colleagues).²¹

In the 2014 RACS census report 'Stress and Health Monitoring', while the majority of surgeons (Fellows) responded that they experienced little or no stress from workplace discrimination, bullying and sexual harassment, 9% reported moderate levels of stress, 3.7% reported high, and 3.4% reported extreme levels of stress as a result. Within the group indicating extreme or high levels of stress from discrimination, bullying and sexual harassment, there was a higher proportion of females than males.²² Some of the findings in this report initially appear to contradict other published research findings, however this survey did not include young doctors or trainees and was designed to survey a range of sources of stress which apparently most surgeons find more stressful than discrimination, bullying and sexual harassment.

A New Zealand study of workplace bullying of junior doctors in one Auckland hospital found that 50% of those who responded to the survey had experienced bullying.²³

- Bullying behaviour included discrimination, unjustified criticism, verbal threats, undue pressure, having jokes being made about them
- The study found that surgical trainees reported a significantly higher incidence of at least one experience of bullying behaviour compared to those doing medical training.

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- Consultants were the main perpetrators of bullying behaviour
- Only 18% of those who had experienced bullying behaviour made an official complaint.

Evidence of the lack of reporting and/or consequences for the perpetrator is that, despite the protections in place across Australasia, only one case involving a surgeon has been publicly litigated. In 2008, a Victorian Tribunal found that a surgical trainee was sexually harassed by her supervisor after the consultant inappropriately touched her, exposed himself and propositioned her for sex. Some years after winning her case, it was reported that she has since found it difficult to find employment in public and private hospitals.²⁴

Recent media reports about the harassment of surgical trainees and other junior medical doctors suggest that surgical trainees in both Australia and New Zealand experience harassment and bullying behaviour, particularly for female trainees.²⁵ Themes the media reported on were that:

- Many instances of sexual harassment and bullying are unwitnessed
- Many female doctors report that harassment from supervisors is more difficult to deal with than harassment from patients and peers
- Many female doctors are reluctant to come forward; they develop feelings of guilt and consider resignation
- Sexual harassment is particularly bad among surgeons because the profession is very hierarchical and male-dominated, with only 11% of Australian surgeons being female. Career advancement depends on personal recommendations from supervisors and women can often find themselves in poor positions of bargaining power, and thus can be vulnerable to sexual harassment
- The harassment of female surgeons is part of a wider culture that is endemic in the medical profession more generally. Many victims state that they are often not believed and even if they are, the perpetrator does not face any consequences.

9. In other regions – medical environments

The finding that at least one quarter of the Australian medical workforce had recently experienced some form of bullying and/or harassment is not unique. There is evidence from many countries and regions – including the UK^{9,26}, Europe²⁷, USA²⁸, Canada²⁹, Scandinavia³⁰ and China³¹ – of similar behaviours continuing despite efforts to overcome this problem over the last three decades.

One study in the UK reported that 19.9% of healthcare staff had been bullied to some degree in the previous six months.⁹ While another study, focusing specifically on junior doctors and nurses on their first clinical placement, found that one fifth of medical and a quarter of nursing students reported experiencing bullying and harassment.²⁶

Across Europe, there is a wide variation in the reported prevalence of bullying or harassment in the workplace from different EU member states. This ranges from 15% in Finland, and 12% in the Netherlands, to 4% in Portugal and 2% in Italy.²⁷ These differences may reflect the differences in community culture, and in the willingness to report and/or the accessibility of effective reporting systems. Another study reported that approximately 5 to 10% of the European working population perceive themselves as being bullied at any given time, with healthcare workers being listed as one of the highest-risk occupations.⁸

There are large numbers of research studies focusing on experiences of inappropriate and/or unprofessional behaviour in the medical workforce in the USA and/or Canada.

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- Many of these studies focus specifically on medical students, junior doctors and residents. One study was a meta-analysis of 177 articles, reporting a prevalence of harassment and discrimination of between 50–60% during undergraduate medical training.²⁸
- One longitudinal study of female medical students over one year studied and identified some of the ways in which their research participants became enculturated to accepting the inappropriate behaviour of male colleagues as part of their work environment.³²
- Other research has focused on specific craft groups such as nurses, family physicians or surgeons; in each case results show that discrimination, bullying and sexual harassment is endemic in the working environment of that group. For example:

*Workgroup forms of bullying are common among nurses, with studies reporting more than 80% of those surveyed experienced this form of bullying.*³³

*The culture of abuse in the family physicians' workplace may be perpetuated through the modelling of abuse starting in medical school, moving through residency and into the daily workplace of family physicians.*⁴

*Although disruptive physician behaviour is widely considered a source of concern in the patient care environment, surgeons have been the specialty most commonly identified as 'disruptive physicians'.*³⁴

In China researchers found that, in the previous 12 months, about 50% of the respondents in a study conducted in 12 hospitals reported at least one type of workplace violence. Within that group they found varied rates of experiencing two or more episodes of physical assault (11%); emotional abuse (26%); threats of assault (12%); verbal sexual harassment (3%); and sexual assault (1%). High risk-factors for such workplace violence included working in the departments of psychiatry, emergency, paediatrics and surgery.³¹

10. In other professions – in Australia

The prevalence of discrimination, bullying and sexual harassment is not unique to the medical profession and there are significant problems in similar professions where training and mentoring of trainees is traditionally conducted along a patronage/apprenticeship model (e.g. the legal profession). In 2012, the Victorian Equal Opportunity and Human Rights Commission reported the results of an online survey investigating the experiences of women in the legal profession. This survey focused on discrimination, sexual harassment and the accommodation of parental and carer responsibilities.³⁵ Twenty-four percent of respondents surveyed reported experiencing sexual harassment while working as a lawyer or legal trainee.

In 2014, the Law Council of Australia conducted research into the attrition and re-engagement of qualified people in the legal profession.³⁶ They used a combination of online surveys (3801 practising lawyers, 84 former lawyers, 75 individuals who have a legal qualification but have not practised law) and 82 interviews (with practising lawyers, lawyers no longer practising, individuals who had never practised, industry body representatives and HR managers). Key findings relating to sexual harassment/bullying/victimisation were that:

- One in two women and more than one in three men had reported having been bullied or intimidated in their current workplace.
- Half of all women reported experiencing discrimination due to their sex compared to one in 10 men
- One in four women experienced sexual harassment in their workplace.

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Like the medical profession, there are very few publicly litigated complaints of sexual harassment and discrimination in the legal profession. One possible reason for this reluctance to complain is fear of possible repercussions.

The following decisions illustrate the extent to which the workplace culture and systems contribute to discriminatory behaviour as much as the behaviour of individual perpetrators.

- In one matter that proceeded to a hearing but was settled confidentially before the hearing was completed, a junior lawyer alleged that she had been subjected to ongoing sexual harassment by a senior colleague after a consensual relationship ended.³⁷ When she complained to her employer about the conduct, the senior colleague produced a file of complaints about her performance and she was terminated on that basis. She argued that the firm had a culture that condoned sexually suggestive and lewd comments, sexual innuendo, and male jokes and pranks against females. She argued that the partners of the firm had tolerated this sexual harassment.
- An earlier case illustrated how traditional work structures and expectations can disproportionately disadvantage women, when sex discrimination was found against a firm for not renewing a partner's contract after her return from maternity leave, because she was required to work full-time as a necessary condition to maintaining her position in the firm.³⁸

11. The impact of discrimination, bullying and sexual harassment in the medical environment

Because discrimination, bullying and sexual harassment in healthcare organisations affects the individuals involved, the organisations, and the patients,^{6;39} three levels defined in socio-ecological theory are being used as a descriptive frame.

At the micro or individual level a number of negative effects have been well documented; these include health issues, psychosomatic symptoms,^{32;40;} loss of confidence or self-esteem, and post-traumatic stress syndrome.^{9;41;42} Other outcomes such as leaving the health system, or deterring potential applicants to surgery,^{10;14;28;43} affect both the individual and the workforce. It is not only the targeted 'victim' who suffers these negative effects. Negative effects have also been found among those who have witnessed bullying but have not been personally targeted.^{10;20;27;33;}

At the meso level, in the team, department or unit, aggressive behaviours can have a significant negative impact on staff relationships. This can include loss of morale, increased interpersonal aggression, and/or avoidance, all of which contribute to breakdowns in communication, task responsibility, and team collaboration.^{6;10;17;44;45}

At the macro level, the hospital and healthcare system, besides the loss of staff and staff efficiency,³⁹ there is substantial evidence that disruptive behaviours have a negative impact on patient safety.^{34;44;46;47} For example, recent research specifically focusing on the impact of surgeons' disruptive behaviour in the operating room found that the two most frequently mentioned outcomes were a shift of focus from the patient to the surgeon, and an increase in surgical errors.³⁴

12. The contribution of the work environment

Each level contributes to ongoing disruptive behaviours – to a 'culture of abuse'³³ and in many health system workplaces this 'culture of abuse' has been found to be endemic.^{6;17;20;41;45} Characteristics of such abusive environments are an inter-connected web of:

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- the hierarchical structure of the workforce and the seniority of the perpetrator^{4;6;17}
- lack of support for victims and/or whistleblowers^{4;33}
- individuals who have become so accustomed to bullying that they frame this behaviour as normal or acceptable, thus ensuring ongoing acceptance of, and conformity with, the discrimination, bullying and/or harassment^{4;33;41}
- bullying and harassment in the workplace being under-reported^{17;41}
- systemic barriers to reporting, for example not wanting to be seen as a troublemaker; fear of retaliation, belief that nothing would change, and/or that the situation might deteriorate further^{6;17;14;20;48}
- the stressful healthcare environment, particularly the pressures to meet administrative deadlines and targets,⁴⁸ and
- lack of leadership engagement in addressing issues.^{20;49}

13. Existing approaches to resolving the issues

Discrimination, bullying and sexual harassment in the workplace generally and the medical profession in particular have been the subject of numerous inquiries and reviews across Australasia, as has the practice of surgery internationally. These reviews demonstrate that there are a number of key themes and levels of impact that need to be addressed in sequence to be effective.

14. Engaging with the broader context of gender discrimination

A number of reviews noted that the challenges facing the medical profession in relation to sexual harassment are not unique to medicine and form part of broader issues with societal structures and attitudes.⁵⁰ Some emphasised that organisations have an opportunity to position themselves proactively in the broader 'gender discrimination' agenda. Professional organisations and peak bodies are particularly well placed to provide 'social leadership' to the broader community on these issues through, for example, policies, education, media engagement, public events, and partnerships

Members of organisations that play proactive roles in the broader social context in which issues of gender discrimination arise have been found to take the issues more seriously, and develop and adopt leadership positions both within and outside the organisation. Engaging in the wider public discourse of gender inequality also affects organisational (or membership) culture, which has the potential to sway members' support away from endorsing, accepting or even simply being indifferent to harassment, to actively standing against it.

The broader context of gender discrimination has also seen significant public support extended to organisations that, despite having issues, openly acknowledge them and the cultural change that needs to occur. 'Coming clean', as it were, appears to attract respect from the general public and send a strong message to perpetrators that the organisation will not protect or condone their behaviour.⁵¹

15. Overcoming the 'old-boys' club' mentality in medical specialities

Recent media coverage has cited a 'boys' club' mentality in some medical specialities as a factor reinforcing a culture of sexual harassment. Research has shown that a 'boys' club' mentality in male-dominated settings is strengthened by organisational and professional structures and assumptions that promote traditional gender stereotypes. Structures that make, for example, balancing work and personal commitments difficult, can discourage women from pursuing work in certain fields and disempower women who already work in those professions, further entrenching sexism. The Victorian

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Equal Opportunity and Human Rights Commission (EOHRC) highlights the nexus between cultures that perpetuate traditional gender stereotypes, sexual discrimination and harassment:

*The operation of similar stereotypes (about men and women) were also reported as contributing to sex discrimination generally. Importantly, 'male dominated settings where cultural norms are associated with sexual bravado ... and where the denigration of feminine behaviours is sanctioned' are associated with an increased likelihood of sexual harassment. Research has also demonstrated that sexual harassment is more prevalent in organisations that have a lower sensitivity to balancing work and personal responsibilities; reinforcing the notion that sexual harassment is in itself a manifestation of sex discrimination.*⁵²

A further example is provided in the following journal article in relation to medical school:

*One female student felt strongly that the medical school environment ignores the concerns of women with families or women who decide to start a family while in medical school, an issue addressed elsewhere in the academic medicine literature. She reported that she had received some "negative comments" from clinical faculty about being married in medical school and especially about having children in medical school.*⁵³

Most reviews emphasise that workplaces, peak bodies and medical education and training organisations should respond to this research with proactive plans to attract and retain women in their profession. The underlying premise of these arguments is that it is not enough to prohibit or reactively punish inappropriate behaviours, if the underlying structures of the profession (and workplaces) perpetuate gender stereotypes and discrimination.

16. Positioning and communicating about harassment

Many reviews warn against embarking on a merely compliance-based response to sexual harassment. Organisations that take this approach risk reinforcing gender inequality and breeding resentment or indifference among employees towards sexual harassment issues. As the Australian Human Rights Commission's 'Review into the Treatment of Women at the Australian Defence Force Academy' explains:

*It is essential that harassment and discrimination are framed as damaging to operational effectiveness, rather than merely a breach of the law ... For example, a study on successful leadership strategies involving female members of the Canadian Forces indicated that practices which aided integration included not singling women out, setting an example, inspiring teamwork, dealing with difference 'without making a big deal', mentoring and, importantly, not defining integration as only an issue relating to women.*⁵⁴

Reviews emphasise the opportunity that organisations, particularly peak bodies, have to change the discourse from one of comply with discrimination policy and legislation, to one about attracting and retaining the very best people, maximising teamwork, creating positive learning environments, valuing diversity and inclusion, maintaining the professionalism and reputation of the profession and ultimately, achieving better patient outcomes.

Reviews note that addressing discrimination, bullying and harassment is not just a compliance issue, but is about promoting constructive team environments that foster teaching and learning:

Bullying can severely disrupt the ability of teams to function and communicate effectively and to manage patients. It is natural, when on the receiving end of bullying behaviour from an individual,

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to avoid that person and therefore avoid future bullying behaviour. This avoiding behaviour could be expressed, 'by a reluctance to call a disrespectful attending physician with questions for clarification of an order, or for clinical concerns that are not clear-cut.' When this happens, there is an increased risk of errors being made or of vital patient information not being shared.⁵⁵

Educating surgeons about the negative impacts of harassment on the team approach to medicine and the loss of learning opportunities for junior surgeons provides a discourse that legitimises the organisation's leadership on these issues. It also demonstrates the breadth of workplace and patient implications that can arise from these behaviours. Ultimately, publications argue the sexual harassment discourse should be connected to pursuing better patient outcomes. The United Kingdom's General Medical Council (GMC) notes that effective patient safety within a department or hospital relies on, among other factors, teamwork, communication and collaboration between professionals. These are essential for patients with multiple comorbidities who rely on treatment from a number of different teams and specialists. The Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia* similarly sets a standard in relation to respecting medical colleagues and other healthcare professionals⁵⁶

17. Formal training standards

For senior or supervising practitioners, the GMC recently instituted a new framework for recognising and approving medical trainers, the purpose of which is to "clearly define the roles of both educational and clinical supervisors".⁵⁴ Clearly articulating the roles and responsibilities of practitioners who supervise junior doctors is seen as an important contributing factor to promoting constructive and supportive work environments. The Canadian Protective Medical Association has also identified an opportunity to improve training for 'medical leaders':

Beyond training opportunities, medical leaders should play a role in monitoring physician behaviour. This may include conducting reviews or regular staff surveys, team member evaluations, and direct observation. Physician leaders need to be familiar with and communicate the process for safe, confidential reporting of disruptive behaviour and the repercussions for failing to adhere to behavioural norms. Doctors require a fair and consistent process for dealing with these complaints.⁵⁷

A key focus of organisations such as the GMC, where training standards state that doctors in training must be aware of reporting arrangements (for bullying or harassment), is to systematically check compliance with these standards through quality assurance visits. They also make sure that junior staff or trainees are given relevant training about appropriate behaviours (both of trainees and their supervisors), support mechanisms are provided and reporting procedures are in place.⁵⁴

18. Organisational culture and leadership

The impact of organisational culture and the role of senior leaders in promoting respect and gender equality is a consistent feature in the reviews.⁵⁸ Strong leadership is often cited in international research as "the single biggest factor in building inclusivity".⁵³ The GMC noted from its site visits to hospitals that senior leadership had a crucial role in supporting improvements in other common themes identified, such as:

- recognising the importance of training and allocating adequate resources
- supporting investment in service reorganisation to allow better training; and
- ensuring good leadership to promote cohesion at the departmental level.

Training and educational organisations alone are unlikely to be able to address issues of workplace culture directly. However, they do have an opportunity to connect with key institutions, including

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health sector employers, to address discrimination, bullying and sexual harassment issues in partnership. The importance of the role played by surgical leadership is underscored by the following publication excerpts:

*Strong statements from leaders about the importance of ethics and respect for others set the tone for those entering [the organisation]. It also positions equity and inclusion as core values, rather than impositions from outside ...*⁵³

One study found that 93% of the respondents indicated that they would report sexual harassment if there was “demonstrated support from top management for enforcing sexual harassment policies ...”⁵² Without a doubt, the commitment of senior leadership to creating a culture of respect within institutions is critical to minimising disruptive behaviour in healthcare⁵⁶

19. Data collection and reporting

The collection of data and its subsequent reporting underscores much of the previous discussion. Organisational changes driven by data and reporting have been cited by a number of publications as a key factor in promoting positive reforms in surgical workplaces.⁵⁹ Despite this, monitoring of harassment and complaint policy effectiveness is cited as an area of “clear weakness” for many organisations.⁶⁰ While medical colleges in Australia and New Zealand do not directly employ nor control the workplaces of senior medical (including surgical) staff, they are uniquely placed to collect data from their Fellows across various settings. Through this they can pinpoint and highlight issues with institutions that may have ‘cultural blind spots’. The literature of best practice indicates a variety of strategies to decrease disruptive behaviour in hospital settings: although they may seem like common sense they can be difficult to execute.⁶¹

The collection, assessment and reporting of data through exit interviews, periodic informal feedback sessions and surveys can provide valuable information which can:

- identify any systemic issues in workplaces or with specific individuals
- identify best practice from high-performing institutions to be shared more broadly
- promote the accountability of supervising staff and the confidence of junior staff and
- provide an effective feedback mechanism for practitioners.

Data and reporting is also seen as a powerful tool because of its ability to draw comparisons and leverage an organisation’s reputational pressures to promote improvement. A similar approach in relation to issues of liability for sexual harassment in the workplace noted:

*Everything – from (a hospital’s) credibility, public perception, and the quality of its programs, to its teaching affiliations and its ability to recruit the best and brightest future doctors – is tarnished by both private payouts and the public relations nightmare of sanctions from a supervisory body.*⁶²

20. Resourcing the effort and the response

Research indicates that allocating specific resources to address issues of discrimination, bullying and sexual harassment often sends a direct and powerful message that this behaviour will not be tolerated.

Independent front line for inquiries

Reviews stress the need for independence in initially receiving and later managing complaints about these issues. Impartial contact officers can advise complainants and if necessary independent

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consultants can be engaged to maintain impartiality, should the conduct of individuals come into question.⁶³ An independent inquiry that reviewed the reporting culture within the National Health Service (UK) went further and called for hospitals to employ 'Ambassadors for Cultural Change' to whom staff could go for advice and support if they had a concern or thought their concern was being ignored.⁶⁴ The advantages cited of this approach included:

- demonstrating a commitment by an organisation to listen to their staff and treat them fairly.
- offering a route to raise concerns that is outside of direct line management and HR structures, but with access to senior management, including both executive and non-executive board members, who can take appropriate action if needed.
- being seen as independent, impartial and objective; and
- being someone who could 'tell it straight, have open and honest conversations and keep the temperature down' and act as a conduit between staff, senior managers and the board.

Providing direct access to senior surgical educational or program directors was also seen as a way of better resourcing complainants.

Assistance lines

The UK's GMC has proposed setting up a confidential bullying hotline that doctors in training can use to contact the education team (either by email or phone) to raise issues. This complements the UK's Whistleblowing Helpline, commissioned by the UK Department of Health. The Helpline provides confidential information and advice on whistleblowing and is provided free of charge by specially trained advisors.

21. Levels to target

Research identifies three 'levels' for action to address issues of discrimination, bullying and harassment: individual (micro), team (meso) and organisational (macro). Because each level has been found to contribute to ongoing disruptive behaviours, it is essential that each level is involved in contributing to the solutions, and that action is taken at all levels simultaneously.

The following strategies have been identified to effectively initiate and maintain change from a culture of abuse to a culture of respect and fairness. This summary reflects the work of many enquiries.

Individual action

At the individual (micro) level this means:

- a) Training for the perpetrator, the victim(s), and all of the other staff:
 - Staff need to be educated about the effect that abuse can have on patient safety^{19:21}
 - To break the cycle of discrimination, bullying and harassment it is essential for each individual member of staff to understand the place that non-intervention of observers and bystanders has in escalating unacceptable and hostile behaviours. Specifically, those who are not part of the solution contribute, albeit passively, to the problem.^{19:65}
- b) Begin the training by acknowledging prior assumptions, as well as emotional and learning needs of each of the staff:
 - Some staff may believe that abusive behaviour has an 'educational value'¹⁵
 - Some staff will have an emotional investment in the status quo and/or for retaining their status within the group^{19:20}

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- Take into consideration the most effective way that different staff members learn. For example, not all staff learn best through lectures, workshops, or large group discussions^{8;66}, therefore a variety of formats, fora and learning opportunities need to be provided.

Team action

At the team, department or unit (meso) level this means:

- Provide training in how to identify discrimination, bullying and harassment^{39;65}
- Teach and model collaborative teamwork – all of those who have a stake in the team or unit need to come together and collectively identify what is good, as well as strategies to address what needs to be changed^{39;67}
- Establish values of transparency, accountability, and mutual respect⁶⁵
- Provide training in a variety of skills that may be needed, for example: communication, conflict management, emotional management, stress management, and leadership^{39;65;68}
- Strive to maintain teams that regularly work together^{11;64;67}
- Provide mentoring for all junior staff so that they have direct and ongoing support within the unit, department, or hospital structure⁶⁹
- Provide information on what is available and how to seek assistance from workplace, and external community resources^{70;71;72}
- Provide ongoing support and protection for whistleblowers against retaliation⁷³
- Provide access to counselling for victims – including bystanders and observers^{20;48}
- Foster an environment in which all team members are expected to raise issues that could affect patient safety through programs such as NOTSS (Non-Technical Skills for Surgeons course); ANTS (Anaesthetists' Non-Technical Skills course) and SPLINTS (Scrub Practitioners' List of Intra-operative Non-Technical Skills course)^{21;67}
- When inappropriate behaviour occurs, address it quickly, consistently and transparently^{66;74}
- There are two very different approaches recommended for approaching any reported inappropriate behaviour. One advises that the issues are dealt with anonymously⁷¹ while the other recommends that, rather than mediating between two individuals, it is appropriate to provide a forum for shared discussion between all of those involved – the perpetrator, the victim, and the bystanders.¹⁹

Organisational action

At the organisation level (hospital and hospital administration or macro), as well as demonstrating clear support for all of the activities outlined in the micro and meso levels, this means:

- Implementing a zero-tolerance policy along with clear reporting processes and making it clear that the policies and standards apply to every member of staff^{48;65;70}
- Ensuring that the institution has an explicit code of conduct and that it is both readily available to everyone, and part of the contract which each staff member signs⁶⁵
- Adopting explicit performance standards of behaviour and competence which have been established at a national or bi-national level⁷⁰
- Implementing annual reviews for all staff against the standards of behaviour and competence. These reviews should include confidential evaluations by colleagues and co-workers as well as an analysis of any complaints by patients or others⁷⁰
- Emphasising that each person is responsible for their own behaviour in meeting expectations of all codes and standards

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- Assisting with the establishment of a graded system of responses designed to address the seriousness of any inappropriate behaviour. This system needs to be directed towards remediation rather than retribution⁴⁷
- Provide training for staff on how to deal with reports of inappropriate behaviour such as discrimination, bullying and sexual harassment⁷¹
- Making sure that when inappropriate behaviour occurs the discipline process is implemented fairly, regardless of the status or money-earning capacity of the perpetrator⁴⁷
- Providing visible leadership supporting the implementation of policies and standards, compliance with those standards, and monitoring of performance^{47:66}
- Keeping the strategy visible and dynamic.¹³

At the macro organisational level, whether that is regional, state, national or bi-national this means:

- Supporting the definition of standards and the development of mechanisms to ensure compliance – including monitoring performance and responding to inappropriate behaviour – that is consistent across institutions and regions^{38:66:69:73}
- Implementing real-time mobile web-based modules and reporting systems⁷⁵
- Commitment to, and teaching across, all levels of medical education and training about professionalism and professional standards. This could also include information about how to identify discrimination, bullying and sexual harassment and how to appropriately respond to this behaviour^{37:76}
- Leadership from organisations such as professional associations, specialist medical colleges and the parts within these such as specialist societies. This could include:
 - Defining standards of behaviour, codes of conduct, mechanisms for monitoring performance, and structured responses to inappropriate behaviour
 - Providing educational resources, either online or in course packages, to facilitate education and training to achieve the outcomes defined for the micro and meso levels
 - Advocating for changes in the funding model to reduce work pressures.⁶

Research identifies that not all attempts to change behaviour or workplace culture have been successful. One longitudinal study over 13 years in one medical school reported that despite providing education for students, residents, and the faculty, creating informal and formal mechanisms of reporting and resolving incidents of mistreatment, and promoting the open discussion of this topic at all levels, there was little change in the number and severity of reported incidents.⁷⁷ This lack of success could be due to a range of factors including: insufficient support from the wider medical community; failure to challenge underlying assumptions; and/or lack of accountability of staff.

22. Conclusion

Discrimination, bullying and sexual harassment persist in the Australian and New Zealand health sector, in the practice of surgery internationally and in other sectors. Long-established laws aimed at addressing these problems have not been effective in preventing unacceptable behaviour in Australian and New Zealand health workplaces. There is significant research published outlining the nature and scope of the problems and identifying contributing causal factors. Changes needed to prevent discrimination, bullying and sexual harassment in the practice of surgery are likely to be long-term, multidisciplinary and will require cultural change.

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23. Glossary

AMA	Australian Medical Association
ANTS	Anaesthetists' Non-Technical Skills (course)
OHS-IMS.NET	Occupational Health and Safety Incident Management System
NOTSS	Non-Technical Skills for Surgeons (course)
RACS	Royal Australasian College of Surgeons
SPLINTS	Scrub Practitioners' List of Intra-operative Non-Technical Skills (course)
UK	United Kingdom
USA	United States of America

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