CONFIDENTIAL DRAFT RESEARCH REPORT

Expert Advisory Group, Royal Australasian College of Surgeons

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Converge international

incorporating **resolutionsRTK**

31 July 2015

TABLE OF CONTENTS

1 EXECUTIVE SUMMARY

1.1 BACKGROUND AND PURPOSE

This report has been produced by Converge International for the Expert Advisory Group, commissioned by the Royal Australasian College of Surgeons (the College). The report contains the background to, and findings of, qualitative research designed to inform the Expert Advisory Group how Fellows, trainees and International Medical Graduates experience discrimination, bullying and sexual harassment in the practice of surgery. The research examined experiences through voluntary submissions of personal stories to facilitate greater insight into how discrimination, bullying and sexual harassment are perceived, and the effects on those who experience it.

The research complements a quantitative survey already undertaken to assess the prevalence of discrimination, bullying and sexual harassment in the practice of surgery. The research is critical in informing the Expert Advisory Group in its consideration of how it may advise the Royal Australasian College of Surgeons to best to deal with, and ultimately eliminate, discrimination, bullying and sexual harassment from the practice of surgery. To assist in the promotion of respectful and safe practices in the workplace, and indeed the broader arena of professional interaction, the research also identifies recommendations for change.

1.2 METHODOLOGY

The research methodology, outlined in the proposal to the Expert Advisory Group, was approved by the Royal Australasian College of Surgeons' ethics committee. A total cohort of around 7,500 Fellows, trainees and International Medical Graduates across Australia and New Zealand were invited to share their personal stories of discrimination, bullying and sexual harassment in a variety of ways to maximise data collection. This included options for face-to-face interviews, telephone interviews, Skype interviews or completion of an online questionnaire, designed by Converge International.

Converge International used research techniques that enabled the participants to input demographics and describe the nature of work behaviour without the requirement to provide identifying details. A semi-structured questionnaire was designed, to provide opportunities for open ended, free flow of information in addition to specific questions related to the research aims.

To maintain consistency of approach and data collection, the same questions that were used for the secure online questionnaire were also utilised in all interviews. 373 questionnaires were submitted, 225 of these provided information and stories beyond demographic data. 41 additional data sets were analysed (interviews and email submissions).

Bookings for interviews were managed by Converge International to ensure confidentiality for participants and all interviews were conducted in one-on-one confidential settings with Converge International consultants. Consultants who facilitated all interviews in Australia and New Zealand were qualified and experienced in psychology, counselling and/or social work. This was to ensure that interviewers had the necessary competencies to ensure confidentiality, to facilitate engagement in the

session, to sensitively manage heightened emotions that may be displayed during the sharing of personal stories, to provide a comfortable environment in which participants could share their stories, and to best support the participants with any appropriate referrals. Interview responses demonstrated that this was a very important criterion in the process. All consultants were fully briefed and individually inducted around the data collection and interview protocols. This ensured consistency of method of data collection.

Participants were advised at the outset of the interviews their voluntary nature, the guarantee of protection of identity, the parameters of confidentiality, purpose of the interview, how the data would be stored and recorded and used, and time allocated to provide input. Data collected was supplied directly to Converge International by secure transfer. Twenty nine interviews were conducted.

As an alternative to the online questionnaire or interviews, participants had the option to provide an open ended submission via email. The invitation was simply to share their story, which was equivalent to the open ended question asked in the online questionnaire and in interviews. Twelve emailed submissions were received.

Data was collected and transferred to a framework that enabled sorting of the data according to various demographics to enable patterns to be discovered. The raw data of personal stories was read several times by multiple researchers before undertaking a themed analysis. Themes were identified, meanings were clarified and agreed upon by multiple researchers who came together for cross referencing, which provided for triangulation and validation of the identified themes.

The data analysis, including the identification of themes, occurred through an inductive approach. The assumptions made are data driven and based on perceptions communicated by the research participants.

The data was coded according to the identified themes, allowing for identification of patterns and frequencies of responses. The data was also sorted by various demographics according to single and multiple themes to identify patterns and frequencies. In an unbiased approach, the researchers actively sought exceptions to common findings that provided alternative viewpoints. The research team came together to cross reference their findings to provide rigour and validate the insights and findings contained within this report.

1.3 RESEARCHERS

Converge International is a wholly Australian owned company; one of the largest providers of psychological employee support, consulting and training providers in the country. Converge International was the first provider in Australia to deliver Employee Assistance Programs and has been operating since 1960.

Converge International specialises in understanding workplace behaviours and is at the forefront of instigating positive behavioural change initiatives. Services are underpinned by up-to-date industry research and extensive customer feedback, backed by best practice protocol.

Converge International clients represent all levels of Government, telecommunications, emergency and defence, health and human services, mining, manufacturing, aviation, banking, insurance and retail industries. They range from the largest Government and public companies through to smaller private and not-for-profit workplaces that are supported on a local, state, national and international scale.

This breadth of experience allows Converge International to understand and respond to the differing needs of complex organisations and employee groups to maximise workplace health and initiate positive workplace behavioural change. A multi-disciplinary research team was formed to undertake this research study, comprising members with senior level expertise, led by Dr Richard Kasperczyk, Managing Director of Converge International.

1.4 RESEARCH SAMPLE

The invitation to participate in this research study was extended to approximately 6086 Fellows, 1245 surgical trainees and 100 International Medical Graduates across Australia and New Zealand – a total cohort of approximately 7,431.

A total of 414 responses were received:

- 225 completed questionnaires
- 148 incomplete questionnaires with only demographic data completed
- 12 email submissions were provided
- 29 interviews were completed.

The participant status breakdown of the 266 responses that provided data included in the analysis is:

- 188 Fellows (3% of the total cohort of Fellows)
- 47 Trainees (3% of the total cohort of Trainees)
- 8 International Medical Graduates (8% of the total cohort of International Medical Graduates)
- 23 Other

Females comprise 93 (35%) of the research sample, 173 (65%) are male.

The response rate to the study was 5.6% and the analysis in this report applies overall to 3.6% of the total cohort in surgical practice that come under the auspice of the College.

1.5 OVERVIEW OF FINDINGS

In this study there are some practitioners who responded but had no detailed stories to share because they had not experienced discrimination, bullying and sexual harassment. The prevalence of these stories are in the minority of those collected and it is acknowledged that the invitation to share such experiences was aimed at providing a platform for those who had experienced discrimination, bullying and sexual harassment.

The personal stories collected and analysed indicate that discrimination, bullying and sexual harassment do exist in the practice of surgery. The Royal Australasian College of Surgeons recognises the existence of these key identifiers and is committed to eliminating them from the profession. Personal stories most commonly contained experiences of bullying, followed by discrimination, followed by sexual harassment. The number of those in the practice of surgery who wanted to share their personal stories was high. Whilst many expressed fear of identification and reprisal for coming forward, there were also expressions of relief and gratitude in being able to be heard for the first time in a confidential and independent setting. Regardless of prevalence, the fact remains that the unreasonable behaviours exist, and require both preventative and responsive action.

Surgeons, in general, occupy a prestigious position in society, respected for their knowledge, wisdom, expertise and commitment to the protection and preservation of human life. An enormous amount of trust is invested in surgeons by members of the wider community. As highly esteemed societal contributors, who make life and death decisions to optimise the care and wellbeing of their patients, it is reasonable to expect that surgeons are role models of ethical, safe and respectful behaviours.

Across the three key identifiers of discrimination, bullying and sexual harassment, there were a further seven common themes, identified by personal experiences. Drawn from the research, these common themes are:

- Fear (of consequences)
- Processes
- Power
- Accountability
- Workplace Culture
- Leadership
- Personality

There are those surgeons who are failing to model safe work practices in general, but most pertinently, as demonstrated by the research, the unreasonable behaviours exist at a critical point in a surgeon's career pathway – during training. This is a real 'opportunity cost' in setting tone, example and in perpetuating a safe, respectful and responsible workplace culture. Stories highlighted the view that some unreasonable behaviour is intentional; that trainees were treated harshly in order to 'toughen them up'; to prepare them for the real work of surgery and to sort 'the wheat from the chaff'; a teaching style that is embedded in the culture, a sense of 'how it's always been done'. The effectiveness of this teaching method is questionable as this study demonstrates the significant long-term negative impact on a considerable number of surgeons and potential surgeons.

Fear is identified by the research as a, if not *the*, major component in acceptance of a cycle of negative and degrading behaviours and the perpetuation of a negative workplace culture. Fear of negative consequences, retribution and victimisation run high, with the ultimate fear being loss of career in surgery, and loss of reputation.

Not all surgeons are behaving 'badly', as demonstrated by the stories told, however there remains significant cause for concern. There are stories of individuals or groups who wield power and are repeat offenders because there is a lack of accountability and an embedded culture that supports the continuance of poor behaviour in some hospital settings. There is a co-existing view among the participants that abnormal personality traits drive these behaviours and that selection processes to surgical practice and supervision are not adequate in identifying personal flaws. There is also the suggestion that the nature of surgical practice attracts some asocial personality types.

Another important finding is that strong networks of senior surgeons with influence and power are a major stumbling block to change. A hierarchical structure with control over career destiny and a culture of shielding senior colleagues from the consequences of their behaviour are viewed as elements that contribute to the unreasonable behaviours and subsequent lack of address.

Research participants describe the failure of hospital human resource departments to act, and even stories of collusion between hospital managers and surgeons. The perception is that hospital administrators are afraid to upset senior surgeons and afraid of losing surgical staff from hospitals. Trainees are seen as vulnerable and disposable, with complaints ignored in favour of support for senior surgeons, in turn sending a discouraging message to others who may seek to complain. There are many stories where management processes are found wanting, either they are perceived as non-existent, or lack procedural fairness or are not based on the principles of natural justice. Time taken to deal with complaints and lack of outcome or resolution are identified by the research. There is a distinct need to have clear processes in place to deal with complaints and the desire by research participants to have an independent and confidential process for voicing complaints and grievances. The building of trust in the management of complaints is of key importance moving forward.

An intimately networked male dominated 'boys' club' is seen as a culture that excludes and actively threatens what they perceive as interlopers – those from external networks, those from overseas, and women. There is little sense of inclusivity for minority groups. Part of the exclusive behaviours stem from competition, and the desire to retain patient lists, particularly in public hospitals and regional settings. Discrimination against race is evident, but more so is discrimination against women.

The personal stories highlight the degradation of women, through lewd and disparaging comments and unwelcome sexual propositions. Once again, systemic issues are highlighted in propagating a culture that is exclusive of women, particularly through a lack of support for women to have and care for children. In the culture of surgical practice, the prevailing view from personal stories is that one must commit full time to the role of surgeon without the distraction of children. Having a surgical career or participating in surgical training and being a mother are not seen by perpetrators of sex discrimination as mutually inclusive, even though there are stories of this being achieved. Whilst there are clear experiences of sex discrimination there is also evidence that the culture of surgical practice is not 'family friendly' in any sense and that men, as well as women, are expected to commit to career above and beyond other life roles.

1.5.1 Enablers

Aligned with the broad themes identified, specific themes and sub-themes that contribute to or maintain discrimination, bullying and sexual harassment are identified as:

- Positions of power and influence
- Hierarchical system
- Ineffectual responses and processes
- Fear of consequences of reporting
- Personality.

To a lesser degree, a lack of diversity in the workforce, and a lack of education about the behaviours were described as enablers.

1.5.2 Barriers

Aligned with the broad themes identified, specific themes arose that were identified as 'barriers' to effective prevention and/or address of discrimination, bullying and/or sexual harassment:

- Workplace culture
- Fear of consequences
- Ineffectual responses and processes
- Personality.

1.6 IMPACT

The impact on those experiencing discrimination, bullying and/or sexual harassment is of major significance. The research found that the impact was generally long-term; there were many stories from mature and senior surgeons who remain affected by, and can recall in vivid detail, earlier negative experiences. There were multiple stories of depression and suicide ideation. Emotional distress was displayed by those who opted to participate in face to face interviews. Disturbing accounts of acts of humiliation and degradation were recounted.

The risk to the individual is therefore high, and in many cases, extreme. The risk to the profession, and to the community, is also high. Risks include the loss of potential quality surgeons through withdrawal from training programs, resignation and suicide. Stories also highlighted risks to patient care. A fear of communicating with, or expressing a differing opinion to, a perceived abuser, is responsible for a perceived risk to patient care. This risk is amplified by lack of responsive action or protection from victimisation in speaking out. The research also highlighted the risk to the family of the 'victim'.

1.7 SOLUTIONS FOR CHANGE

Participants were asked about, and put forward, their view of solutions for change. Most research participants did put forward their view of a better workplace, free of unreasonable behaviours.

Across the submissions as a whole, the following areas were most commonly identified as those requiring change:

- *Processes*, particularly around: selection of supervisors; the management of, and responses to, complaints; performance management of those behaving poorly; objective assessments of trainees and ways to empower recipients of unreasonable behaviours
- *Structures* (particularly to the trainee program) that facilitate: objective feedback; flexible and family friendly pathways; independent feedback mechanisms; less hierarchical sharing of expertise
- *Leadership,* greater intervention by the College to accredit training hospitals, appoint suitable supervising surgeons and support those at risk, particularly trainees and women, through influencing change and improvements in the workplace; supervisors who are role models and have a teaching methodology that supports inclusive learning
- *Accountability,* at both hospital and professional network levels, to have mechanisms in place that are independent, objective and readily utilised without fear of retribution to provide consequences for perpetrators of unreasonable behaviours, including dismissal as an option
- *Workplace culture,* to foster a culture that promotes and supports reasonable behaviours and provides for equitable, inclusive and respectful professional interactions amongst all involved in the practice of surgery.

To a lesser extent, the following were seen as important elements of change:

- *Training,* greater education and awareness around legislative frameworks and respectful behaviours, particularly for those involved in supervision. Resilience training was also suggested for trainees
- *Patient focus,* a greater emphasis on patient care and reduction in the impact of unreasonable behaviours on patient care
- *Personality,* quantified by the recognition by most who raised this as an issue, that it would be difficult for change to occur and that dismissal from supervision of trainees was probably the most optimal outcome that could be achieved
- *Counselling* of the perpetrators as an intervention to eradicate unreasonable behaviours
- *Natural attrition,* the view that 'things would change for the better' through the resignation of older males and more females coming into the system.

1.8 RECOMMENDATIONS

A fundamental issue to deal with is that the relationship of the various levels of the surgical hierarchy is not simple and the role of the College as a regulator of professional standards and professional conduct intersects with the responsibilities of hospitals as employer of most categories in the medical workforce. This situation is further complicated by the legal responsibilities and duties which hospitals must assume under laws relating to discrimination, workplace bullying, sexual harassment and occupational health and safety. Whilst the hospital holds a great deal of responsibility as the employer in creating a safe workplace, the College has the opportunity to influence and lead change as the peak body for accrediting surgical training and supervision. Given its pivotal role as the professional network of surgeons, the College is ideally placed to exemplify expected standards of professional practice, and to seek ways to actively encourage respectful behaviours from its Members. Many of the research participants would like to see the College take a greater leadership role in addressing the issues contained within this report.

Taking into account the findings of the research and the participants' input into solutions for change, Converge International puts forward the following recommendations for consideration by the Expert Advisory Group in order to change workplace culture and achieve effective address of discrimination, bullying and sexual harassment in the practice of surgery. These recommendations are provided with the view to how the Royal Australasian College of Surgeons could play a leadership role.

1. **Undertake a review of processes in relation to complaints and selection to identify and implement ways to make these more effective**

   Develop an independent complaints process:

   Admittedly, we have not had the opportunity to examine the processes and structures of complaint handling in the College, so subject to our limited knowledge we suggest that it is necessary to ensure that the complaints handling process is, and is seen to be, independent of the College. An independent office could be established to make recommendations on how the issue may be resolved. Matters could be confidentially and independently assessed and referred to external investigation as required. There also needs to be consequences for substantiated unreasonable behaviours that are widely communicated to Members, as to what those consequences are and how they will be applied, for example, suspension from supervising trainees.

   So that Members and the public could have confidence in an independent process, the College could annually publish broad details of the number and nature of complaints notified to it and the outcomes. Established standards, such as those followed in an ombudsman process, could be applied to the operations of the College.

Increase communication between hospital management/human resource departments and the College:

The College to work with hospitals to promote and develop protocols around respectful behaviours and dealing with complaints. The College could advise on, and support, the handling of complaints in terms of professional accreditations and referrals to an independent process.

Improve selection processes:

The College to select Members suitable for positions of leadership and training based on mandatory selection criteria that is inclusive of behavioural style and personality, that are independently assessed. The College may also consider 360° feedback about surgeons' behaviours that informs future employment as an accredited supervisor of trainees.

2. Provide appropriate and widely recognised avenues of support

Mentor trainees, International Medical Graduates and females:

The College to provide independent support for trainees, International Medical Graduates and females, to support vulnerable minority groups by allocating them to mentors with a widely recognised role who could provide them with advice and support around issues of concern, and who have been satisfactorily assessed as suitable mentors through 360° feedback and psychological testing.

Appoint Contact Officers:

To appoint Contact Officers at the College who have thorough understandings of employment and legislative frameworks as they apply to discrimination, bullying and sexual harassment, who can advise Members, trainees and mentors about appropriate behaviours, refer parties in conflict to independent alternative dispute resolution such as mediation, communicate with hospital HR departments and an office established to independently assess complaints, and use information and any patterns or trends in complaints to inform further action for change.

3. Provide for greater measures of accountability

Implement training programs:

The College to undertake systematic and ongoing review of the surgical training process including teaching methods and objective assessment criteria. Also considered important is to identify any patterns of withdrawal from training and failure rates and complaints about supervisors. Current and timely feedback from trainees on hospitals, training programs and supervisors could be collected and assessed by an external body so that trainees are provided with the opportunity to confidentially report on their experiences without fear of reprisal. The external agency could identify patterns and make recommendations for change. Clearly articulated criteria for continued accreditation as supervisor, or in the case of hospitals, as training facility could be developed. It is recommended that this review be undertaken and monitored by a steering committee that includes independent input as a quality control mechanism.

Review performance management systems:

The College to develop and implement a strategy to hold surgeons accountable to the Professional Practice Principles in response to breaches.

The College to work in partnership with hospitals to develop a rigorous performance management system for surgeons that takes into account the capacity to work with others in a respectful and professional manner. It is recommended that withdrawal and failure rates of trainees allocated to supervising surgeons form part of professional assessment, as would a 360° feedback system with independent analysis and questions around professional competence and adherence to professional practice standards in the treatment of colleagues, hospital personnel and patients.

4. Develop ways to lead and influence

Develop training and awareness programs:

The College to lead hospital and health networks to develop and implement joint awareness campaigns to promote workplaces free from discrimination, bullying and sexual harassment.

Identify exemplars of both genders and establish ways for them to professionally develop others – those leaders who are widely respected for modelling respectful and inclusive behaviours, who would be willing to mentor, coach or present to relatively new leaders or supervisors.

Trainees and Surgeons to participate in mandatory training around professional practice principles, respectful and inclusive behaviours in the workplace and revised grievance/complaints processes.

5. Review structures for more inclusive practice

The College to continue to explore and implement flexible approaches to completing traineeships that support the balance of career and carer commitments for both genders, particularly in relation to women throughout periods of pregnancy and childbirth.

The report provides in detail the background to the research undertaken, the methodology, the key findings and recommendations for change.

2 INTRODUCTION

2.1 BACKGROUND

This report has been produced by Converge International for the Expert Advisory Group, commissioned by the Royal Australasian College of Surgeons (the College). The report contains the background to, and findings of, qualitative research designed to inform the Expert Advisory Group how Fellows, trainees and International Medical Graduates experience discrimination, bullying and sexual harassment in the practice of surgery.

The College has determined to take a leadership role in seeking to protect and provide guidance and safeguards for all those affected by the issues – Fellows, trainees and International Medical Graduates. The College wishes to ensure that discrimination, bullying and sexual harassment is not tolerated and is eliminated into the future. To do so, the College seeks to more thoroughly understand the nature of the issues and receive advice on its role, policies, processes and advocacy in relation to how the College can best influence the eradication of unacceptable behaviours. This qualitative research report is provided to the College as a contribution to providing the understanding necessary to inform change.

In 2015 the College established an independent Expert Advisory Group (EAG), chaired by the Hon Rob Knowles AO, previous Minister of Health in Victoria and current Chair of the Royal Children's Hospital in Melbourne, to provide the College with practical and powerful advice about how the College can take a leadership role within the practice of surgery to address discrimination, bullying and sexual harassment. A comprehensive literature search was also undertaken.

The Royal Australasian College of Surgeons, formed in 1927, is a non-profit organisation training surgeons and maintaining excellence in surgical standards in Australia and New Zealand. The College is governed by a Council made up of elected and co-opted members representing all surgical specialties and regions of Australia and New Zealand. Committee members serve in an honorary capacity.

The research complements a quantitative survey already undertaken to assess the prevalence of discrimination, bullying and sexual harassment in the practice of surgery. The EAG wished to establish a process for individuals to tell their personal stories of discrimination, bullying and sexual harassment by way of a qualitative approach.

On 1 May 2015, Converge International received an invitation from the College, on behalf of the Expert Advisory Group, to provide a proposal for services to undertake the collection and/or analysis of personal stories from people impacted by discrimination, bullying and sexual harassment in the practice of surgery.

Converge International's successful proposal included the methodology for the collection of personal stories in a confidential and unbiased manner, via a range of communication options such as telephone, Skype, online or face to face, in all capital cities in Australia, and in Auckland, Wellington and Christchurch, New Zealand. A thematic analysis of the personal stories and narratives was also proposed. This report details the approach taken by Converge International. The report also includes recommendations for change, based on the research findings.

2.2 AIMS OF THE RESEARCH

The purpose of this qualitative research was to complement the quantitative prevalence survey undertaken by the College and provide deeper understandings about the personal experiences of those impacted by discrimination, bullying and sexual harassment. These stories also support the identification of systemic issues within the surgical practice that are overtly or covertly supporting discrimination, bullying and sexual harassment. The collection of personal stories is not intended as, nor does it provide, a pathway for individual complaints.

The research is designed to assist the EAG in their assessment of discrimination, bullying and sexual harassment at an individual, organisational and systems level as it relates to the College, its Fellows, trainees and International Medical Graduates, and other areas in which the College is involved or has influence. The EAG will also consider how gender inequality impacts on these concerns. The aim of the research is to assist the EAG in its remit of advising the College of recommendations for change.

The research is considered critical, initial work to assist the EAG to identify issues and recommend options to the College so that the College can take an effective leadership role in addressing the issues.

3 METHODOLOGY

3.1 RESEARCH APPROACH

The research methodology was outlined in the proposal to the Expert Advisory Group and approved by the Royal Australasian College of Surgeons' ethics committee. Communications about the research to the research sample, and invitations to participate in the research, were initiated by the College to Fellows, surgical trainees and International Medical Graduates, a total sample of around 7,500 across Australia and New Zealand. Research participants were invited to share their personal stories in a variety of ways so that accessibility to provide information was optimised in order to maximise data collection. This included options for face to face interviews, telephone interviews, Skype interviews or completion of a secure online questionnaire.

The questionnaire was designed by Converge International. Converge International has designed and implemented similar online interview tools for organisations in relation to cultural and health and wellbeing assessments, specifically designed to elicit systemic issues. In designing the online interview instrument, Converge International used research techniques that enabled the participants to input demographics and precisely describe the nature of work behaviour without the requirement to provide identifying details. The format of the questionnaire was in five parts which included:

1. Introduction to inform the participants of the purpose of the research, an assurance of anonymity (non-identifying information) and independence of analysis, an outline of the survey structure and contact details for the registration of complaints through the College hotline and contact details for those wishing to access independent and confidential support through the Surgeon Support Program.
2. A section to collect demographic information, including Member category, gender, age, location of workplace by State (Australia) and country (New Zealand), area of surgical speciality and stage of career.
3. A section to collect information about personal experiences of discrimination, bullying and/or sexual harassment.
4. A section to collect information about participants' views about what needs to change, criteria of a workplace free of discrimination, bullying and sexual harassment and to capture any additional comments the participants would like to add.
5. A section acknowledging the participant's input and reminding them again of the contact details provided in Section One.

The questions were designed to provide a semi-structured approach whereby there were opportunities for open ended, free flow of information in addition to specific questions related to the research aims.

Participants were asked to input freely around their experiences of discrimination, bullying and sexual harassment, and again at the end of the session, to provide any additional comments. They were also asked specific questions about perceived enablers, barriers, solutions for change and their view of what a workplace free of discrimination, bullying and sexual harassment would look like.

To maintain consistency of approach and data collection, the same questions that were used for the online questionnaire were also utilised in all interviews.

Participants accessing the online option were provided with a secure login for web access with data securely collected and stored by Converge International.

Bookings for interviews were managed by Converge International to ensure confidentiality for participants and at flexible times to meet participant need. All interviews were conducted one-on-one in confidential settings with Converge International consultants.

Consultants who facilitated all interviews in Australia and New Zealand are qualified and experienced in psychology, counselling and/or social work. This was to ensure that interviewers had the necessary competencies to ensure confidentiality, to facilitate engagement in the session to sensitively manage heightened emotions that may be displayed during the sharing of personal stories, to provide a comfortable environment in which participants could share their stories, and to best support the participants with any appropriate referrals. Interview responses demonstrated that this was a very important criterion in the process. All consultants were fully briefed and individually inducted around the data collection and interview process. This ensured consistency of method of data collection.

Participants were advised at the outset of the interviews their voluntary nature, the guarantee of protection of identity, the parameters of confidentiality, purpose of the interview, how the data would be stored and recorded and used, and time allocated to provide input. Ninety minute sessions were generally allowed for the interviews and this met the needs for data collection. Data collected was supplied directly to Converge International by secure transfer.

As an alternative to the online questionnaire or interviews, participants had the option to provide an open ended submission via email. The invitation was simply to share their story, which was equivalent to the open ended question asked in the online questionnaire and in interviews.

Data was collected and then transferred to a framework that facilitated sorting of the data according to various demographics to enable patterns to be discovered. The raw data was read several times by multiple researchers before undertaking the themed analysis. Themes were identified and agreed upon by multiple researchers who came together for cross referencing, which provided for triangulation and validation of the identified themes.

The data analysis, including the identification of themes, occurred through an inductive approach. Qualitative research is typically inductive, and findings are grounded in the analysis of the data. The assumptions made are data driven and based on the perceptions communicated by the participants. There was no attempt to fit the data into a pre-existing model or frame, as would occur in a deductive approach, which is theory driven. The inductive approach matched the need for the research to inform how the participants experienced discrimination, bullying and sexual harassment, and for the participants to drive that knowledge.

The researchers reached common understandings about definitions and meanings of key identifiers to ensure consistency of coding. The data was coded according to the identified themes, also allowing for identification of patterns and frequencies of responses. The data was also sorted by the various demographics to identify patterns and frequencies. The researchers actively sought exceptions to common findings that provided alternative viewpoints in an unbiased approach. Multiple researchers came together to cross reference their findings to provide rigour and validate the insights and findings contained within this report.

3.2 RESEARCHERS

3.2.1 The Company

Converge International is a wholly Australian owned company; one of the largest Employee Assistance Program, consulting and training providers in the country. Converge International was the first provider in Australia to deliver Employee Assistance Programs and has been operating since 1960.

Converge International specialises in understanding workplace behaviours and is at the forefront of instigating positive behavioural change initiatives. Services are underpinned by up-to-date industry research and extensive customer feedback, backed by best practice protocol.

Converge International clients represent all levels of Government, telecommunications, emergency and defence, health and human services, mining, manufacturing, aviation, banking, insurance and retail industries. They range from the largest Government and public companies through to smaller private and not-for-profit workplaces that are supported on a local, state, national and international scale.

This breadth of experience allows Converge International to understand and respond to the differing needs of complex organisations and employee groups to maximise workplace health and initiate positive workplace behavioural change.

3.2.2 The Research Team

Senior members of Converge International have led this research project, supported by psychologists and social workers of Converge International who facilitated interviews with research participants.

Project Leader, Dr Richard Kasperczyk, Managing Director of Converge International, heads the research team. With over 20 years of experience, Organisational Psychologist Richard has experience in developing and delivering practical, research-based strategies to address organisational and people issues in complex organisations. Richard is a specialist in the areas of risk management, focusing on work-related stress prevention, and psychological health. Richard has presented hundreds of workshops and training seminars and authored a number of articles in international scientific journals. Richard is a Fellow of the Australian Psychological Society and former National Chair of its Division of Independently Practising Psychologists. He has chaired a non-for-profit Board for over seven years in addition to being a director of two private company Boards. Richard has facilitated the development of strategic plans for a number of not-for-profit, private and government enterprises.

Director of Research, Professor Julian Teicher is currently engaged with the Department of Management, Faculty of Business and Economics, Monash University. Julian is the Director of Research in the Department of Management and Director of the Australian Consortium for Research on Work and Employment (ACREW), a group dedicated to researching workplace relations and human resources issues. Julian's research is in two related fields: workplace (industrial) relations and public policy and management and he has published widely. In 2011 Julian was the joint recipient of an Australian Research Council grant to undertake a large scale project, 'Efficiency, Justice and Voice: A Study of Effective Ways to Prevent and Settle Workplace Disputes in Australia'. Julian's present research includes a cross cultural comparison of workplace bullying in Australia and Pakistan.

Project Manager, Megan Blair is Manager of Consulting Services for Converge International.

A Principal Consultant, Megan has more than 20 years' experience in the areas of human resources, learning and development, organisational consulting, executive coaching, counselling and alternative dispute resolution. A nationally accredited mediator, and practitioner member of LEADR, Megan leads a national team of specialised consultants to deliver conflict resolution, HR consulting, health and wellbeing assessments, coaching and career transitions. Megan has worked widely across the public and private sectors, holding senior leadership roles in education (both government and private) and professional services sectors.

Principal Consultant, Beth Parker is Manager of Training Services at Converge International, overseeing the design and delivery of training programs for the large portfolio of clients across Australia. With qualifications in psychology and communication, Beth brings to Converge International more than 25 years' experience in the Victorian state public sector and a solution focussed approach. Beth leads a national team of highly professional training consultants who are each subject matter experts in their fields. Beth also facilitates and delivers health and wellbeing services for clients.

Senior Consultant, Jasmina Svoboda is a qualified Social Worker and nationally accredited Mediator who brings more than 20 years of experience working with individuals, groups and organisations in a diverse range of practices. Jasmina has a breadth and depth of experience in Alternative Dispute Resolution and is inclusive of Family Dispute Resolution, Neighbourhood disputes, Wills and Probate and Work Place disputes. A practitioner member of LEADR, Jasmina has worked in the private and public sectors incorporating skills as counsellor, coach, mediator and supervisor to other practitioners. Jasmina regularly facilitates team assessments in the workplace with the view to optimising team dynamics.

3.3 RESEARCH SAMPLE

The invitation to participate in this research study was extended to approximately 6086 Fellows, 1245 surgical trainees and 100 International Medical Graduates across Australia and New Zealand – a total cohort of approximately 7,431. A request was made by the EAG to include an 'Other' category so as not to exclude non-members of the Royal Australasian College of Surgeons, however they had to be involved, or had been involved, in the practice of surgery. Twenty-three questionnaire responses were received for the 'Other category'.

The opportunity to participate in the study was made available for a period of five weeks, May-June 2015. Responses were received for the whole of that period and email enquiries were received beyond the closure date. The later enquiries were responded to with the suggestion they could contribute to the EAG Issues Paper, as recommended by the EAG.

A total of 414 responses were received:

- 225 completed questionnaires
- 148 incomplete questionnaires with only demographic data completed
- 12 email submissions were provided
- 29 interviews were completed.

Of the 148 who only provided demographic data on the questionnaire, 76 were Fellows, 48 were Trainees, 3 were International Medical Graduates and 21 belonged to the 'Other' category.

The breakdown of the 266 responses that provided data included in the analysis is:

- 188 Fellows (3% of the total cohort of Fellows)
- 47 Trainees (3% of the total cohort of Trainees)
- 8 International Medical Graduates (8% of the total cohort of International Medical Graduates)
- 23 Other

The response rate to the study was 5.2% and the analysis in this report applies overall to 3.5% of the total cohort in surgical practice.

Of the research sample that provided stories beyond demographic data, 93 are female and 173 male. Approximately one third of the sample is female, two thirds male.

As would be expected given the distribution of the total cohort to the various specialities, General Surgery received the highest number of questionnaire responses, comprising 45% of the sample. All specialties were represented. The percentage responses from the various specialties are provided in the table below:

Clinical discipline	% responses
Cardiothoracic Surgery	**4.21%**
General Surgery	**45.51%**
Neurosurgery	**5.06%**
Orthopedic Surgery	**16.85%**
Otolaryngology Head and Neck Surgery	**10.11%**
Pediatric Surgery	**1.12%**
Plastic and Reconstructive Surgery	**7.87%**
Urology	**7.87%**
Vascular Surgery	**3.09%**

The relative ages of the questionnaire respondents as a percentage of the total respondents are provided in the table below:

Age group	% responses
25-39 years	**45.50%**
40-55 years	**35.45%**
56-70 years	**15.34%**
71+ years	**3.70%**

Victoria and New South Wales had the highest number of responses to the online questionnaire. The workplace location of respondents as a percentage of total respondents is provided in the table below:

State	% responses
NZ	**14.81%**
ACT	**2.12%**
NSW	**24.07%**
NT	**1.85%**
QLD	**15.61%**
SA	**10.05%**
TAS	**1.06%**
VIC	**25.93%**
WA	**8.99%**

Victoria also had a significantly large number of requests for interviews in comparison to other work locations. 24 interviews were conducted in Victoria, 3 in Queensland, 1 in New South Wales and 1 in New Zealand.

4 ANALYSIS AND FINDINGS

A thematic analysis involved identifying, recording and examining patterns within the data that emanated from the collection of the personal stories. Certainly the premise upon which the research was initiated was substantiated. Discrimination, bullying and sexual harassment were experienced in the practice of surgery. This is not to say that all of the research sample experienced behaviours related to these identifiers, indeed some did not, or that experiences were in equal measures between individuals, or that individuals had experiences across all identifiers. Suffice to say that individual members of the sample did experience discrimination, bullying and sexual harassment in the practice of surgery and to an extent that enabled the researchers to identify meaningful patterns of commonality. They felt strongly enough to share their experiences, some in substantial depth, and to offer their views and suggestions for improvement. There are also likely to be those who did not respond to the invitation to participate in the research who have had experiences of discrimination, bullying and sexual harassment.

The common themes of discrimination, bullying and sexual harassment are further described in the sections below. Whilst acknowledging that a smaller group within the sample had no experience of the key identifiers, the descriptions from the research provide deeper understanding and insight into how participants experienced discrimination, bullying and sexual harassment, and their impact. They also identify alternative ways that those experiences are perceived.

70% of the total study sample describe being bullied, 27% describe being discriminated against and 12% describe being sexually harassed.

The table and charts below provide a breakdown of these experiences in terms of gender.

For each type of experience described - discrimination, bullying or sexual harassment - the numbers of males and the numbers of females reporting each type of experience were recorded.

122 males and 65 females reported experiences of bullying.

34 males and 38 females reported experiences of discrimination.

7 males and 25 females reported experiences of sexual harassment.

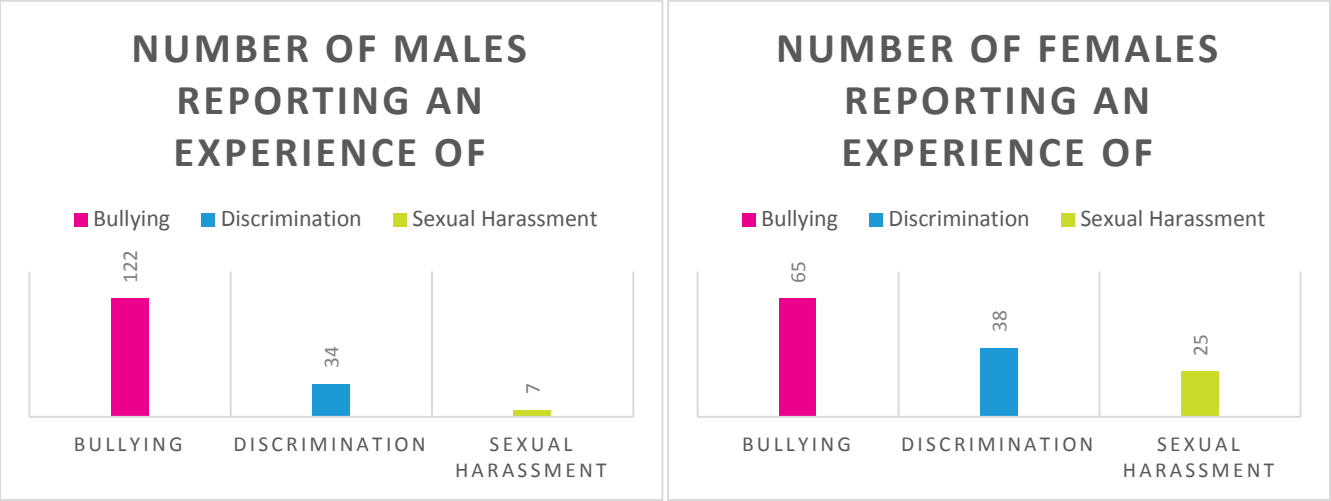
These numbers are shown in *Chart 1* below.

The figures demonstrate that, similarly for both genders, bullying is the most common experience, followed by discrimination, followed by sexual harassment. Regardless of gender, the participants were exposed to each *type* of experience.

Discrimination reported in the research also includes references to exclusion or unfavourable treatment, which participants described as discrimination.

At first glance it may seem that more males than females are experiencing bullying, and that discrimination is relatively evenly experienced by both genders but this is not quite the case.

CHART 1.



Whilst it may appear in *Chart 1* that more males than females are experiencing bullying, and that discrimination is relatively evenly experienced by both genders, it is important to drill down further and look at the gender ratio of research participants.

Of the total study sample of personal stories that were analysed, 65% were male and 35% female. A different picture emerges when the numbers experiencing each type of behaviour are expressed as a percentage of the total sample of each gender - as discrete samples. This produces a more accurate picture of the types of behaviours being experienced by each gender.

The analysis of these figures show that experiences of bullying are relatively evenly spread across genders, whereas a significantly greater proportion of females experience discrimination and sexual harassment. Almost twice as many females as males experienced discrimination. There is almost a seven-fold increase in the amount of females who experienced sexual harassment when compared to males.

Table 1 and *Chart 2* below depict the percentages of males and females experiencing each type of behaviour, expressed as discrete percentages relevant to their specific gender, in relation to the total participants for each gender.

71% of males and 70% of females (as a percentage of the total sample of each gender) described experiences of bullying.

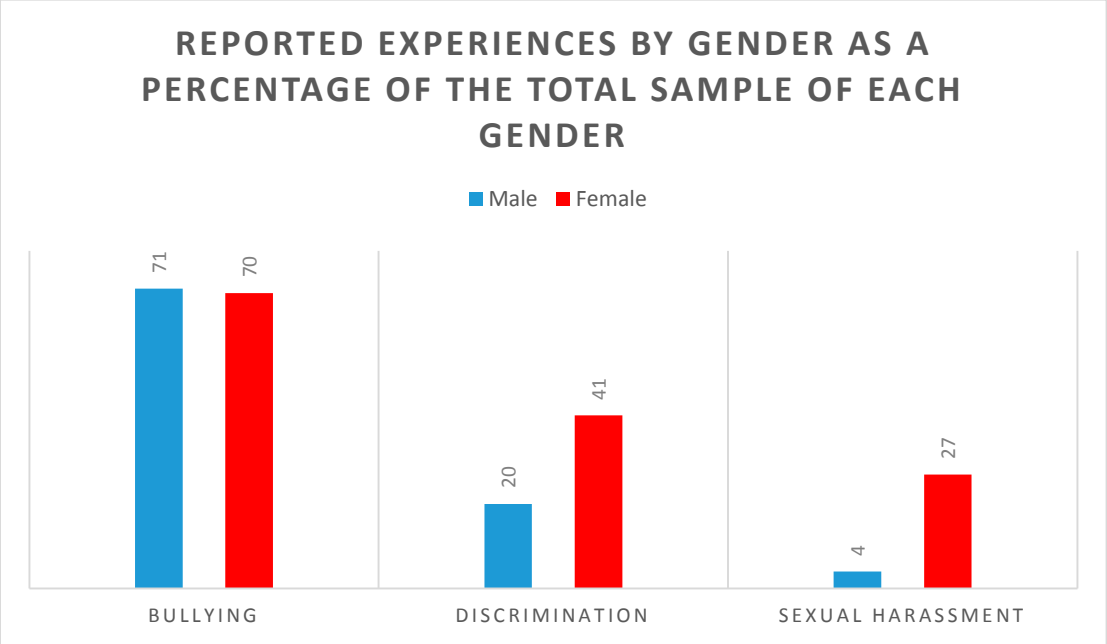
20% of males and 41% of females described experiences of discrimination.

4% of males and 27% of females described experiences of sexual harassment.

TABLE 1.

Reported Experiences by Gender as a percentage % of the Total Sample of each Gender	Male	Female
Bullying	**71%**	**70%**
Discrimination	**20%**	**41%**
Sexual Harassment	**4%**	**27%**

CHART 2.



Across the three key identifiers of discrimination, bullying and sexual harassment, there were a further seven common themes, or patterns, identified by personal experiences. Drawn from the research, these common themes are:

- Fear (of consequences)
- Processes
- Power
- Accountability
- Workplace Culture
- Leadership
- Personality

Each of the common themes are described in further detail in the sections below. In addition to identifying patterns from the general pool of data, the semi-structured questions around enablers, barriers, solutions for change and the construct of a workplace free of discrimination, bullying and sexual harassment, elicited responses from the participants that supported and reinforced the emergent themes from the open ended data set. In other words, when asked specific questions, the participants responded with answers consistent with their input of free flow text or conversation. This provides substance to the commonality and patterning of the seven themes listed above. Poor treatment of trainees received particular mention, and what was insightful was the input from senior surgeons who wanted to share past events about unreasonable behaviours that occurred during their training.

4.1 DISCRIMINATION

Personal stories of discrimination include adverse action being taken against surgeons/trainees on the basis of the protected (under the law) attributes of sex, race, family or carer's responsibilities and pregnancy. There were also stories of perceived discrimination based on unprotected attributes such as state of origin.

Those who felt discriminated against believed they had been treated unfavourably or differently to others or been placed in a position of disadvantage in terms of pursuing their surgical career.

There was also a view that discrimination was not based on the attribute of sex (or gender); that regardless of being male or female, family or carer responsibilities were not supported, and were actively discouraged. A research participant told a story of witnessing a male colleague forced to resign because of his seriously ill child.

"I had DARED suggest that their beloved specialty could be done part time."

Stories include being actively excluded after requesting part-time work to care for a young child, and subsequently suffering false rumours about mental state and being 'screamed at' for requesting part time status even though it existed in College regulations.

The view is held that this reaction was not gender based, and would have been the same for a man if he requested part time work.

Stories of discrimination around pregnancy, mainly during training, were extremely powerful in their messaging and consistency. A number of women felt forced to keep their pregnancies 'secret' for as long as possible 'because of ramifications for the hospital', as they couldn't easily be replaced or simply to retain their place at the stage of their career. Some female surgeons felt compelled to go to extraordinary measures to conceal their pregnancies, with the impact of this carried forward decades later. There was some serious expression of grief in losing time spent with their child. Some of the male participants expressed empathy for the predicament of females reaching a point in age when they had to determine their progress to parenthood at a time that coincided with surgical training. Inflexibility around maternity leave was stated. Stories of active discouragement of females to bear children were presented. Comments such as those below are representative of the stories told:

"Bringing up a subject like part time training, maternity leave or expressing breast milk at work made the surgeons angry."

"I was required to do 30 hour shifts in the last weeks of pregnancy."

"I had to make up my maternity leave when I returned by doing all the on call roster, nobody else taking any other type of leave had to do this."

"I was told I would only be considered for a job if I had my tubes tied."

"I was asked if I planned to have children."

Although rare in comparison, there were some women who did not experience any gender issues during training. There is a story of a successful pregnancy and maternity leave during training.

There is a strong sense that the 'boys' club' mentality is facilitating a culture which females are actively prevented from joining. A lack of gender inclusivity arises from personal stories with the exclusion described as 'institutional sexism at every level'. There is the view that attitudes will improve in time as more women become surgeons and that the older surgeons are 'unable to comprehend women as colleagues'.

Women's suitability for surgery is questioned by some male counterparts; this was a recurring sub-theme, with recollections predominantly from the training period. Stories included male surgeons walking out of case presentations given by female colleagues and blatantly being told that one couldn't be a surgeon because of being female.

It was put forward that female dispositions were perceived more derogatively than males. Angry male surgeons were viewed as 'assertive' whereas a female may be considered 'hysterical' or 'aggressive'. Paternalistic attitudes were described. There were those females who, although cognisant of the discrimination, believed they rose above it and were accepted into surgical practice by 'playing the game' and joining in 'male behaviour' and acting like 'one of the boys'. Stories included being privately upset at having to act in this way but it being the way to survive and be accepted. Multiple participants spoke of the need for women to have a 'strong personality' in order to have a surgical career. There was recognition by women who deemed themselves strong, of how the behaviours would adversely impact those with less self-efficacy.

To a lesser extent, female participants spoke or wrote of the lack of acceptance of women in surgery, and correlating discrimination, existing in the broader sphere of surgical practice. Examples given included:

- Female nursing staff giving preferential treatment to male surgeons over female surgeons
- Patients assuming the male is in charge rather than the female surgeon
- Male surgeons from certain overseas cultures not wanting to take directions from a female surgeon, to the extent that patient care is compromised.

The issue of race discrimination was a recurrent theme, but to a lesser extent than sex discrimination. This is described not merely as a lack of welcome or inclusion, but active measures to exclude surgeons from practice in Australia. Whilst this may be perceived as racial discrimination, there is also a recurring sub-theme of competition and the territorial nature of surgical practice. The exclusion is not limited to surgeons from overseas. There exists a perceived discrimination between cohorts or cliques – of surgeons being treated less favourably because they come from a different network, for example, from interstate.

"If you stay in Australia, we'll make it hard for you."

"They want you out of the country or they want you dead."

"They gang up on you."

"In surgery there is intense competition which continues until the end of a surgeon's professional life."

4.2 BULLYING

The qualitative research project undertook to explore personal experiences of discrimination, bullying and sexual harassment. The most common experiences of the participants as a total cohort relate to bullying.

The research demonstrates mixed opinion over the prevalence of bullying in the practice of surgery, from nil bullying being observed or experienced, to beliefs in a small minority who engage in such behaviour, to a belief in an embedded culture of bullying, to a sense of outrage at the extent of bullying in practice.

Sample comments from contrasting views as to prevalence are provided below:

"The vast majority of consultants have been supportive and good role models. As with any profession, a few rotten apples will spoil the cart."

"The bullies are a sub-set of surgeons, most are very supportive."

"Bullying is limited to a few individuals who are repeat offenders."

"Everyone knows who they are."

"They've had complaints against them but it's difficult to get rid of them."

"Small group of people need to be weeded out."

"I think it's uncommon and the rare incidences gather more attention in what is mostly a fair and egalitarian system."

The majority of participants recalled detailed experiences of bullying. It is precisely the participants' personal experiences that this study seeks to understand. Regardless of prevalence, bullying clearly exists.

"There has been overt and established bullying, within the college and condoned by willful blindness to act."

"This is a deep, serious and major issue."

"I have told you about this so you can get a feeling of how systemic the bullying problem is."

"Widespread bullying in general surgery training."

"Bullying is endemic in surgery."

"Bullying is rife in our surgical community and anyone who says it's not is kidding themselves."

"It is industrial bullying."

"Bullying is an everyday thing. If you are a courier driver you are cautious of cars. If you are a junior surgeon you are cautious of surgeons."

Participants who believed they had been bullied and/or who described repeated, unreasonable behaviours, had clear recollections of actions they had either directly experienced, or had observed being experienced by others. Such behaviours include verbal abuse, swearing, yelling, temper tantrums, head banging in theatre, taunts, throwing of instruments, belittling, humiliation in front of others, being made to work excessive hours, physical intimidation, threats, dismissiveness, deprivation of meal/toilet breaks and, most predominantly, severe criticism.

Although not limited to trainees, most participants who experienced bullying, experienced it as trainees, and that they were the direct recipients of bullying behaviours. There were those who had experienced bullying as trainees, and those who had witnessed trainees being subjected to it.

"The trainee was told to go outside and take his life. This sort of behaviour was not out of the ordinary."

"Some of the trainees arrive quite cowed and it's amazing to watch them unfold as they realise they won't be shouted at."

"Yelling is more or less accepted as ordinary behaviour."

"He deliberately knocked my hand then yelled at me saying I was incompetent."

"Throughout the course of my training I have been sworn at and criticised."

"These harassments and bullying occur in public, in front of patients, other health staff."

Of importance to note, is the significant number of participants of mature and senior years who recall being bullied as a trainee. The impact of the experience has continued throughout their career and is still recalled in much detail.

"The actual bullying behaviour was essentially belittling and intimidation, public humiliation, deprivation of teaching and blocking of opportunities to learn to operate. He repeatedly told me that surgery could not be taught, that being a surgeon was an innate quality that I did not have as I was a weak personality. He would criticise me in front of others and make me do menial tasks. He once physically grasped me by the collar when I was doing a ward round. He shouted at and pushed me through the door to a meeting….The harder I tried the more he became contemptuous of me…I was enormously strengthened by the support of the College and some individual surgeons who helped me. I could not have changed it alone, feeling utterly powerless at the time."

Predominately, bullies were identified as senior surgeons who have some position of power and influence. Some references were made to female surgeons who also bullied. Gender of the bully may be secondary to the accepted workplace culture of bullying. It is a male dominated workplace, and predominantly the bullies are male.

It should be acknowledged that some participants describe the impact of bullying as not having had much effect on themselves, or their careers. The minority who feel this way attribute their resilience to their disposition or 'strength of character'. Some of these participants recognised that bullying can have a far more detrimental effect on those with less resilience.

The majority of participants who experienced bullying describe its damaging impact. This included feelings of shame, worthlessness, anxiety, depression and also, in multiple cases, suicide ideation. Although not in the majority, suicide ideation is by no means rare amongst the participants to the research, and is a recurring sub-theme. In some cases, the impact has led to surgeons and trainees resigning from the practice of surgery. Given such experiences, there is likely to be additional surgeons or trainees who did not pursue or complete this career path due to similar experiences. At the more extreme end of risk, there is likely to be those who have taken their own lives. The impact of bullying is further described in a separate section of this report.

The bullying of trainees is described by a significant number of participants as a 'rite of passage' or 'form of initiation' to 'weed out the wheat from the chaff'. Bullying in this sense is seen as intentional to 'toughen up' trainees in readiness for the 'real work' of surgery and the challenges that lay ahead in what's considered to be a high stress environment where literally life and death decisions are made. Some participants put forward the view that what is perceived as bullying is, in reality, management of performance, specifically of trainees. Stories included a description of being congratulated for getting through training without tears. Whilst the occasional participant describes this approach as beneficial in preparing them for their career journey, the majority have been negatively impacted by this style of teaching and development which begs the question as to its effectiveness. Even with the best of

intentions, this approach, given the detrimental impact on those who have gone on to become successful surgeons, may be, at the very least, misguided.

"There is a need to test for and eliminate weak personality types. You need personalities you can rely on when things get really serious and you don't want emotional breakdown under critical situations. Selection and training must be robust and real life based. It's selection of the fittest."

Participants also attribute bullying to placing patient care at risk. Risk factors for unaddressed bullying behaviour therefore extend beyond the risk to individual, and beyond the risk to the profession, to the risk to the patient, the care and wellbeing of whom is viewed as the essence of the surgeon's profession.

"It's very easy for a trainee not to care about the patient of a consultant they consider a bully. If there are complications, it's more difficult to communicate to the bully so it does affect patient care."

"His behaviour was erratic and scary…patients, students and staff were on the receiving end."

"My concerns… posing an ongoing risk to patients."

Compounding the impact of the act of bullying itself, is the permeating belief that there is no avenue of support for victims. Pursuing a complaint of bullying is viewed as futile – either at senior surgeon level, hospital management/human resource level, or at professional network level such as the Royal Australasian College of Surgeons. Explored in further detail in subsequent chapters is the view of 'culture' and 'power' in the practice of surgery, whereby bullying is, if not explicitly, at least implicitly condoned through a structure whereby surgeons support each other regardless of behaviour. The overriding perception of research participants is a wielding of power by senior surgeons that engenders fear, not only in trainees, but in colleagues who challenge the status quo and also in hospital management, who fear the loss of quality surgeons should their behaviour be challenged. The bullying behaviours were linked to persons of seniority, power and influence.

Associated with the construct of power, and described in further detail in a subsequent section, is a pervading fear of consequence in making a complaint about bullying. The predominant fear is that of significant negative impact to career, to the point of total loss of career prospects.

The loss of career prospects is also highlighted in the research by participants who experienced bullying in contexts other than traineeship. Exclusion is a common theme, particularly with regard to competition. Participants with such experiences state they were intentionally 'squeezed out' of the market in being able to practice, most particularly in public hospitals and in regional areas, where competition for patient lists is deemed to be strong. There was a perspective of senior surgeons banding together to deliberately isolate those who challenged the status quo or who were simply not seen to be part of the established peer group.

In addition, there is perceived intentional isolation and exclusion of those who aren't part of 'the club'. This view is supported by a number of participants from overseas countries, from the 'wrong medical school', and from interstate. The research suggests that there are smaller cliques within the total surgeon cohort that do not promote inclusivity and which raises issues of access and equity.

4.3 SEXUAL HARASSMENT

Sexual harassment was a recurrent theme. Although the personal stories were less prevalent than sex discrimination, the stories themselves were highly descriptive in the degradation experienced by female participants. Some male participants expressed sympathy for the treatment female colleagues were subjected to.

"I stood up for a number of women and was threatened with being kicked off the trainee program."

Multiple examples were provided of recurring episodes of unwelcome sexual advances, requests for sexual favours or other conduct of a sexual nature which humiliated or offended female surgeons/trainees. Sexual jokes and lewd comments were experienced, mostly from colleagues, but also from male patients.

"Comments about whether I'm wearing fishnets or suspenders or about my breasts are not okay."

"Sexual comments were repeatedly made to me during an operation."

Some females, looking back at their time as trainees, felt vulnerable and powerless when propositioned by senior male surgeons. They reported feeling an obligation to provide sexual favours to supervisors in order to maintain their place in surgical practice. There are stories of acceptance at the time, as a 'necessary evil' with subsequent feelings of regret and shame. The impact of the sexual harassment was varied, ranging from annoyance at having to deal with it to utter despair and feelings of worthlessness.

"I was expected to provide sexual favours in his consulting rooms in return for tutorship."

"It was known amongst the registrars that the majority of senior supervising surgeons had mistresses or engaged in similar activities."

"He made physical sexual advances. I snapped and thought, I'm sick of being treated like a piece of fun who happens to be good at her job."

"I was propositioned in different hospitals by different surgeons."

"I felt sure I was marked down because I didn't respond to my supervisor's sexual advances."

"I was told I was hard to work with but would be good to sleep with."

There were examples of the propositioning continuing beyond training years. Others expressed receiving 'great support' from the same male colleagues once they had completed their training. It is akin to the initiation or 'rite of passage' cultural approach seen in the stories of bullying.

A perspective is held that sexual harassment is a 'form of bullying, with gender the focus'; that female trainees experience bullying as sexual harassment. Given the male dominated culture, with females a minority group, the women are inherently placed in a vulnerable position which is an identifiable risk. Fear of consequences for speaking out, a common theme described in more detail in the following section, also extends to women in surgery who experience unwelcome sexual comments and actions.

"Saying 'No' had to be done in a way that didn't dent the ego of the sleazy senior."

"The ultimate penalty for a harassed female who speaks out is being unable to find employment in Australia."

"These women deserve a public apology from the College."

4.4 FEAR (OF CONSEQUENCES)

"I am terrified even to say what I say here."

"I complete this questionnaire with a large degree of fear and trepidation."

"Nothing is anonymous in medicine….even filling in this questionnaire is extremely uncomfortable."

Fear of consequences, of reprisal, of retribution is a commonly recurring theme. A significant proportion of participants expressed fear of participating in the research project itself. Distress was evident. Whilst there was a strong desire to take up the opportunity to share their stories, there was also a lack of trust in confidentiality being maintained, in participants' identities being divulged and a general fear of impact on career. Some participants sought repeated assurances of the confidential aspect of the research.

Conversely, though fewer in number, there were participants who offered to provide detailed documentation and further information and who freely put their names forward.

Some were cynical about the research, fearing a 'whitewash' by the College, or 'a political stunt'. More common, were those who expressed appreciation for the opportunity provided to tell their stories.

"…the positives that can come out of this are worth the stress."

"I'm very optimistic about this process….I think we may have reached a tipping point in Surgery….I think we can do this."

"The opportunity to participate in this survey is much appreciated."

"I welcome the opportunity the College has created because until now there has never been an avenue to speak out about it without fear of retribution…"

The greatest fear made evident by the research is fear of career loss. This risk of this loss is viewed as extreme, given the significant investment of time, money and effort to reach the stage of surgical practice. The level of commitment to get to this point is considered huge and trainees want to strongly protect against this loss. A measure of this protection is the tolerance of behaviour that is viewed as, not merely disrespectful, but intentionally humiliating and degrading. The fear of career loss extends to bystanders, those who aren't direct recipients of the behaviour, but who witness it and feel powerless to do anything about it. Those who witness degradation of others also fear becoming a target.

"What really disturbed me was seeing the effect bullying had on colleagues, some who have quit, and feeling I couldn't do anything to help because my own career would end if I spoke out."

"I still fear that he could ruin my reputation and destroy my life."

"…try to fly under the radar as juniors because senior colleagues decide who will get a job."

"I don't feel I can tell you because I'm concerned about the potential negative impact on my career."

"It would have been career suicide to complain when a trainee."

"Surgical training has always been about creating fear in the workplace."

Surgeons, and the practice of surgery is seen as a strongly networked and influential group, so the fear is not simply loss of career per se, it is fear of exclusion from the group, it is reputational, of being labelled and branded as a 'troublemaker', a word repeated amongst personal stories. There is also an associated fear of being accused by counter claim and fear of a legal or document trail, of 'a record', that will adversely impact on reputation.

"Reputation is everything…public hospital appointments depend on reputation."

A fear exists of being subjected to further discrimination, bullying and sexual harassment, and that this may even become covert, rather than overt. In the main, personal stories described bullying behaviours as overt with frequent episodes of public humiliation. The frequently described open displays of bullying

lends weight to bullying being an accepted part of workplace culture and a lack of fear of consequences in perpetrating this conduct.

A minority alternative view put forward is a reluctance to take on trainee surgeons for fear of being subjected to a bullying claim.

It is this overriding fear of consequences, linked to feelings of vulnerability and perceived power of senior surgeons in controlling career progression that is preventing surgeons and trainees from reporting instances of discrimination, bullying and/or sexual harassment.

4.5 PROCESSES

References to ineffectual processes were repeatedly featured in participants' accounts and this was viewed by many as a key area of change in order to have meaningful and effective responses to complaints of discrimination, bullying and/or sexual harassment.

Most participants experienced that their complaints were not addressed at all or were inadequately responded to. There was a minority group of participants, however, who had been accused of unreasonable behaviours, who felt they were treated in a 'heavy handed' manner. These participants believed that they were deemed guilty from the outset, that they received no details of allegations made, that the processes were manipulated to discredit them, that the processes continued for lengthy periods of time, and that there was no real resolution or outcome. The participants in cases of unsubstantiated complaints still felt that their reputations were somewhat tarnished and the complainant was not 'held to account' for making false or vexatious allegations.

Apart from fear of consequences or retribution, there is a strong sense of futility from participants in initiating any complaints process with either hospital management or the College. Reasons given include:

- Perceived lack of procedural fairness
- Complaints are ignored
- Lack of transparency
- No clear process
- Length of time taken
- Lack of confidentiality
- Collusion amongst senior surgeons, or at best, failure to act.

While many of the complaints revealed by the participants should be dealt with by hospital managements, there is evidence that this does not always occur. In such cases, complaints are being made by one member of the College in respect of another. There is, however a significant perception that complaints are not always investigated and decided on, and this gives rise to a suggestion of complicity. The situation referred to here is complicated by the fact that senior hospital figures can be senior Members of the College, giving rise to a suspicion that it is not always neutral in this process.

A safe, confidential and independent avenue for reporting issues of discrimination, bullying and/or sexual harassment is seen to be vital to trust in the process. Suggestions were made of anonymous

reporting by all trainees and registrars about supervisors, a form of evaluation, so that patterns of behaviour could be identified. An appeals process was suggested, that was independent of the College. It was put forward that standards could be set for surgical encounters, with 'a robust, open, accountable and effective complaints system'. There was a clear desire for independent assessment or a complaints process that was subject to independent, external scrutiny. Early intervention and the capacity to enforce a penalty were also suggested.

Criticisms of the College were made – of a lack of process to deal with complaints and refusal to get involved as complaints were seen as an employment issue and outside the scope of the College. Criticisms of hospital human relations departments were also made in relation to a reluctance to get involved or to investigate complaints of senior surgeons, and a desire to retain hospital personnel taking precedence over the need to address inappropriate behaviour. A recurrent sub-theme is a failure to act, a failure to respond or a response that's ineffectual. Participants put forward that Fellows of the College were the responsibility of the College; that leaders in the College need to listen, to acknowledge, to immerse in reality, to enter unpleasant discussions, to set example, to take complaints seriously.

"There needs to be confidential avenues whereby a trainee can complain even against the person at the top and not have to worry about losing their career."

4.6 POWER

The issue of power is a recurrent theme with in excess of 120 separate references to power by participants with the main sub-themes being abuse of power, inequality of power and entrenchment of power. A close examination of the responses highlights the inter-connectedness of power with the other themes, especially leadership, fear, accountability, discrimination and bullying. What is particularly interesting here is the way in which the word 'power' is used. Power is widely viewed as both a descriptor of the surgical workplace and as something that is vested in particular people.

"It's all about power."

"Power centralised in an individual who is highly regarded."

"They are often consultants who may be senior or in positions of power."

"Power imbalance, hierarchical structure, old school attitude of older surgeons. Behaviour tolerated by other surgeons even if don't agree with it."

"Discrimination enabled by the position of power – surgeon."

While much of the commentary on abuse of positions of power, including engaging in bullying behaviour, highlights the vulnerability of trainees, especially female trainees, there are multiple indications of horizontal bullying based on ethnic or racial background. Surgeons from culturally and linguistically diverse backgrounds also described experiencing horizontal bullying by members of their

own culture who held leadership positions, and, this horizontal bullying was described as giving credibility or reinforcing their position within the 'old boys club'.

The perceived layering and intensification of power was identified by some participants along with the use of positions in the College to support misuse of power and provide protection from engaging in bullying behaviours.

"Power is concentrated in certain individuals in the College and Hospitals. Often these individuals have overlapping positions in both institutions. They allocate your training, approve your leave, assess you, examine you and are your future employers. Often the biggest bullies get to the top of their profession and then set the example for others."

This series of statements underscores, not only the inter-relationship between themes, but that power is seen as 'centralised' and 'concentrated'. While senior members of the profession are normally people with the highest levels of skills and experience, the participants' acute awareness of power and their own powerlessness is to say the least unusual in the modern workplace as is their axiomatic linking of professional status and power.

Many of the comments received identified the ways in which power can be abused.

"Career advancement - most people who do the bullying have a direct responsibility to fill out the trainee's review. If a trainee gets 1 bad report they can be put on probation and 2 bad reports can result in termination of training."

There was a large degree of consensus among participants as to the sources of power and the factors that reinforce power. Sources of power include the:

- surgical hierarchy and the associated training system;
- existence of a master-apprentice relationship;
- fear of reporting or acting on inappropriate behaviour in terms of training assessments, professional recommendations or even deliberate interventions to damage career prospects;
- ways in which people in positions of power backed each other up either condoning or failing to condemn bad behaviour; and
- absence of consequences for bad behaviour at the level of either the hospital or the College and the associated sense that those in positions of power are 'untouchable'.

Factors that operate to reinforce the power of more senior colleagues that were identified were primarily the perception of highly developed networks with an associated 'old boys club' culture; and lack of independent processing of complaints either within the hospital or College contexts. In relation to the former point, we encountered many examples of participants arriving at examinations or placements and having the distinct impression that the surgeon in charge had already pre-judged their character or competence. Quite obviously there are other factors that operate to support the abuse of power including the prevailing workplace culture which is one of the major themes identified in this research.

As with the leadership theme which is discussed in a further section of this report, there were some participants who appreciated the potential for people in positions of power to make a positive difference.

"That involves having people in positions of power who are interested in instigating change and are not bullies themselves."

"Power imbalance needs to be addressed."

The notion that concentration of power is not the normal order of things and that this may be associated with leaders actively modelling desirable behaviours was neatly encapsulated by one surgeon and one trainee who make the same point in quite different ways. The point of commonality in the following statements is the recognition that teams based on mutual respect rather than power inequalities are a most effective way to deliver patient care.

"I don't condone this sort of behaviour and actively seek to shut it down. The use of a flat societal structure where everyone is there to make a difference gives value to each member. I think that hierarchical structures generate this behaviour. Leading by example through every member contributing to the ethic of patient focussed care takes away from any individual having overriding importance. I am not aware of any episode of bullying in our unit in many years through this policy."

"Ultimately it is ego and power that drives this. Shifting emphasis to the development of excellence in patient care changes this focus. Each individual in the team is equally invaluable but also replaceable, like riding on a train that is running at full speed. The machine of the unit only works well when all members contribute equally to the common goal. Respect and friendship are the bonds that hold workers together through this. You do not demand respect, but you earn it through your actions."

4.7 ACCOUNTABILITY

"Everyone has to be accountable for their behaviour no matter how senior their position."

Running through the interviews was a widespread concern about accountability. Although we did not ask the participants how they understood the term, two sub-themes were evident, lack of accountability of senior surgeons (particularly consultants and unit heads) and a lack of accountability of hospital administrators. In some cases participants were unaware of policies and procedures at hospital level covering matters such as bullying, harassment and the various forms of legally proscribed

discrimination; but regardless of the participants' state of knowledge, there was a common perception that senior members of the profession could engage in bad conduct without any consequence. Our examination of the data files also suggests that many participants experienced hospital management (both medical and non-medical) as uninterested in addressing bullying issues and in some cases, as unwilling to intervene. The following quote encapsulates the situation.

"Top down. Starts with the CE of the institution. Managers. Administration. Trainees beholden to supervisors for passing/failing terms. Trainees dependant on direct supervisors for learning opportunities, operating time etc. Lack of accountability of supervisors who are responsible for training; i.e. universities view failed students as a "failure of teaching", surgeon supervisors view failed trainees as a fundamental failure of the trainee, not as a reflection of the teaching the trainee has received."

That poor treatment was embedded in the hierarchical system and is longstanding was evident.

"There is a hierarchical system which is often dictated by senior consultants behaving in a chauvinistic manner, which I believe has been handed down over time. The acceptance/tolerance of appalling behaviours in the past has no doubt enabled the tradition of bullying/narcissism to continue."

Comments such as the above suggest that the hierarchy of positions from trainee through unit head may operate to reinforce a negative workplace culture rather than to challenge it through effective accountability mechanisms.

In respect of surgeons as a group, it has been suggested that a lack of accountability stems in part from the extended apprenticeship system and the associated hierarchy which, at least informally, places senior members in a unique position.

"Lack of accountability as people become consultants. Suddenly there is no one they have to answer to."

Lack of accountability was also linked to the training system.

"While it is important that supervisors are made accountable for the quality of their teaching and student success rates, we do not make the mistake of removing accountability of the trainee for their learning. Both should be balanced. At the moment, we have a system that places all weight on the trainee."

The problem of accountability was also expressed in a lack of confidence in some of the elected officials of the College with a sub-theme being that bullies find their way into senior positions in various institutions (hospitals, universities and professional associations) and they then use this to reinforce their power and associated lack of accountability:

"Until the profession stands up to these people nothing will change. In truth these bullies are rewarded for their behaviour by being promoted to jobs as unit heads, committee members and professorships."

Lack of accountability of consultants was seen to stem from multiple and related sources including: acceptance of the predominant workplace culture, fears of the consequences of antagonising the consultants, and indifference to the well-being of trainees. Each of these points warrants a brief explanation:

Acceptance of the predominant culture: Although we discuss workplace culture elsewhere in this report, it is worth reiterating that the dominant surgical culture is at best robust. To some extent this culture originates from the technical imperatives of the job and the high pressure of the work environment which may give rise to the need for an emotional release. But this is also a culture in which there has been a norm of acceptance of abusive supervision, bullying, and sexual harassment. At the same time it is important to note that some of our participants felt that this was not characteristic of their workplace or that these negative norms are now changing due to increased awareness and generational shift.

Fear of antagonising the consultants: For some participants it was apparent that the mobility of surgeons means that the threat of ceasing to practice at a particular hospital would lead to loss of income or reputational damage or both. Consequently, even where surgeons have engaged in behaviour in conflict with human resources policies or legislation, there has been a reluctance to intervene. It should be noted that in some cases there were suggestions of collusion between hospital administrators and surgeons in the sense that the two groups were seen as mutually supporting and unwilling to act on complaints.

Indifference to the well-being of trainees: Some of the participants noted that trainees are transient in the hospital where the consultants are continuing. In those circumstances, to act against a surgeon would have long term negative consequences and that the short term costs of an aggrieved or emotionally distraught trainee was an acceptable cost.

"Lack of human resources management within the college of surgeons; surgeons are outside of the HR jurisdiction of the hospital administration and are accountable to no one for their behaviour…There needs to be internal RACS based HR systems…5 year employment contracts for VMO positions - means surgeons are essentially untouchable and can behave however they like … Widespread superiority complexes, narcissism, arrogance among surgeons."

4.8 WORKPLACE CULTURE

By culture we mean the taken for granted norms and values which shape people's behaviour and their expectations around performance and success in the workplace. As Goffman (1959)[1] observed, 'Culture lies in the rituals of day-to-day conformity: the forms of talk, styles of dress and modes of interaction that signal our belief in it'. In our theming of responses the term 'workplace culture' was one which we used to characterise many of the accounts we received but it was also a term frequently mentioned by participants. Although culture and accountability emerged as separate themes, the work hierarchy seems to link both themes because it is the hierarchical nature of the profession with consultants at the top that is seen to protect the perpetrators and defines a culture in which mistreatment and even bullying is condoned.

Writing in respect of engineering careers, another male dominated area of practice, McIlwee and Robinson (1992: 5)[2] observed that 'Where engineers as a group are powerful, they are able to define workplace culture in a strong male identified way, and women's careers suffer. In considering the responses in the present study, the word 'engineer' could readily be replaced with 'surgeon', however the behaviours under consideration here are more severe. In some workplaces there was a strongly male culture and true to the nature of culture it was pervasive. Hence many trainees and former trainees reported that among their peers there was a 'blokey' or worse still, an overtly sexist culture.

"The common frequent behaviour as previously described is what I call low level sexism -repeated taunts re my gender, belittling and often exclusion from additional teaching sessions or socialising events in which more junior males were invited as part of the team…Comments on my appearance post a busy night on call in trauma meetings about my need to wear a short dress not scrubs when all my male counterparts are wearing scrubs."

In summary, while much of the commentary places emphasis on the role of senior members of the profession in bullying subordinates or even peers, negative workplace cultures include trainees even if they are not directly involved in bullying behaviours. However, it is important to stress that the issue of a male culture was not confined to trainees and there were numerous comments about the male culture of surgery and this was understood as providing a permissive environment for lack of respect for individuals, discrimination and bullying.

Elsewhere we have highlighted that people often fail to speak up about bullying and other negative behaviours for fear of the career consequences. This is a form of enforcement that is almost a defining feature of the workplace culture but there are other elements too, such as the observation by a fellow that a trainee who spoke out against bullying was 'labelled a difficult and troubled trainee'. In effect trainees who complain are seen as part of the problem and implicit in this is a sense of grave injustice.

[1] Goffman, E. (1959) The presentation of self in everyday life, Doubleday: New York

[2] McIlwee, J.S. & Robinson, J.G. (1992) Women in Engineering: Gender, Power, and Workplace Culture, US: SUNY Press.

"The culture is suck it up, don't report it or it could affect your career. There are numerous personal examples which should have been reported and the consultant surgeon reprimanded. The culture in surgery has not encouraged an environment whereby the innocence of the complainant is accepted but instead seen as a cause of significant concern .The culture needs to change."

In the research literature, witnessing of bullying is often considered from the point of view of the harm inflicted on people other than the victim, however, the responses received highlight that in a bullying culture these behaviours are tolerated or even embraced.

"The unit was poorly organised and managed in structure and leadership which lead to significant work stress. The culture of bullying was initiated and perpetuated by a few key consultants, and followed by several others. If a consultant went on a tirade, others would watch and not stop them, or even join in."

Whether these supportive behaviours function as a stress release mechanism or reflect the power of a dominant personality over the rest of the 'herd' (a term used by one participant) is unclear.
Some participants described the workplace culture as one in which bullying was more than a behaviour but a defining feature of the culture and one which is perpetuated from one generation to the next.

"There was one consultant who was a constant bully…I was warned by my previous fellow to be wary of this man. They as well as others before them had suffered as well but tolerated it. I experienced the same thing. He never scrubbed in for cases to teach me to do cases. Instead he would stand behind me in theatre and criticise."

In this hospital setting consultants are pivotal even though they are not fully nested in the workplace culture. Some participants pointed out the way in which this group, as it were, 'floated in and out' of the hospital so that they were not necessarily a part of the repartee and banter. At the same time the formation of a male dominated culture which is predisposed to bullying is attributed to these senior figures. As the holders of power (assessors of professional competence and income and career prospects) the behaviours modelled by this group are seen as crucial in sustaining the workplace culture. As noted elsewhere the negative behaviours exhibited either privately or in public included: head banging, shouting, abuse and derision, accusations of incompetence, threats to career, and sexual references. In summary, we can say that while the picture of the abusive consultant is far from universal and varies across geographic locations, hospital size, and specialisation, it remains that the widely reported negative behaviours contribute to a culture in which people are not respected, especially those in the lower levels of the career hierarchy.

In this regard when asked about what a hospital without bullying or abuse would look like responses included words like 'heaven' and a great place to work'. These participants also talked of such ideal workplaces being characterised by respect, collaboration and teamwork.

> *"Where it is ok to speak up, be listened to, have concerns investigated independently of the college Performance management of those involved in contact with trainees, students…The attitudes of the college…The boys club needs to be broken…More mentors who are not the bullies themselves or not involved in training and teaching the individual directly…Hospital admins - be more proactive, getting feedback from juniors and nurses about surgeons and their behaviours."*

That culture was an important issue for the participants is demonstrated by the fact that it received approximately 70 separate mentions and the sources of a workplace culture that tolerates bullying were viewed as multiple. Two sources stand out in this regard: the dominance of males and a hierarchical training system. In this system, one group in particular, trainees, and particularly female trainees, are regarded as having little value. Trainees are transient features of the workplace in comparison to senior surgeons, whose continuing presence at a hospital is regarded as a source of value in itself.

4.9 LEADERSHIP

In both the academic and professional management literature, leadership is almost invariably considered as a good. The exception here is the 'great man' leadership theories which posit that leadership traits are inborn rather than acquired. In this project, we typically encountered the 'dark' or dysfunctional sides of leadership; these were influential or powerful surgeons who provided negative role models. On the other hand, in considering what was needed to improve the surgical workplace, participants also painted a picture of what good leadership would look like.

The discussion of leadership here has two inter-related dimensions; one provided by senior surgeons in hospitals and the other by the College and its office holders. In the hospital context consultants and unit heads in particular were singled out by some participants as failing to provide leadership in the sense of positive role models.

> *"Many of our 'leaders' are those who bully, whether subconsciously or deliberately. I cannot see large scale changes being successful when those actively enforcing bad behaviour do so due to their own personality flaws or experiences."*

In such statements we also see echoes of the 'great man' leadership theories; however, other participants emphasised the role of environmental factors in creating dysfunctional leaders, particularly the pressure of work but also a variety of factors associated with the work culture:

More than this, consultants in particular were repeatedly singled out for their dysfunctional behaviour, which included temper tantrums, verbal abuse of subordinates, sexist behaviour, sexual harassment and abuse of a position of responsibility.

"Senior surgeons believing that happened to them and perpetuating it… inadequate rostering and/or staffing lack of respect (for trainees or gender)…toxic culture…poor leadership."

In terms of the College itself the concerns expressed were of two types; one being a failure to provide the right type of leadership to the surgical profession and the other being an extension or contributor to the dysfunctional leadership exhibited by some surgeons in the hospital context. A commonly expressed concern is that the leadership of the College may also include some of those who, according to their shared experiences, displayed inappropriate behaviours in hospital settings, and consequently that the College has failed to assiduously remediate bullying behaviours. Participants recounted experiences where they felt there was more of an emphasis on the protection of the College as an organisation or resistance to criticism of the College. This protectiveness was seen as being enabled by the College not being seen as an organisation that takes complaints seriously and as one lacking effective and transparent processes to deal with complaints. Of greater concern is that some participants outlined situations whereby surgeons were involved in determining matters in which they were the respondent of the complaint.

Apart from the evident lack of confidence in the College, this is seen as producing a situation where bullies are either tolerated or protected by the organisation charged with upholding the highest standards of professional practice. There was also concern that in a variety of ways there was insufficient action directed towards eliminating or preventing bullying and other dysfunctional behaviours, for example, by improving the training of supervisors and ensuring that that their conduct is monitored effectively. It was also suggested that the College could play a greater role in influencing morality and ethical behaviours in the practice of surgery. Such comments included:

"Strict enforcement of feedback between all trainees/college re: supervision and senior staff. Hospital led rotation surveys to assess concerns. More leadership from college to weed out rogue consultants."

"The College of Surgeons needs to take a look at Australia's Chief of Army David Morrison's response to bullying behaviour; this sort of leadership from someone with integrity and the respect of his or her peers is needed to clean up unacceptable behaviour within the profession."

In referring to the shortcomings of leadership in surgical workplaces this is not confined to engaging in bullying behaviours but includes surgeons in leadership positions: being 'covert enablers' by ignoring or doing nothing about such behaviours; as contributing to complainants or victims having 'nowhere to go' with their issues and complaints or for support; creating an environment where potential complainants fear retribution from senior surgeons (either the bully or their associates); demonstrating an attitude that is about either 'punishing' or 'toughening up' trainees (rather than providing pastoral care); exhibiting 'unrealistic expectations'.

In the research literature there is an increasing awareness of the importance of leadership styles in contributing to a workplace culture free of bullying and other negative behaviours (e.g. Hoel, et. al, 2010)[3]. Interestingly, some participants exhibited an aspiration for what ethical leadership would look like. The importance of leaders leading by example and modelling exemplary behaviour was noted by several participants. The need for leaders possessing the qualities of excellence, compassion, respect, honesty and integrity was also enunciated. Some participants presented a quite specific vision of good leadership, one where trainees were actively managed in the hospital context and in which the College would broaden its focus:

"It would have a leader who focuses on dignity, humility, fairness, and respect for others. Supporting their stance would be a College process of reporting that all members of the team are aware of (including nurses etc.). Regular meetings to assess workload, trainee and consultant performance and behaviour would take place. Encouragement to attend RACS and other professional courses to address non-technical skills would be strong."

[3] Hoel, H., Glasø, L., Hetland, J., Cooper, C. L., & Einarsen, S. (2010). Leadership Styles as Predictors of Self-reported and Observed Workplace Bullying. *British Journal of Management, 21*(2), 453-468. doi: 10.1111/j.1467-8551.2009.00664.x

There were a range of comments about the need for positive role models, for example:

"Teams that actually communicate well with mutual respect. Good pathways for reporting that ensure the safety (not necessarily the anonymity) of the reporter. Leaders that tackle (with experience and training) hard issues like this. Leaders that lead by example VISIBLY."

"Such a workplace depends on the people who work there - particularly the leaders. An ideal that does exist - it is possible with the leaders bringing the qualities of excellence, compassion, respect, honesty, integrity and teamwork into the workplace and inspiring a team of people to act in the same way as them or to try and emulate that leadership."

"Strong, inclusive leadership. Open and honest culture. Manage the psychopaths. Empower everyone to challenge poor behaviour, individually and collectively. Abandon the old, heroic surgeon stereotypes."

"Real leadership, demonstrate a true zero tolerance attitude towards bullying and harassment. Reward those that are excellent at creating positive teams. And create real spaces for women to work in surgery."

An absence of positive models of leadership was variously attributed to the process by which leaders are selected. There was a commonly expressed view that leadership positions both in the hospital setting and the College were an 'old boys club'. There was a recurrent notion that leadership positions were not achieved by merit but as being 'bestowed' due to the 'old boys' network. This notion links with the prevalent view of the workplace culture being male dominated, that is, one in which sexism and sexist behaviours are prevalent and in which the dominant values are determined by senior males. Whether or not this is factually correct participants referred to the need for leaders to be trained and rigorously selected in order to 'earn' their position. In this regard, there were repeated suggestions of the importance of providing leadership training along with the need for coaching and mentoring.

"Adequate training for surgeons, leadership training, mentorship, coaching should be part of surgical training. In the same way as business do it. HR needs to have power to reprimand on bad behaviour. 3 strikes you're out."

"Our leaders need to be put through leadership courses and maintain this as part of professional development."

The influence of the 'old boys club' in selecting for leadership positions was also linked with the lack of diversity or embracing of differences within the surgical community. In turn this is viewed as playing out in hostility to female surgeons, particularly those who took maternity leave or wished to practice on a part-time basis. There was even intolerance of males who sought to deviate from the normal working pattern of a surgical career.

4.10 PERSONALITY

Personal disposition was repeatedly viewed as a contributing factor to incidences of discrimination, bullying and/or sexual harassment, most particularly in relation to bullying. Comments about personality or behavioural style were made in relation to both trainees and surgeons.

There are a number of variations on this theme.

Resilience was one aspect viewed necessary to being a surgeon. There was some comment that those of a timid or helpless disposition would not likely survive the training, that they weren't able to cope and that there was even a need 'to eliminate shrinking violets'; that surgeons needed to be 'robust' individuals.

There were also interpretations of a surgeon's poor behaviour as an incapacity to deal with stress, which was largely viewed as an inherent component of the surgeon's role.

Those surgeons who were deemed bullies were viewed by some as having 'personality flaws', 'abnormal behavioural norms', 'lacking compassion', 'sociopaths', 'alpha males' and 'obsessive compulsive types'. An alternative view was that surgeons who were perceived as arrogant were instead self-confident. Arrogance, rather than self-confidence, was more commonly attributed to bullying individuals; arrogance also in 'getting away with' poor behaviour. Traits were attributed to bullies that included a 'God like attitude', large 'ego', low self-esteem, 'selfishness' and 'lacking insight'.

The nature of the bully was described as a person who doesn't like being questioned, and who creates doubt about their actual clinical judgement. Comment was made that surgery attracts 'ego larger than duty of care'.

A systemic element was attributed to bullying and personal disposition in that selection and retention criteria required socially atypical people who were willing to regularly relocate, work extremely long hours and dedicate their lives to work, all at the expense of normal social relationships. A view exists that 'clones' of this stereotype are admitted to surgical training programs, perpetuating asocial behaviours and the appointment of those who don't particularly value human relationships. Repeat offending by the bully was viewed as the norm. A need for more cautious screening in the selection process of appointments, and who is selected, or better still elected, to positions of power and influence, was a recurring sub-theme.

4.11 ENABLERS

After facilitating the input of free flow text or dialogue from each research participant, the specific question was asked *'What do you see as the enablers of discrimination, bullying and/or sexual harassment in the workplace?'*

The aim of this question was to 'drill down' beyond generic responses of total experience, to provide greater insight into the characteristics that participants viewed as key to enabling discrimination, bullying or sexual harassment to take place. In order to facilitate change leading to improved behaviours in the workplace, it isit is important to understand whether the enablers are singular or multi-faceted or commonly experienced so that targeted interventions may be developed and effectively implemented.

There was a great deal of consistency in the responses to this question. The responses also reflected items of mention in the prior question about total experience and validates the common themes identified. These recurring themes provide clarity of focus for areas of improvement.

Workplace culture arises as a common theme but it is important to acknowledge that culture is a 'blanket theme' in the sense that culture is generally attributed by the research participants to the workplace as a whole i.e. 'the way we do things around here'. The embedded culture is largely viewed by participants as *acceptance* of discrimination, bullying and sexual harassment to the point where even those who don't initiate it, do nothing or little about addressing or resolving it, and are willing to support fellow senior colleagues who are seen to be involved in it. Without proactive action to the contrary being viewed as the norm, discrimination, bullying and sexual harassment become accepted and embedded elements of workplace culture, 'the way we do things around here'.

Specific themes arose that contribute to or maintain this workplace culture. These can be summarised as:

- Positions of power and influence
- Hierarchical system
- Ineffectual responses and processes
- Fear of consequences of reporting
- Personality

To a lesser degree, a lack of diversity in the workforce, and a lack of education about the behaviours were described as enablers.

As has been described elsewhere in this report, participants see that surgeons are endowed with considerable positions of power and influence with little accountability for their behaviour. A hierarchical structure, whereby trainees are considered relatively unimportant at the base of the system, is repeatedly described as an enabler of discrimination, bullying and sexual harassment.

This research highlights that knowledge is viewed as emanating from top down and being delivered in an instructive teaching model rather than opinions and learnings being shared, respected and encouraged as may occur in a flatter organisational structure and constructive teaching model. Part of the issue may well be that this is an older style of teaching that is not so familiar to the new generation of trainees who stem from an education system that promotes student-centred and constructive

teaching methods. The use of belittling and criticism to teach potential surgeons is having a damaging effect.

Even hospital management is described as fearful of addressing poor conduct due to the need to retain surgeons in the workplace in a competitive environment. Those who did complain describe exclusion, reprisal and at times, adversarial contests that involved litigation. The general sense was a lack of complaint resolution or satisfactory outcomes, let alone issues being addressed in a timely and unbiased manner.

Responses were viewed as ineffectual as described but also as lacking in clarity in terms of steps and processes. Procedural fairness and principles of natural justice were not entirely evident. A pervading fear of reporting poor conduct enables its continuance. Issues that are not brought to anyone's attention are not being addressed, because the belief is that they won't be addressed. A key consideration is how to break this cycle. If there are no motivators to discontinue poor behaviour, it is unlikely to change. If responsiveness isn't occurring, or can't occur until a complaint is lodged, other mechanisms need to be put in place to instill trust and provide a more proactive approach to identification of unsafe workplace practices.

Personality is viewed as a key enabler; that it is people of a particular disposition who discriminate, bully and sexually harass others. Descriptors of personality by research participants are provided elsewhere in this report. It is personality traits coupled with positions of power and influence that are viewed as key enablers of the continuance of the selection. Significant emphasis was placed on the need for improved screening, selection and appointment processes in the first instance, followed by a means to 'eradicate' the perpetrators if members of the system.

4.12 BARRIERS

Similarly to 'enablers', research participants were asked a specific question about barriers *'What do you think are some of the barriers to addressing discrimination, bullying and/or sexual harassment in the workplace?*

Once again, there was a great deal of consistency in the responses to this question. The responses also reflected items of mention in the prior question about total experience and validates the common themes identified. These recurring themes provide clarity of focus for areas of improvement.

Similarly to the question about enablers, the aim of this question was to 'drill down' beyond generic responses of total experience, to provide greater insight into the characteristics that participants viewed as key to preventing effective address of discrimination, bullying or sexual harassment, so that targeted interventions may be developed and effectively implemented.

Common themes that were also identified as 'barriers' to effective prevention and/or address of discrimination, bullying and/or sexual harassment are:

- Workplace culture
- Fear of consequences
- Ineffectual responses and processes
- Personality

To a lesser degree, fatigue and being too tired to intervene was seen as a barrier, as was the consideration that complaints could be vexatious. The latter consideration was put forward in relation to trainees who make false allegations because they are being assessed as lacking in performance. A view was held by some participants that it was reasonable to challenge performance and that the trainees who made false allegations made it more difficult for those who had genuine complaints to come forward. A smaller proportion of participants had felt wrongfully accused by trainees or junior surgeons when they were managing performance. These participants also found the responses and processes wanting. Timeliness and lack of information about allegations were key concerns. Frustrations with the processes to deal with complaints are a repeated theme of the research findings.

The most common themes arising from the question in relation to barriers mirrors the themes from enablers with the exception of 'hierarchical system' and 'positions of power and influence'. It would seem that power and position have a more direct bearing on the initiation of poor conduct than its subsequent address. It is important to note that the participants' responses around fear of consequences were indirectly related to the theme of power and what would happen to them if they actually complained about the conduct.

5 IMPACT OF INAPPROPRIATE BEHAVIOURS

The negative impact that the experience of bullying has had is generally high and has resulted in significant risks for the surgeons, patients and for the profession. Emotional distress was generally high among those surgeons/trainees who elected to have face to face interviews. As anticipated, it was important that these interviews were conducted by suitably qualified and experienced professionals, and that further support was available to the surgeons/trainees post interview. Online participants who experienced bullying also described varying degrees of emotional distress and were provided with information about post questionnaire support measures. Emanating from the research is the discovery that the participants who've experienced bullying have had little or no support to deal with it. Heightened anxiety and/or emotional distress has existed for extended periods of time during the practice of surgery.

The majority of participants who have experienced discrimination, bullying and/or sexual discrimination describe the extent of impact with clarity and emotional recognition. While the responses to the experiences vary, impact is undeniable. There are feelings of shame and worthlessness. There is mental health impairment of anxiety and depression. At the severe end of the risk scale, there is suicide ideation, in multiple cases. This leads to a harsh reality question of how many potential participants may have already left the profession by way of withdrawal, resignation and, to the extreme, taken their own life.

Actual examples of participant descriptions of impact, in their own words, are provided below, with phrases repeated by multiple participants in various ways:

- *Paralysed with fear*
- *Very traumatised*
- *Major impact*
- *Constant trauma*
- *Has affected my lifetime happiness*
- *Try not to give in to self-pity or you will top yourself*
- *I was so depressed*
- *I had suicidal thoughts*
- *Still become anxious and angry over what happened*
- *I would like the perpetrators to know how badly it affected me*
- *I considered leaving training because of their behaviour*
- *Overall my training time was awful*
- *I still feel like crying when I think about it*
- *It's surprised how distressed I've been by discussing it, all these years later*
- *I had to close my practice*
- *I sought counselling to help cope with the stress*
- *I required therapy*
- *Almost ruined my career*
- *My work suffered*

- *Devastated*
- *Severe emotional impact*
- *Resigned*
- *Physical and emotional health impacted*
- *Drinking more*
- *Sleep issues*
- *Impact on marriage*
- *Loss of confidence*
- *Severe mental distress*

"It would be good to have a forum where the perpetrators could hear the victims' stories and actually feel remorse."

"Someone who isn't so resilient would leave the country or commit suicide."

What this research has brought to light is the longevity of impact. Undoubtedly the majority of poor behaviours are directed towards trainees. However, it is significant that the many participants who describe negative impact are mature surgeons.

The research also highlights that impact extends beyond the individual's direct experience to a broader net. It impacts those witnessing the behaviours, it impacts the families of the victim and it impacts, according to participants, patient care. So there are a number of considerable risks in activities of discrimination, bullying and sexual harassment that go unaddressed and perhaps even unrecognised. In addition, there is the impact on the profession. There were stories of surgeons resigning and stories of trainees withdrawing from the practice of surgery.

"My partner and kids suffered the most."

"A loving and supportive family saved me from suicide."

"My partner would have committed suicide if I did."

6 FUTURE FOCUS

6.1 SOLUTIONS FOR CHANGE

Research participants were asked a specific, yet open ended question about change: *What do you think needs to change?*

This question provided the participants with the opportunity to input whether they considered a need for change and to put forward their own solutions for improvement.

A random sample of participant comments are provided below. These sample comments reflect those stated in the larger collection of submissions. There is a strong desire for improved structures and processes, measures of accountability and leadership. Ultimately the desire for a change in culture in evident.

"Foster a culture of caring for juniors….encourage a culture where having a registrar to assess and manage patients for a consultant is treated as a privilege rather than a service for consultants."

"Enforce the law, punish those who break it, investigate powerful perpetrators and find out why they get away with it."

"There is always a place for open constructive criticism but bullying and harassment is far from that."

"So much power of someone's career should not be placed in the hands of one or two individuals."

"Selection criteria needs to prioritise ethics, modesty and humility…currently it is an excercise in the loudest wins."

"Appropriate people need to be appointed to the role of supervisor and when more than one trainee complains there should be a formal investigation."

"Complaints and feedback relating to consultant performance should be welcomed. When seniors aren't held accountable what incentive do they have to behave properly?"

"Perhaps an anonymous college reporting system is required."

"Performance management needs to be in place for every consultant employed in a public hospital."

"Bosses can't be the sole report taken into account for progression in surgery…have a 360 degree assessment for each rotation – reports from peers, juniors and nursing staff."

"While confidence is important, I believe we need to foster a less arrogant culture in surgery in general, and perhaps some of these sociopathic tendencies in some departments will be bred out."

"Need to encourage reporting."

"If there are any discrepancies in assessment for junior staff there must be a safe forum to voice concerns."

"There are other ways to foster strong leaders other than trial by ordeal (abuse)."

"Need to identify bullies, educate, rehabilitate and kick out if no improvement in behaviour."

"Need to support victims fully."

"HR needs to have power to reprimand on bad behaviour."

"Adequate training for surgeons, leadership training, mentoring, coaching should be part of surgical training. In the same way as businesses do it."

"Need to educate early and well, including how to stand up for those around you who are affected."

"Acceptance of this behaviour has to change."

"The culture has to change."

Across the submissions as a whole, the following areas were most commonly identified as those requiring change:

- *Processes*, particularly around: selection of supervisors; the management of, and responses to, complaints; performance management of those behaving poorly; objective assessments of trainees and ways to empower recipients of unreasonable behaviours
- *Structures* (particularly to the trainee program) that facilitate: objective feedback; flexible and family friendly pathways; independent reporting mechanisms; less hierarchical sharing of expertise
- *Leadership,* greater intervention by the College to accredit training hospitals, appoint suitable supervising surgeons and support those at risk, particularly trainees and women, through influencing change and improvements in the workplace; supervisors who are role models and have a teaching methodology that supports inclusive learning

- *Accountability,* at both hospital and professional network levels, to have mechanisms in place that are independent, objective and readily utilised without fear of retribution to provide consequences for perpetrators of unreasonable behaviours, including dismissal as an option
- *Workplace culture,* to foster a culture that promotes and supports reasonable behaviours and provides for equitable, inclusive and respectful professional interactions amongst all involved in the practice of surgery.

To a lesser extent, the following were seen as important to establish effective change:

- *Training,* greater education and awareness around legislative frameworks and respectful behaviours, particularly for those involved in supervision. Resilience training was also suggested for trainees
- *Patient focus,* a greater emphasis on patient care and reduction in the impact of unreasonable behaviours on patient care
- *Personality,* quantified by the recognition by most who raised this as an issue that it would be difficult for change to occur and that dismissal from supervision of trainees was probably the most optimal outcome that could be achieved
- *Counselling* of the perpetrators as an intervention to eradicate unreasonable behaviours
- *Natural attrition,* the view that 'things would change for the better' through the resignation of older males and more females coming into the system.

Participants described both the current state in relation their experiences of bullying, harassment and discrimination. Many also described a desired future state. The table below is a summary of sample participants' statements.

Reported State	Desired State
Fear of consequences	
Don't report as it will ruin your career Your reputation will be destroyed if you complain You would fail your traineeship if you dared complain I'm terrified to say what I am saying here I complete this questionnaire with fear and trepidation	If you have an issue there is someone you can talk to who will listen If you have a complaint it will be treated respectfully Trainees, IMG's and surgeons won't be afraid to speak up

Reported State	Desired State
Processes	
There is a lack of fairness in the procedures If complaints are made, they are ignored HR people and processes in hospitals are ineffectual If you make a report to HR, RACS or any other body, it takes far too long to resolve There is no real confidentiality when a complaint is made You don't report because the processes just don't work	Clear, transparent and effective processes exist RACS and hospital networks have mutually supportive and dovetailing processes and procedures for responding to complaints Surgeons have complete confidence that reports of abuse, discrimination or harassment are managed with utmost confidence
Power	
It's a boys club So many men have a lot of power It is necessarily hierarchical but this hierarchical arrangement is abused Perpetrators of abuse have all the power – you can't challenge them As an IMG your power to control your situation is limited Women have less power than men Trainees have so little power over their situation RACS abrogates its power	Necessary hierarchies exist but are not exploited by those with higher standing within the organisational hierarchy The power and responsibility to determine a trainee's and an IMG's future is in the hands of more than one person and that process is transparent
Accountability	
People know who the perpetrators are but they are not held to account RACS does little to hold abusers to account The accountability falls between the hospital networks and RACS	Perpetrators of discrimination and harassment are held to account by the hospital network and by RACS Members of RACS indicate strong support for the maintenance of professional practice principles and do nothing to impede full investigation of allegations

Reported State	Desired State
Culture	
The hierarchical nature of master and apprentice is ingrained in the culture Women are not welcomed into the surgical profession Surgeons promote a culture of exclusion of those who seek to work flexibly There is a male-dominated culture that makes it okay to make women feel unwelcome There is a culture where people are afraid to stand up against the bullies	Surgical culture is supportive, collegial and flexible Surgeons will be known for collaborating with others Women will be proactively welcomed into surgery Surgical traineeships will offer flexibility to allow pregnant women and women with children to complete their traineeships more easily
Leadership	
RACS does not provide effective leadership to change the culture There are some surgeons in leadership position who condone very bad behaviour HR departments show no leadership when it comes to addressing workplace discrimination and harassment Hospital network CEO's don't show enough leadership in challenging abusive behaviours RACS doesn't show real leadership around the issue of women in surgery	RACS leads a strong and effective campaign to address workplace bullying and harassment RACS and hospital networks show combined, strong and effective leadership in publicly promoting workplaces free of bullying and harassment Senior surgeons, consultants and surgical registrars stand up against workplace bullying and harassment
Personality	
If you don't have the right personality then you get eaten alive There are some surgeons who you'd call sociopathic in their behaviour There is an alpha-male type that thrives in the surgical profession There are ruthless, driven personalities There is no check on the size of some people's egos	Strong personalities are welcomed; abusive personalities are effectively challenged

6.2 A WORKPLACE FREE OF INAPPROPRIATE BEHAVIOURS

In keeping with an appreciative inquiry approach, research participants were asked the specific, yet open ended question: *What would a workplace free of discrimination, bullying and sexual harassment look like?*

Some participants felt their current workplace was free of the three key identifiers and they had had nil experiences of the unreasonable behaviours; there were others whose current workplace was considered 'free' but who'd had past experiences of discrimination, bullying and/or sexual harassment.

There was a view that no workplace could be free of the key identifiers; that it was impossible for this ideal state to exist 'doesn't exist'; 'utopia'; 'frankly can't imagine it happening'; 'unreal'; 'fiction'. Yet even for those who expressed this view, many still desired to aspire to this 'free state', believing that it is still 'a good goal to strive for' and that 'we can work to eliminating the worst of it'.

Most research participants did put forward their view of a better workplace, free of unreasonable behaviours. Sample comments included:

- *No fear*
- *Team orientation*
- *Effective processes*
- *Less hierarchical*
- *Better leadership*
- *Better structures*
- *Transparent*
- *Diverse*
- *Modern*
- *No game playing*
- *Interest in others' opinions*
- *Very productive*
- *Mutual respect*
- *Independent assessment of performance*
- *Comfortable*
- *Fair*
- *Opportunity for everyone*
- *Major reflection on patient care*
- *Tolerance*
- *Collegiate*
- *Supportive*
- *Harmony*

In considering the collective responses from all participants, there is an overriding sense of inclusivity, equity, collaboration and respect that is expressed as the desired state, with multiple mentions of increased focus on patient care. A lack of fear and open dialogue are also key elements of the imagined state.

7 SUMMARY OF FINDINGS

From this qualitative study, a number of findings are made, embedded in the exploration and analysis of the previous sections. It must be acknowledged that these findings are based on input provided by the participants to this research. The findings are summarised below according to occurrence and type of behaviour; processes and responses; power, leadership and accountability; culture; and impact.

OCCURRENCE AND TYPE

1. Discrimination, bullying and sexual harassment exist in the practice of surgery
2. Seven common themes, or patterns, can be identified by personal experiences:
    - Fear (of consequences)
    - Processes
    - Power
    - Accountability
    - Workplace Culture
    - Leadership
    - Personality
3. Almost double the amount of males than females experienced bullying
4. Most bullying is directed towards trainee surgeons
5. Discrimination includes sex (gender) discrimination
6. Almost 80% of those who experienced sexual harassment are female
7. Discrimination includes carer discrimination – family friendly practices are actively discouraged and apply to both male and female surgeons
8. Discrimination includes race discrimination
9. Exclusion occurs of surgeons/trainees from other countries, other states and different medical schools
10. A smaller number of participants had not experienced discrimination, bullying and/or sexual harassment
11. Unreasonable behaviours are generally overtly displayed
12. A range of bullying behaviours exist that are intimidatory
13. There is recognition that some complaints of bullying are vexatious and may be performance related
14. Females, particularly trainees, are subjected to sexual harassment with a range of behaviours from lewd comments to demands for sexual intercourse
15. Sexual harassment is viewed as a form of bullying

PROCESSES AND RESPONSES

1. There is a lack of support for victims
2. There is a lack of responsible action
3. Responses to complaints are generally ineffectual – by hospitals and the College
4. The complaints processes lack effective application of procedural fairness and principles of natural justice

5. Hospital management are afraid to upset senior surgeons
6. Selection processes for leadership and supervisory positions could be improved

POWER, LEADERSHIP AND ACCOUNTABILITY

1. People in positions of power and influence dominate the workplace culture and drive fear
2. Most perpetrators on unreasonable behaviours are in positions of power and influence
3. Unreasonable behaviours are tolerated by senior colleagues of perpetrators
4. A hierarchical structure supports the power base
5. A lack of independent reporting mechanism and complaints process supports the power base
6. There is a lack of accountability for perpetrators of discrimination, bullying and sexual harassment – from other senior surgeons, from the hospital, from the College
7. A power imbalance exists between surgeons and trainees and between males and females; trainees and females are placed in a vulnerable position
8. Powerful networks of surgeons can control career destiny in a competitive environment
9. The College has a greater capacity to influence change and set acceptable standards
10. More role models of respectful behaviours are needed
11. Personality that is narcissistic is a contributor to discrimination, bullying and sexual harassment

CULTURE

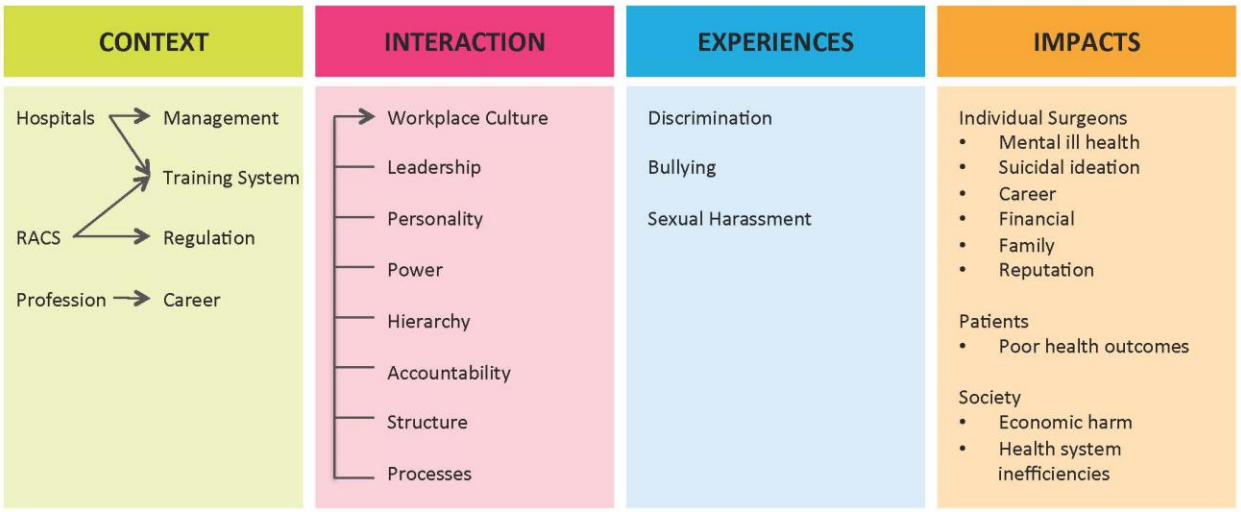
1. There is a culture of bullying as 'a rite of passage', an expression of intent to prepare trainees for surgery
2. There is a culture of fear – fear of consequences prevent reporting of unreasonable behaviours
3. Minority groups, particularly trainees and women, are devalued; women are not considered suitable for surgery
4. The culture is male dominated, considered a 'boys' club' and overtly sexist
5. Bullying is tolerated and overt – bullies are widely known
6. Bullies tarnish the profession as a whole
7. The culture is non egalitarian
8. The culture is historical and embedded
9. There is a strong desire for change

IMPACT

1. Fear is common, the greatest fears being loss of career, and loss of reputation. Fear of reprisal for participating in this survey is present
2. Fear extends to bystanders, who fear retribution if they intervene
3. Discrimination, bullying and sexual harassment have led to significant mental health issues in victims, including multiple accounts of anxiety, depression and suicide ideation
4. Unreasonable behaviours have led to loss of surgeons and potential surgeons from the profession
5. Significant emotional distress was expressed by participants and observed by interviewers
6. Impact of discrimination, bullying and sexual harassment is long term
7. Impact has a broad reach, extending to colleagues of the victim and family members
8. There is an identified risk to patient care.

The context of inappropriate behaviours includes complex regulatory and organisational dynamics that cross over health care management systems and the College responsibilities. The interrelationships of the key factors discovered through this research is presented graphically in Figure 1 below.

FIGURE 1.



8 RECOMMENDATIONS

A fundamental issue to deal with is that the relationship of the various levels of the surgical hierarchy is not simple and the role of the College as a regulator of professional standards and professional conduct intersects with the responsibilities of hospitals as employer of most categories in the medical workforce. This situation is further complicated by the legal responsibilities and duties which hospitals must assume under laws relating to discrimination, workplace bullying, sexual harassment and occupational health and safety. Whilst the hospital holds a great deal of responsibility as the employer in creating a safe workplace, the College has the opportunity to influence and lead change as the peak body for accrediting surgical training and supervision. Given its pivotal role as the professional network of surgeons, the College is ideally placed to exemplify expected standards of professional practice, and to seek ways to actively encourage respectful behaviours from its Members. Many of the research participants would like to see the College take a greater leadership role in addressing the issues contained within this report.

Taking into account the findings of the research and the participants' input into solutions for change, Converge International puts forward the following recommendations for consideration by the Expert Advisory Group in order to change workplace culture and achieve effective address of discrimination, bullying and sexual harassment in the practice of surgery. These recommendations are provided with the view to how the Royal Australasian College of Surgeons could play a leadership role.

1. **Undertake a review of processes in relation to complaints and selection to identify and implement ways to make these more effective**

   Develop an independent complaints process:

   Admittedly, we have not had the opportunity to examine the processes and structures of complaint handling in the College, so subject to our limited knowledge we suggest that it is necessary to ensure that the complaints handling process is, and is seen to be, independent of the College. An independent office could be established to make recommendations on how the issue may be resolved. Matters could be confidentially and independently assessed and referred to external investigation as required. There also needs to be consequences for substantiated unreasonable behaviours that are widely communicated to Members, as to what those consequences are and how they will be applied, for example, suspension from supervising trainees.

   So that Members and the public could have confidence in an independent process, the College could annually publish broad details of the number and nature of complaints notified to it and the outcomes. Established standards, such as those followed in an ombudsman process, could be applied to the operations of the College.

Increase communication between hospital management/human resource departments and the College:

The College to work with hospitals to promote and develop protocols around respectful behaviours and dealing with complaints. The College could advise on, and support, the handling of complaints in terms of professional accreditations and referrals to an independent process.

Improve selection processes:

The College to select Members suitable for positions of leadership and training based on mandatory selection criteria that is inclusive of behavioural style and personality, that are independently assessed. The College may also consider 360° feedback about surgeons' behaviours that informs future employment as an accredited supervisor of trainees.

2. Provide appropriate and widely recognised avenues of support

Mentor trainees, International Medical Graduates and females:

The College to provide independent support for trainees, International Medical Graduates and females, to support vulnerable minority groups by allocating them to mentors with a widely recognised role who could provide them with advice and support around issues of concern, and who have been satisfactorily assessed as suitable mentors through 360° feedback and psychological testing.

Appoint Contact Officers:

To appoint Contact Officers at the College who have thorough understandings of employment and legislative frameworks as they apply to discrimination, bullying and sexual harassment, who can advise Members, trainees and mentors about appropriate behaviours, refer parties in conflict to independent alternative dispute resolution such as mediation, communicate with hospital HR departments and an office established to independently assess complaints, and use information and any patterns or trends in complaints to inform further action for change.

3. Provide for greater measures of accountability

Implement training programs:

The College to undertake systematic and ongoing review of the surgical training process including teaching methods and objective assessment criteria. Also considered important is to identify any patterns of withdrawal from training and failure rates and complaints about supervisors. Current and timely feedback from trainees on hospitals, training programs and supervisors could be collected and assessed by an external body so that trainees are provided with the opportunity to confidentially report on their experiences without fear of reprisal. The external agency could identify patterns and make recommendations for change. Clearly articulated criteria for continued accreditation as supervisor, or in the case of hospitals, as training facility could be developed. It is recommended that this review be undertaken and monitored by a steering committee that includes independent input as a quality control mechanism.

Review performance management systems:

The College to develop and implement a strategy to hold surgeons accountable to the Professional Practice Principles in response to breaches.

The College to work in partnership with hospitals to develop a rigorous performance management system for surgeons that takes into account the capacity to work with others in a respectful and professional manner. It is recommended that withdrawal and failure rates of trainees allocated to supervising surgeons form part of professional assessment, as would a 360° feedback system with independent analysis and questions around professional competence and adherence to professional practice standards in the treatment of colleagues, hospital personnel and patients.

4. Develop ways to lead and influence

Develop training and awareness programs:

The College to lead hospital and health networks to develop and implement joint awareness campaigns to promote workplaces free from discrimination, bullying and sexual harassment.

Identify exemplars of both genders and establish ways for them to professionally develop others – those leaders who are widely respected for modelling respectful and inclusive behaviours, who would be willing to mentor, coach or present to relatively new leaders or supervisors.

Trainees and Surgeons to participate in mandatory training around professional practice principles, respectful and inclusive behaviours in the workplace and revised grievance/complaints processes.

5. Review structures for more inclusive practice

The College to continue to explore and implement flexible approaches to completing traineeships that support the balance of career and carer commitments for both genders, particularly in relation to women throughout periods of pregnancy and childbirth.