ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Response to the Australian Human Rights Commission National Inquiry into Sexual Harassment in Australian Workplaces

January 2019

About the Royal Australasian College of Surgeons

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

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

As part of our commitment to standards and professionalism, RACS takes very seriously the subject of this inquiry and acknowledges that discrimination, bullying and sexual harassment (DBSH) occur in the surgical workplace. Over the past three years in particular, the College has dedicated considerable resources to ensuring a comprehensive response to this issue.

Background

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

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

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

- An **independent prevalence survey** of all RACS Fellows, Trainees and IMGs. The survey was conducted by Best Practice Australia.
- A series of **online forums where** RACS Fellows, Trainees and IMGs were invited to participate in four independently facilitated and confidential sessions and discuss ideas about how to prevent and address DBSH in the profession.
- Another independent provider was contracted to collect **personal stories** from people who had experienced DBSH but did not wish to make a formal complaint.
- The EAG sent an **organisational survey** to more than 300 hospitals and employers to learn about their approaches to preventing and addressing DBSH.

Key findings

The research found that:

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

In relation to sexual harassment, the EAG noted there was 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. Of those respondents in the prevalence survey who reported discrimination, racial discrimination was the most common form of discrimination experienced (33%), followed by sexual discrimination (16%).

Despite these unacceptable behaviours being prohibited by workplace laws, and in some cases a criminal offence, we know that DBSH occurs in many workplace environments. In regards to the health system, and in particular surgery - Trainees, IMGs and female staff were identified as the most likely targets.

The EAG provided its final report to RACS in September 2015.The report comprised 42 recommendations, which the College accepted in full. The then RACS President, Professor David Watters, made an unreserved public apology to anybody who had suffered from DBSH in the practice of surgery. The report can be accessed on the RACS website.

RACS response: development and implementation of the DBSH Action Plan

The findings of the EAG resulted in the development of the DBSH Action Plan. This plan is a comprehensive, multi-year program of work designed to promote respect, counter DBSH in the practice of surgery and improve patient safety. The Action Plan translated the recommendations of the EAG into work that has been prioritised and phased.

The Action Plan addresses each of the 42 recommendations, with eight goals, organised around the following three pillars:

- Cultural change and leadership
- Surgical education
- Complaints management

The Action Plan comprises a range of complementary strategies, ranging from; awareness raising, education, skills development, policy, advocacy and partnerships. It also focusses on transparent and timely complaints management, strengthened sanctions, and peer support for complainants and respondents to the complaints management process. Complimentary psychological support can also be accessed by RACS members and their families.

Further actions include a dedicated focus on actions to increase diversity and inclusion, recognising that "RACS' capacity to enhance the contribution of surgeons to the broader community is influenced by its own representativeness of the

community".

Almost 30 initiatives are underway, the majority of these will continue over several years. However, it is recognised that cultural change of the magnitude envisaged will require a sustained focus.

Summary of select achievements to date

RACS reports publicly on an annual basis regarding progress in addressing the 42 recommendations. Below is a summary of some of the progress made to date. Further detail and the full annual progress reports can be accessed on the RACS website.

1 Cultural Change and Leadership

- Development and implementation of the RACS Diversity and Inclusion plan, with a key focus on gender equity, including establishment of targets for female participation in surgical training and on RACS Boards and Committees. This plan has led to improved data collection and reporting of gender, cultural and ethnic diversity, the implementation of Aboriginal and Torres Strait Island and Maori Health Action Plans, and RACS membership of 'Male Champions of Change' including adoption of the Panel Pledge.

Slow but steady improvements in female participation rates are as shown:

Update to RACS female participation, 2018

	Applications to Surgical Training	Accepted into Surgical Training	Total of Trainees	New Fellows	Total Active Fellows	Women on Council and Main Committees (combined)
2016	30%	25%	29%	22%	12%	21%
2017	33%	31%	29%	22%	12%	23%
2018	33%	35%	29%	24%	12.6%	27%

Women on RACS Council

2016 - 2017	**29%**
2017 - 2018	**32%**
2018 – May 2019	**36%**

- Establishment of more than thirty partnership agreements across the health sector (including university medical schools, hospitals, health jurisdictions, medical colleges) recognising DBSH as a priority issue and a willingness to collaborate to achieve mutual goals

- Sustained execution of the Let's Operate with Respect communications campaign, including; digital, web, posters, print – awareness raising and agenda setting, widely shared via social media

2 Education and training

- Development and delivery of the ‘Operating with Respect e-module’ as a mandatory component of continuing professional development for all Fellows, IMGs and Trainees. Completion rate amongst is at over 98% as of January 2019; this e-module is now a pre-requisite for all those applying to surgical training

- Delivery of’ ‘Foundation Skills for Surgical Educators’ course–mandated for all those with a role in surgical training

- Development and training of course faculty for delivery of ‘Operating with Respect’ Face to Face course, providing advanced skills training for all surgical supervisors and members of major committees in addressing DBSH in the surgical workplace

- Development and piloting of the ‘Surgeons in Everyday Practice’ Leadership Program, tailored to the specific leadership role of the surgeon

- Development and implementation of complementary programs including the ‘Advanced Feedback’ module, and ‘Human Factors’ module – with an emphasis on professional surgical (non-technical) skills.

3 Complaints management

- The establishment of a dedicated complaints office and staff, improved complaints handling processes with an emphasis on procedural fairness, timeliness and transparency

- The appointment of an independent external reviewer of DBSH who provides ongoing feedback on our complaints handling processes

Additional highlights of relevance to this inquiry include the following:

- Commencement of research to understand the barriers to women selecting surgery as a medical specialty

- Completion of research to understand reasons for women leaving surgical training and the practice of surgery

- Active ongoing promotion of women as surgical role models via all surgical communications channels

- Advocacy to highlight and address structural barriers and issues such as the non-transferability of leave entitlements when training in different jurisdictions

- Overt policy support for the provision of flexible models of surgical training (including part time)

- Inclusion of a DBSH focus in support of the RACS Trainees Association such that the voice of trainees can be heard in the ongoing monitoring, and efforts to support cultural change.

Challenges

1 Continued underreporting of DBSH

Analysis of RACS' complaints management data suggests that underreporting of unacceptable behaviours continues.

Barriers to the reporting of DBSH, whether real or perceived, were found in 2015 by the EAG to include

- 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
- 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
- fear of being seen as weak or unsuitable for surgery and concerns about marginalisation
- fear among Trainees and junior medical doctors that complaining can impact on career or training of making a complaint, such as 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.
- despite legal obligations, a reluctance on the part of hospitals 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.

RACS is working to ameliorate these findings through the actions previously described, given its duty of care in relation to provision of safe training environments, and a broader desire to address the culture of surgical practice, and so to impact positively on patient safety.

However, training is conducted in workplaces in relation to which RACS is not the employer. It should be recognised that that the primary responsibility for workplace safety is with the employer.

2 Privacy concerns as a barrier to collaboration

In addition to supporting surgeons in leading cultural change, RACS is reaching out to partners across the health sector, including university medical schools, health service providers, governments, and other medical colleges to gain their commitment to working together, and collaborating towards achieving a common goal.

As a result, RACS seeks to work in partnership with health jurisdictions and hospitals to ensure a consistent policy position and increasingly, to share complaints information in a timely manner. Privacy considerations arise out of the sharing of information necessary to take action. RACS has found this to be a major barrier to co-ordination of the appropriate response.

3 Failure to take action

Despite these unacceptable behaviours being prohibited by workplace laws and in some cases a criminal offence, it is well known that DBSH occurs in many workplace environments across the health sector.

When employers foster a culture of abuse through inaction, tacit approval in turning a blind eye, discouraging change or covert sanctions against complainers, efforts to achieve cultural change are thwarted. This has significant consequences for those directly or indirectly

involved and importantly, evidence now documents the impact of unprofessional conduct on patient safety. Much work still needs to be done to bridge the disconnect between organisational values and organisational responses in individual cases of unacceptable behaviour.

Next steps

As we mark the three-year anniversary of the release of the Action Plan, RACS has finalised the development of an evidence-based Evaluation Framework, designed to provide a means of assessing the reach and impact of the Building Respect Initiative over the medium and long term (at the three, five and ten year mark). Using the project's planned outcomes as a base, key evaluation questions and relevant indicators and data sources have been identified, taking into account commitments already made to repeat particular pieces of research conducted at the outset of this initiative, and data already being collected during day to day activity implementation. The data collected plus triangulated findings will inform program improvement and evolution, in addition to providing a measure of the extent to which the program goals have been achieved, at the different points in time when effectiveness measures are undertaken.

RACS is poised to commence phase one of our evaluation, which given the long-term nature of this initiative, focuses on governance, implementation and indicators of early success.

Conclusion

It is clear that the issues of discrimination, bullying and sexual harassment extend well beyond surgery, the health sector and affect society at large. It is apparent from evidence amassed in achieving long term change of this ilk, that achievement of the goals that RACS has identified can take as much as a generation of effort. It is also clear that no single action delivered in isolation will deliver the change we seek, and therefore RACS cannot achieve change of this magnitude by working alone.

Most pleasingly, it is apparent that our efforts are in-step with public opinion and supported by the work of groups such as the Australian Human Rights Commission.

RACS applauds the Commission in conducting this inquiry and awaits its findings with great interest.

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