

Expert Advisory Group

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

Report to RACS



ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

Report to RACS: DRAFT

8 September 2015

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1. EAG Statement

Every patient has a right to expect that their healthcare is uncompromised by discrimination, bullying and sexual harassment in the practice of surgery.

Every surgical trainee has a right to an education free of discrimination, bullying and sexual harassment.

Every international medical graduate has a right to be assessed on their merits, free of discrimination, bullying and sexual harassment.

And every healthcare worker – including every surgeon – has a right to a workplace free of discrimination, bullying and sexual harassment.

In this workplace, patient safety is the absolute and common priority; teams work together effectively, respecting the skills, experience and contribution of each member; the success of surgical teams is measured by the safety of the workplace and training post, and by the extent to which all team members recognise that what they achieve together is more valuable than anything they can achieve on their own.

Workplaces like this exist now in some places in Australia and New Zealand. But they are a long way from the everyday reality of most people involved in the practice of surgery.

This must change. It is what both patients and surgeons in Australia and New Zealand deserve.

Effective change will take sustained commitment from individual surgeons, the College, public and private hospital employers, the healthcare sector and governments.

It will take a collective recognition that there must be a profound shift in the culture of surgery and an unwavering commitment to achieving this. Long-established traditions that have been inherited and have normalised unprofessional, and sometimes illegal, behaviours must be relinquished. Gender inequity must be addressed. Discrimination, bullying and sexual harassment must become problems of the past.

Everyone involved in the practice of surgery in Australia and New Zealand has a role in leading the way. With courage and purpose, on a foundation of transparency and independent scrutiny, a culture of respect and professional excellence in the practice of surgery can be built.

It will take individual surgeons meeting – and being held to account against – their legal and professional responsibilities to their patients, their trainees, their healthcare colleagues and their peers.

It will take bystanders speaking up and not being silent witnesses to discrimination, bullying or sexual harassment.

The College must be bold and embrace this opportunity to lead lasting, positive change by:

- filling gaps in training, education and policy
- working in effective partnership with the Specialty Societies and Training Boards
- establishing partnerships with employers and others in the health sector
- actively holding practitioners and employers to account against agreed standards
- meeting their duty of care to trainees
- addressing gender inequity
- making it safe for people to raise concerns without fear of retribution
- making surgery the career of choice for the best young doctors who will reflect the qualities, diversity and professional excellence that the College wants the profession to be known for and
- showing others in the health sector what it looks like to successfully address and prevent discrimination, bullying and sexual harassment.

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There is no room for bystanders. Employers, hospitals, governments, health professional and industrial associations and other partners in the health sector must also commit to sustained action.

It will take employers taking seriously their responsibilities to provide a safe workplace and governments supporting hospitals to do this. It will take new partnerships, committed collaboration and fresh approaches.

There needs to be a new, shared language that makes clear the risk to patient safety from discrimination, bullying and sexual harassment. There will be lessons for the rest of medicine, and the health sector more widely, to learn.

This does not involve trashing the past. It involves mindfully, deliberately taking what is best from the rich history of the practice of surgery and re-settling it on foundations of respect, transparency and professional excellence.

Nearly 50% of College Fellows, trainees and international medical graduates report being subjected to discrimination, bullying or sexual harassment. It is inconceivable that anyone finds this acceptable or contests the seriousness and spread of these problems.

The status quo will not serve the future. Individually and collectively, College Fellows must recognise and commit to closing the gap between how it has been, and how it must become.

The Hon. Rob Knowles AO (Chair)

Dr Helen Szoke (Deputy Chair)

Mr Graeme Campbell

Dr Cathy Ferguson

Dr Joanna Flynn AM

Mr Ken Lay APM

Dame Judith Potter DNZM, CBE

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2. Introduction

This Draft Report summarises the issues raised in research and consultation commissioned by the Expert Advisory Group (EAG) to the Royal Australasian College of Surgeons in 2015. It recommends actions the College can take alone and in partnership to address and prevent discrimination, bullying and sexual harassment in the practice of surgery.

The EAG has been shocked by what it has heard. The time for action has come. The College must be bold and embrace this opportunity to lead lasting, positive change. There is no room for bystanders and hospitals, employers, governments, health professional and industrial associations, and other partners in the health sector must also meet their responsibilities and make a sustained commitment to action.

3. Executive summary

There was strong participation in all consultations and surveys and the research results are statistically valid.

Research results and consultation feedback confirm that discrimination, bullying and sexual harassment are pervasive and serious problems in the practice of surgery in Australia and New Zealand. The effects are significant and damaging. Discrimination, bullying and sexual harassment affect not only the individuals who are subjected to these behaviours, but also the healthcare teams who witness or are part of them, and patients whose safety is risked as a result of them. The research shows that there are some surgeons who do not believe these problems exist.

There was considerable support for the College in tackling these issues and establishing the EAG. As well, most participants valued the profession and the enormous contribution it makes to the healthcare sector and the community. Among those who believed there are serious issues to address, there was hope that lasting, positive change can be achieved.

The EAG accepts the view that there are serious issues to address. It focuses on the problems that have been identified and makes recommendations aimed at lasting change. The EAG recognises the enormous contribution of surgeons to the healthcare sector and the community, the integrity and positive role modelling of many in the profession, and the commitment of the College in establishing and resourcing the EAG, and leaving it to do its work unconstrained.

The research found that:

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

Discrimination: Reported by 18% of prevalence survey participants, is most commonly about cultural or racial discrimination (33%), followed by sexual discrimination (16%); was effectively resolved in only 12% of cases; and was most commonly reported by international medical graduates (27%).

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Bullying: Is endemic in surgery; common in training and the surgical workplace; and central to the culture of surgery. There was general consensus that the worst cases were deliberately orchestrated and perpetrated by a small number of people who abused their institutional positions of power.

Sexual harassment: There is significant gender inequity in surgery, which influences and is influenced by the dominant surgical culture in which inappropriate behaviour is rarely 'called out'. There are reported instances of sexual harassment, and sexism more broadly is commonplace in surgery.

These terms are defined in Appendix One.

All forms of research and consultation raised a consistent set of issues and themes. Concerns about discrimination, bullying and sexual harassment focussed on:

1. Culture of fear and reprisal – making a complaint is 'career suicide'. People are afraid to raise an issue or make a complaint, fearing risk to their traineeship or their career and livelihood. This appears to be the single biggest issue fostering continuing poor behaviour by perpetrators, as so few people are prepared to challenge the status quo. Fear of reprisal – or consequences – stopped some Fellows, Trainees and International Medical Graduates participating in the EAG research and consultation processes.
2. Complaints handling – in addition to fear of reporting, there is a lack of trust and confidence in the people handling complaints and the processes in place at the College and across the health sector. There is confusion about processes that are often legalistic and narrowly defined; and a demonstrable lack of consequences for perpetrators.
3. Surgical education – supervisors have technical skills but less often the necessary teaching skills, interpersonal skills or leadership capability to educate trainees. Most are not equipped to provide constructive feedback. There are also concerns about inherent conflicts of interest.
4. Lack of transparency and independent external scrutiny – in examinations; in feedback and other forms of assessment; in complaints handling and College processes; and with data.
5. Leadership – there is a uniform commitment to high standards, but widespread concern about inherited bad behaviours; poor role modelling from senior to junior members of the profession; lack of leadership; abuse of power; and bystander silence.
6. Conflicts of interest – commercial gain and protection of 'market share' is reported to drive bad behaviour; hospital reliance on surgical throughput stops employers acting on surgeons' bad behaviour despite their legal obligations to provide a safe workplace; conflicts of interest are believed to compromise the assessment of international medical graduates and trainees, and prevent fair complaints management.
7. Unhealthy work practices and training arrangements – are cited as barriers to gender equity; are reported to facilitate bad behaviour; preclude work-life balance for men and women; and are culturally embedded in the practice of surgery, including in hospitals. Excessive unpaid work hours are used as a form of bullying and is a problem across the health sector. Lack of diversity, gender inequity and strong hierarchies in the surgical profession are linked to increased prevalence of discrimination, bullying and sexual harassment.

Major General David Morrison of the Australian Army made it clear to all army personnel that 'everyone is responsible for culture'. He told his teams that if the changes required did not suit them, to leave. He made it clear that the 'standard you walk past is the standard you accept'.^a The same applies to the profession of

^a Message from the Chief of Army, Lieutenant General David Morrison, AO: <http://www.army.gov.au/Our-work/Speeches-and-transcripts/Message-from-the-Chief-of-Army>

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surgery. The College showed courage and commitment in establishing the EAG. It now has the opportunity to champion change.

4. Summary of research and consultation methods

In developing this report, the EAG relied on the results of five forms of research and consultation with Fellows, Trainees and International Medical Graduates of the College; others in the healthcare sector; and the wider community. All were conducted between April and July 2015. Reports of the outcomes of this research are published on the [College website](#). This Draft Report reflects the findings and feedback from the following five major pieces of work commissioned by the EAG in 2015:

1. Prevalence survey – quantitative and qualitative research conducted independently by Best Practice Australia
2. Qualitative research (personal accounts) – managed by independent agency Converge International
3. Organisational survey – implemented by independent agency ORC International
4. Submissions to the Issues Paper, based on a Background Briefing, which summarised published research on these issues
5. Online discussions – for College Fellows, Trainees and International Medical Graduates, facilitated by independent agency Pax Republic.

Participation rates

There was significant participation in all forms of research and consultation and the research results are statistically valid:

1. 47% of those invited participated in the prevalence research (3,516 of 7,405). Of these, 49.8%, were Fellows over 10 years post FRACS; 29.5% were Fellows less than 10 years post FRACS; 16.5% were Trainees; and 4.2% were International Medical Graduates. 45% also provided open comments.
2. 414 individuals provided their personal stories through online qualitative surveys, email submissions or personal interviews (by Skype or face to face)
3. 33% (117 of 352 hospitals invited) responded to the organisational survey
4. 91 individuals and organisations made submissions in response to the Issues Paper
5. 8% of Fellows, Trainees and International Medical Graduates participated in online discussions. Participation rates varied across discussion groups, with 7% of Fellows, 16% of female Fellows, 9% of trainees and 27% of International Medical Graduates taking part.

The EAG acknowledges that the views of those who have withdrawn from surgical training in recent years have not yet been heard. This is an important gap. The EAG notes that the College has committed to this research. The results will provide rich insights into the reasons for attrition from surgical education. The EAG expects the results will inform future College actions to address and prevent discrimination, bullying and sexual harassment that contributes to the loss of skilled and talented trainees.

Qualitative research – source of quotes

The qualitative feedback provided across all forms of consultation and research was thoughtful and considered. The processes gave a voice to individuals who have been subjected to discrimination, bullying or sexual harassment. Their accounts deepened the EAG's understanding of the issues and their impact. Comments were also provided by people who do not agree there is an issue. The EAG recognises the courage and commitment it took for individuals to share their stories.

Anonymised, direct quotes are used in this report to illustrate the key issues raised and some perspectives about them. More detail and context are available in the published research report from Converge

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International, Issues Paper submissions and the de-identified report of online discussions provided to the EAG by Pax Republic. A summary report of these discussions is published on the [College website](#).

5. Key issues and themes

There is consistency across the consultations and research projects about the key issues that lie at the heart of discrimination, bullying and sexual harassment in the practice of surgery. In each of the research projects and consultations, consistent issues were identified by those who believe there is a problem, and similarly, consistent comments were made by those who do not agree there is a problem. Issues in discrimination, bullying and sexual harassment are inter-related and overlapping, as are the causes and the possible actions to address and prevent them. There is rarely an isolated cause of or a single effect of these issues.

Culture and leadership

Issues of discrimination, bullying and sexual harassment are enmeshed with questions about the culture of surgical practice, as well as the culture of medicine and the healthcare sector more widely. There was general consensus that the worst offenders were a few people who held power and exercised it to retain it. Most participants noted that there were many in the profession who were good role models and also recognised the importance of the College's decision to establish and resource the EAG.

Comments about the culture of surgery and leadership included:

'... 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 ...'

'The personalities involved in surgery lend themselves to bullying to some degree. We are highly competitive, demanding and expect perfection from ourselves and others ... this has been our culture and will continue to be our culture because we teach the same way we have been taught. To change this, we need to change an entire ethos of thinking and attitudes.'

'Surgery is a stressful speciality. If you can't deal with the stress, and that includes bullying, you should choose a different profession.'

'... there has been overt and established bullying within the College and condoned by [a] wilful blindness to act.'

The College and Speciality Societies

- General concerns related to the **College's lack of leadership** in addressing issues of discrimination, bullying and sexual harassment; its reluctance to hold Fellows to account against College standards and policies; or to address instances of discrimination, bullying and sexual harassment in the workplace.
- There were many who suggested that the **College was a law unto itself**, that some surgeons considered themselves above the law, and that the College's focus on developing policies and procedures was not matched by its willingness to hold surgeons to account against them.
- There was some support for **targets for women in senior positions in the College**, including committees and Specialty Societies.

The perpetrators

- There was a strong sense that **'known bullies' are untouchable** (by the College/ societies and in the workplace) and that bullying has become normalised as a culturally accepted behaviour.
- **Poor performance management in the workplace** – with accountability not connected to behaviour – is an ongoing issue, with perpetrators promoted more often than held to account.

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- The **intergenerational nature of bullying** was noted and there were many observations about surgeons modelling their own behaviour and leadership styles on bad behaviours modelled by previous generations.
- Selection into surgery – both self-selection due to personality type or character and selection of trainees and IMGs by current Fellows – is seen as a mechanism to preserve the cultural status quo.
- Characteristics linked to discrimination, bullying and sexual harassment include that surgeons may have a strong sense of entitlement and may lack impulse control; many would benefit from more skills in managing stress and developing emotional intelligence.

Toxic culture

- Abuse of power and authority is a significant cultural issue.
- There was some feedback that bullying – and a toxic culture – more commonly **affected whole surgical or workplace teams or units**, and was less commonly limited to individual surgeons or ‘bad apples’.
- The **silence of bystanders** was consistently identified as a critical issue: this stems from fear of reprisal, fear of ‘making it worse’, concerns about their position or right to raise an issue given hierarchical structures and power differences; prominent people are perpetrators, bullies are seen as untouchable.
- Gender inequity and limited cultural diversity also featured as both cause and effect in relation to culture. Both were seen to enable the continuation of the dominant surgical culture and were a consequence of it.

Surgical education

Many issues were raised about the links between existing models and practices of surgical education and the incidence of discrimination, bullying and sexual harassment.

‘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’

‘Bullying is seen as an acceptable teaching method and it is far from accepted that bullying cannot be allowed’

‘You have one minute to act to save a person’s life ... wilting violets may not be able to handle the interpersonal stress and may not make the best decisions for the patient under pressure, so if a trainee can’t respond to fair criticism without labelling it, then what chance they can handle more desperate scenarios? We are not training accountants!’

Uniformly, research and consultation participants supported the maintenance of high standards. Most believed that innovation and changes to surgical education could address these issues without compromising standards.

There are a number of common and overlapping features in the concerns raised:

Supervisor capability

- Supervisors’ technical skills were not questioned, but lack of teaching skills and ignorance of contemporary adult education models was seen as a direct contributor to bad behaviour in general and bullying in particular. There are reports that many teachers teach the way they were taught, using humiliation and bullying.
- Supervisors were frequently reported to have poor interpersonal skills or leadership capability, which leads to both deliberate and unintentional bullying and ineffective teamwork. There was a general sense that badly behaved surgeons were unaware of – or dismissed – the link between effective teams and quality patient care.

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- Many senior surgeons, especially those ‘known’ to behave poorly, were seen to have poor interpersonal skills and/or leadership capability.
- Allegations of poor performance and bullying are often enmeshed. A core issue appears to be supervisors’ lack of skill or capacity to provide constructive feedback or undertake appropriate performance management. Both sides are affected. Supervisors who are responsible for giving feedback report being concerned that they are open to allegations of bullying; trainees report that supervisors are often ill-equipped to provide constructive, timely and detailed feedback appropriately, without bullying.
- Supervisors were frequently seen to not value the ‘soft’ clinical skills of team leadership and teaching methods designed to increase team and individual performance.

Surgical unit structure and team performance

- Surgical units and surgeons are caught in a cultural conflict, between concepts of a ‘strong leader’ and expectations of collaboration and teamwork, which they struggle to reconcile.
- Supervising surgeons and trainees are also caught in a cultural conflict between giving (and receiving) critical feedback, and the belief that not being critical is being ‘soft’ and therefore ‘unsafe’.
- There is little support for quotas to address gender inequity in the surgical profession. However, there is support for removing barriers to (e.g. by increasing flexible and part time training, addressing issues around hours of work, reviewing entrance requirements etc).

Role of the College and Specialty Societies in surgical education

- The current practice of removing trainees from difficult or untenable training positions can disadvantage trainees and frequently fails to address the underlying dysfunction or bullying in the unit.
- There were some perceptions of conflict of interest between the College’s role in setting standards and controlling entry to the profession. Workplace competition can have a negative impact on both individual surgeons and the reputation of the College.
- The lack of independent, external scrutiny in training and assessment by the College raised concerns.

Lack of transparency and independent external scrutiny

The College and Specialty Societies (which provide training in surgical specialties) need to increase the transparency and independent external scrutiny of their educational and other operations – including assessment, complaints management and accreditation. Current arrangements were widely linked to enabling at best, or promoting at worst, a culture in which discrimination, bullying and sexual harassment are normalised.

‘... 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.’

‘... lack of accountability as people become consultants. Suddenly there is no-one they have to answer to ...’

Issues raised include:

- Externally, the **role of Specialty Societies relative to the College is not well understood**. External stakeholder expectations of the College relate in many cases to the operations of Specialty Societies with which the College shares variable levels of co-operation, information and common purpose. Lack of clarity in relation to accountability, responsibility and control in these relationships and a lack of transparency are serious concerns voiced in the research that have wide-ranging ramifications.

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- **Need for increased transparency in complaints handling processes** – by the College, Specialty Societies and employers – is a significant issue. College processes are viewed as closed and designed to protect current Fellows and the status quo. The processes involve assessment by those who are close peers of those against whom complaints are levelled, or in some cases the person complained about would be the same person dealing with the complaint, if it were made.
- There is a sense that there are **no consequences for perpetrators**. No action is seen to be taken even against those about whom allegations have been proven.
- The College needs to **increase external input** so that it does not appear self-serving and unaware of its broader responsibilities. There is a strong sense that the same people hold senior roles in the College and in the Specialty Societies and that they are invested in maintaining the status quo. Assessing complaints about peers is therefore problematic at best, particularly in the smaller specialties.
- **Lack of timely, transparent, constructive feedback to trainees** is an issue – linked also to the capacity or skills of supervisors in this area. Trainees report receiving positive or no feedback from supervisors and then failing assessment without warning.
- **Need for increased transparency in the examination of international medical graduates**, where some candidates believe they are given limited feedback on performance post-examination and assessment of comparability. Without detailed, timely and transparent feedback, some candidates are left to doubt the motivation for or legitimacy of assessment. There is concern that commercial motivations at times compromise academic and technical assessment.
- Some trainees and IMGs argue there is a **need for more transparency in assessment criteria** and how these are applied by assessors.

Complaints handling

There was significant concern raised by participants in the consultations and research about the management of discrimination, bullying and sexual harassment complaints by the College, the Specialty Societies, employers and regulators.

Comments included:

‘... the culture is suck it up, don't report it or it could affect your career’

‘... the ultimate penalty for a harassed female who speaks out is being unable to find employment in Australia’

‘...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’

There are a number of common and overlapping features:

Fear of reprisal

- Fear about the impact on career or training of making a complaint effectively stops people from reporting complaints or speaking out. Hierarchy and power are central issues.
- People report not speaking out (about bullying or conditions or the behaviour of others) for fear of being seen as weak or unsuitable for surgery; concerns about marginalisation; and being denied workplace opportunities, including in theatre. They report making a complaint as ‘career suicide’ and fear being ‘black-balled’ in areas such as selection, references, job recommendations, appointment processes, and career path.

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- There is a lack of any mechanism to raise – and address – concerns or issues early, which means they either escalate into formal complaints or are not addressed at all.

Poor processes

- Lack of trust in the people handling complaints, with the person responsible for dealing with complaints often the same (or a close colleague of) the person who is being complained about. (See also conflict of interest)
- Scepticism about the integrity of the process and lack of confidence that any sanction will be imposed even if matters are proven.
- Confusion about complaints processes – with a lack of coordination or clarity about where to lodge a complaint or how to raise an issue (between the College, employers and, for students, universities), if one were brave enough to do so.
- The absence of centralised complaints management – given the lack of information-sharing and knowledge between the Specialty Societies and the College – is out of step with stakeholder expectations. Management of complaints within Specialty Societies – not shared with the College – prevents a whole of surgical profession understanding/awareness; raises concerns about conflicts of interest (especially within smaller specialties); decreases transparency; and is seen to prevent effective resolution. It also leads to inconsistencies in policies and investigative approaches; assessment approaches; outcomes/consequences; on-going monitoring and compliance.
- Legalistic approaches commonly in place for complaints management narrow the focus of investigations, fail to address the real issues and focus on the individual not the issue. This approach can polarise the parties, fail to deal with root causes and rely for resolution on individuals exposing themselves to significant risk of reprisal.
- Uneven skill and capacity in hospital HR processes and lack of confidence in ‘pro forma’ HR resolution processes that at times pit the bullied person against the bully in an unhelpful one-on-one mediation, or unrealistically require junior HR staff to deal with serious allegations about senior surgeons.

Lack of consequences

- The College’s reluctance to address bullying in the workplace, regarding this as an issue for employers, is seen as an abrogation of responsibility and failure of professional leadership and leaves trainees exposed to unsafe or unhealthy work environments.
- A lack of consequences for perpetrators, and the failure of employers and the College to act on ‘known’ bullies.
- Lack of insight about their behaviour is a key issue among some protagonists and makes solutions more difficult.
- Despite their legal obligations, hospitals are reported to be reluctant to take action on badly behaved surgeons for a range of reasons, including potential financial and operational consequences; potential negative impacts on hospital performance and reputation; and skill gaps in executive leadership.

Conflicts of interest

Concerns about conflicts of interest – and the links between this and discrimination, bullying and harassment – manifest in a range of areas.

Comments included:

‘if you stay in Australia, we’ll make it hard for you.’

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

Commercial gain was identified as an important motivator for a significant proportion of Fellows and was linked to both bullying and actual or potential compromised assessment of international medical graduates.

There were reports that concern to maintain **'market share' drives uncooperative professional behaviour** between surgeons.

More broadly, **hospital reliance on surgical throughput** – and funding and reputation – was reported to inhibit employers from acting on bad behaviour. Institutions fear publicity and/or litigation as well as loss of revenue.

In particular in small specialties, there are reports that it is difficult to separate out commercial imperatives from bullying, assessment of new entrants to the profession (both trainees and international medical graduates) and fair complaints management.

Unhealthy work practices and training arrangements

Some of the celebrated qualities of surgeons – the capacity to work punishing hours, make tough decisions and deal with difficult people and circumstances – are entrenched in the culture of surgery. There are also less healthy corollaries, and links to discrimination, bullying and sexual harassment.

Comments included:

'I was required to do 30-hour shifts in the last weeks of pregnancy'

'Why don't you just go and do the grocery shopping' ... or 'you can join us in theatre – not to do anything, just for eye candy'

'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'

Core issues include:

- An unhealthy expectation that current trainees should endure the same training circumstances – in terms of hours, demands and personal sacrifice – as those in place when supervisors were themselves trained.
- There were reports that supervisors demanding unpaid overtime is used to 'toughen up' trainees and is itself a form of bullying that also facilitates or triggers bad behaviour.
- Arduous work hours (36-hour shifts are not uncommon) are widely regarded as barriers to women's participation in surgery and preclude work-life balance for men and women.
- Surgical training arrangements are inherently family-unfriendly and seen to provide disincentives for women and men seeking a form of work-life balance to join the surgical profession. The same arrangements favour individuals without family commitments or with partners with less demanding careers, and thereby perpetuate the cultural status quo.
- Other colleges – such as Obstetricians and Gynaecologists – have more flexible training arrangements in place that the College can learn from.

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6. Recommendations at a glance

The College must act – alone and in partnership – as it leads the way in addressing and preventing discrimination, bullying and sexual harassment. The causes and effects of discrimination, bullying and sexual harassment are overlapping and interconnected. Gender inequity is a central issue that must be addressed. In this complexity, the EAG has identified three core areas for action: Culture and leadership, surgical education and complaints management.

Increased transparency, independent scrutiny and external accountability must be fully integrated into all aspects of change. This is essential for the College to earn back confidence and trust, inspire professionalism and drive cultural change, and prevent conflicts of interest. Above all, it is needed to make the surgical workplace safe.

1. Cultural change and leadership

With the active support of all Fellows, the College and Speciality Societies can lead the way to a future in which there is no place for discrimination, bullying and sexual harassment in the practice of surgery. This will take courage, resources and a commitment to change. It will take enforcing the law and imposing sanctions as needed. It will take the College showing how to prevent and address discrimination, bullying and sexual harassment and how to hold people to account for their behaviour, working with the medical profession, employers and the healthcare sector more widely. Effective partnerships will be essential. It will take witnesses ending their silence and speaking out. To achieve the necessary fundamental cultural change, the College must also shine the light of independent scrutiny and greater transparency on its own assumptions and approaches. Critical self-reflection, fearless questioning of old habits and inherited practices, and a looser grip on tradition will be needed to shift the status quo. The risk to patient safety from discrimination, bullying and sexual harassment must be top of mind.

2. Surgical education

Surgical education needs to improve. Bullying, intimidation and harassment are not acceptable approaches to educating adults. Profound changes to surgical education are therefore needed to address and prevent discrimination, bullying and sexual harassment in the practice of surgery. All students learn best when they feel safe and supported. Surgical education at all levels needs to be reconfigured on the principles of respect, transparency and broad professional excellence. In surgical education, the College and Speciality Societies must foster, ensure and celebrate excellence in teaching and a broad understanding of professionalism, as well as technical skill. Independent oversight, individual and collective accountability for professional behaviour and external scrutiny at all levels are needed.

3. Complaints management

There needs to be a fundamental change in the management of complaints about discrimination, bullying and sexual harassment in the practice of surgery. Independent scrutiny in complaints processes at all levels is non-negotiable, if trust and confidence is to replace fear of retribution and silence. There must be processes that are transparent, robust and fair. They must enable people to raise concerns without fear of victimisation and deal with both the causes and the effects of discrimination, bullying and sexual harassment. Lodgement of complaints must be centralised across the College and independent oversight maintained.

Consistent policies and agreed standards of behaviour are needed across the practice of surgery. Knowledge must be shared by those responsible for dealing with the issues, with information exchanged between the College, Speciality Societies and employers. The College must hold individuals to account against its own standards, leading the way and supporting employers to follow suit.

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7. Recommendations to the College

There is no place for discrimination, bullying and sexual harassment in the practice of surgery.

	Area for action	EAG recommendations to the College
1.	Cultural change and leadership	<p>Take a stand:</p> <ul style="list-style-type: none"> • Take the lead role with Fellows, Speciality Societies and Training Boards to ensure an effective, consistent and centrally coordinated approach to addressing discrimination, bullying and sexual harassment and provide a safe environment for 'speaking out' • Demonstrate a new approach to dealing with discrimination, bullying and sexual harassment and publish a statement that includes a strong commitment to change and a clear purpose, against which the College can be held to account • Commit to and publish an action plan that responds to these recommendations to address and prevent discrimination, bullying and sexual harassment, and report annually on progress to the public, health ministers and College Fellows • Work with hospitals (public and private sector), to ensure they will not tolerate surgeons who subject others to discrimination, bullying and sexual harassment and will support bystanders who speak out about it • Work with employers, Medical Colleges and governments (state and commonwealth) to foster partnerships and develop joint approaches to ensure these issues are addressed and standards are upheld • Ensure the College is able and willing to remove Fellowship from surgeons who do not meet the required standards in relation to discrimination, bullying and sexual harassment • College Council to ensure that a senior office bearer is explicitly responsible for overseeing the change management program required to address discrimination, bullying and sexual harassment and is appropriately resourced and supported by senior staff. These responsibilities should be attached to a role not an individual and continue until this cultural change has been achieved. <p>Set standards:</p> <ul style="list-style-type: none"> • Set, promote, uphold and publish clear and consistent standards in relation to discrimination, bullying and sexual harassment, including a review of existing policies • Review all policies and work with employers to actively promote and enforce standards/ expectations of professional behaviour in surgical practice, including through agreements with hospitals. <p>Increase external input and scrutiny:</p> <ul style="list-style-type: none"> • Integrate independent, external (i.e. non-RACS) oversight across College activities and in committees, Training Boards and Speciality Societies and: <ul style="list-style-type: none"> ○ Appoint an ombudsman to provide independent, external scrutiny and accountability, and an alternative pathway to address issues of concern ○ Commit to a further review in five years by an external, independent committee (e.g. EAG) and report publicly • Increase transparency by continuing and increasing public reporting – of data, of progress against commitments, about complaints, etc. • Review contractual agreements between the College and Speciality Societies to align responsibility and authority for addressing these issues, embed information sharing and support best practice complaints management.

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		<p>Foster diversity:</p> <ul style="list-style-type: none"> • Ensure diversity of representation on College committees, the Speciality Societies and Training Boards, by including women surgeons, independent non-medical members, educational experts, surgical trainees and jurisdictional representatives • Identify and address barriers to gender equity and diversity in surgery and support change by: <ul style="list-style-type: none"> ○ Reviewing the features that will increase the appeal of surgery to more diverse groups including women (e.g. by providing workplace and training flexibility) ○ Setting targets, monitoring and reporting on numbers of women attracted to surgery and their successful completion of or attrition from surgical training ○ Developing a strategy to encourage women to take on leadership roles in surgery – on Training Boards, Speciality Societies and throughout College hierarchy ○ Identifying champions to celebrate and support cultural change ○ Using social media and other mechanisms to support and encourage mentoring across specialties
2.	Surgical education	<p>Educate about discrimination, bullying and sexual harassment:</p> <ul style="list-style-type: none"> • Develop and implement an education program on discrimination, bullying and sexual harassment that is mandatory for all Fellows through Continuing Professional Development (CPD) and for all trainees and international medical graduates • Provide additional mandatory training about discrimination, bullying and sexual harassment for all College office bearers including those in the Speciality Societies, Training Boards, and supervisors <p>Educate the educators:</p> <ul style="list-style-type: none"> • Mandatory training for educators in surgical practice in: <ul style="list-style-type: none"> ○ Adult education principles ○ Effective assessment and constructive feedback ○ Explicit content on discrimination, bullying and sexual harassment ○ Teamwork, leadership and other non-technical skills. • Equip all surgical educators and supervisors to teach and provide constructive, clear and timely feedback • Provide training in resilience and stress management as a component of surgical training. <p>Trainers and training posts:</p> <ul style="list-style-type: none"> • Accreditation of training posts: establish generic and consistent mandatory requirements for the accreditation of training posts for surgical education, considering implications for resourcing and timeframes for implementation of no more than three years • Establish central and consistent selection, appointment and review processes for surgical supervisors, heads of department and Training Board surgical members • Introduce mandatory multi-sourced feedback for: <ul style="list-style-type: none"> ○ Trainees ○ Supervisors ○ Surgical department heads ○ Surgical units.

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		<p>Increase external input and scrutiny:</p> <ul style="list-style-type: none"> • Include external, independent participation in training and assessment of non-technical skills • Establish a process for the independent review of training rotations that can be triggered by a trainee, supervisor, or international medical graduate • Undertake an annual survey of training positions and publish the results to improve transparency of decision-making and make visible the underlying culture of the unit, working with RACSTA to address concerns about identification of trainees • Review processes for selection into surgical training to support diversity and ensure independent, external non-College and non-medical membership of selection and recruitment panels • Appoint independent educational experts to all Training Boards • Introduce explicit requirements for the membership of Training Boards – women surgeons, independent (non-medical) person, educational experts, surgical trainees and jurisdictional representatives • Ensure neutral and independent oversight of IMG assessment • Consider use of video/recorded assessments in the workplace and examinations • Support hospitals to ensure transparent hospital appointment processes. <p>Foster diversity:</p> <ul style="list-style-type: none"> • Foster diversity by aiming to become the industry leader in providing flexible training opportunities (considering working hours and arrangements, family-friendly practices, learning from the approach of the College of Obstetricians and Gynaecologists) • Boost support and resources to Royal Australasian College of Surgeons Trainees Association (RACSTA) • Improve gender equity in surgery through providing flexible training options, promoting diversity and having targets of numbers of women on Training Boards and in College leadership roles.
3.	Complaints	<ul style="list-style-type: none"> • Introduce best practice complaints management built on the following principles: <ul style="list-style-type: none"> ○ Visibility and accessibility of complaint mechanisms – processes should be well publicised and information made available about avenues for making complaints and options for resolution ○ Responsiveness with a focus on early intervention. This requires immediate acknowledgement of complaints and prompt responsiveness in addressing them, relative to their seriousness and impact ○ Restorative approaches to resolution of disputes, focusing on the impact of behaviours in the workplace and on others (such as colleagues and patients), and aimed at improving insight of participants and behaviour change ○ Processes should include elements of independence and objectivity to build confidence and integrity and ensure complaints are addressed in an equitable, objective and unbiased manner ○ Confidentiality of the process is essential and should be guaranteed. Confidentiality of complainants should be respected where possible, with investigations focused on the nature of the allegations with specific identifiable information only provided when needed. Confidentiality should not be treated as secrecy and complaint outcomes should be appropriately communicated to participants in the process ○ Established framework of accountability for taking, and reporting on, the actions and outcomes arising from complaints to participants in the

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		<p>process</p> <ul style="list-style-type: none">○ Monitoring of complaint issues/trends, resolution rates and user satisfaction should be a feature and used to inform continuous improvement and assess the quality and effectiveness of complaint mechanisms and further interventions.○ Centralised, anonymous, accessible and detailed information about making complaints: e.g. clarity of enquiry, registering, lodgement, progressing and ongoing reporting of all complaints, applying to all types of complaints: formal and informal, options, requirements○ Whistleblower protection <ul style="list-style-type: none">● Build trust and confidence in complaints-handling process by introducing centralised lodgement, assessment, co-ordination and ongoing oversight of complaints across all specialities of the College, including complaints about surgical practice, education and behaviour● Accredited training posts in hospitals required to have mechanisms in place and share all information with the College about surgical-practice related complaints at that post, through explicit agreements between workplaces and the College● Appoint independent and external surgical ombudsman role to:<ul style="list-style-type: none">○ provide complaints oversight and a pathway for review of College actions to address and prevent discrimination, bullying and sexual harassment and○ make sure concerns can be raised and issues addressed fairly, without fear of reprisal or retribution.● Ensure public reporting of complaints, trends, and data including annual report on progress against actions taken to address discrimination, bullying and sexual harassment● Work proactively with hospitals to:<ul style="list-style-type: none">○ develop a commonly understood approach to sanctions, including mechanisms for identifying, preventing and eliminating illegal and inappropriate behaviour and reporting surgeons as needed○ commit to cultural and organisational changes that will help to end bystander and collective silence about discrimination, bullying and sexual misconduct○ support cultural change including by improving transparency about the underlying culture of a unit, unprofessional behaviour and actions taken to address breaches○ address the consequences of inappropriate behaviour, introducing both restorative and punitive mechanisms that protect those who seek to implement positive change the workplace (locally in teams and by hospital management).
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8. Conclusion

The EAG is grateful to all the individuals and organisations that took the time and made the effort to participate in the research and contribute to the consultations. We strived to create a transparent and clear process so that people would come forward and share their stories, so we could learn.

Very significant participation rates in the quantitative, prevalence survey have established beyond doubt the scope of these problems. The courage of individuals who shared their personal stories has given depth to the EAG's understanding.

Now that the extent and impact of these issues is clear, there can be no turning back.

The College must be bold. It has a duty of care to Fellows, Trainees and International Medical Graduates – and a wider ethical and professional responsibility to the healthcare sector and ultimately to patients – to act now to address and prevent these problems. Leadership from the College, the Speciality Societies and College Fellows is essential and has the potential to create lasting, positive change on an issue that is widespread in surgery and across the healthcare sector.

Hospitals, employers, governments and other partners in the health sector must also meet their responsibilities and make a sustained commitment to action.

The EAG congratulates the College for establishing the EAG and providing it with the resources to do its work. We recognise that the research findings are challenging; that culture change is difficult and takes time; and that acting on our recommendations will require significant, sustained commitment.

In the brief time available before the EAG concludes its work, we are open to comment on this Draft Report. We invite advice about errors of fact or suggestions for action that will strengthen our recommendations by email to eag@surgeons.org by 18 September 2015.

The EAG will provide a final report to the College by the end of September 2015, when our work will be done.

We sincerely hope that the work of the EAG has created a tipping point for action that will increase patient safety by making discrimination, bullying and sexual harassment in the practice of surgery a thing of the past.

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9. Appendix One

Definitions

Across this research and consultation process, the following definitions apply:

Discrimination

Discrimination means treating a person with an identified attribute or personal characteristics less favourably than a person who does not have the attribute or personal characteristic. Legislation in Australia at both federal and state level and in New Zealand outline a list of characteristics protected by law against which discrimination is unlawful. (For example: gender, age, religious belief, political belief, pregnancy, breastfeeding, disability, impairment, marital status, family responsibilities, sexual orientation, race and cultural background).

Bullying

Bullying is unreasonable behaviour that creates a risk to health and safety. It is behaviour that is repeated over time or occurs as part of a pattern of behaviour. 'Unreasonable behaviour' is behaviour that a reasonable person, having regard to all the circumstances, would expect to victimise, humiliate, undermine or threaten the person to whom the behaviour is directed.

Sexual harassment

Sexual harassment is defined as unwelcome sexual advances, request for sexual favours and other unwelcome conduct of a sexual nature, by which a reasonable person would be offended, humiliated or intimidated. Sexual harassment may include, but is not limited to: leering; displays of sexually suggestive pictures, videos, audio tapes, emails & blogs, etc., books or objects; sexual innuendo; sexually explicit or offensive jokes; graphic verbal commentaries about an individual's body; sexually degrading words used to describe an individual; pressure for sexual activity; persistent requests for dates; intrusive remarks, questions or insinuations about a person's sexual or private life; unwelcome sexual flirtations, advances or propositions; and unwelcome touching of an individual, molestation or physical violence such as rape.

Harassment

Harassment is unwanted, unwelcome or uninvited behaviour that makes a person feel humiliated, intimidated or offended. Harassment can include racial hatred and vilification; be related to disability; or the victimisation of a person who has made a complaint.