Level Medicine Submission to the 2019 National Inquiry into sexual harassment in Australian workplaces

Background to submission

Level Medicine Inc. (Level) is an organisation advocating for gender equity in the medical profession. Founded by a group of Sydney University medical students in 2015, Level is focused on policy development, professional culture change and building advocacy skills in medical students and junior doctors throughout Australia. Our research explores the nature of gender-based discrepancies in the Australian medical workforce, and the forces that perpetuate these.

For the purposes of this submission, we consider the medical workforce to be comprised of medical doctors and medical students - whose training takes place within public hospital environments.

Level also acknowledges that sexual harassment is experienced differently by individuals who are marginalised in a range of ways - including by existing outside the gender binary.

Prevalence of Sexual Harassment as experienced by medical professionals

As in many domains, it is difficult to quantify the prevalence of sexual harassment as experienced by medical professionals (including medical students). In 2016, the Australian Medical Association Western Australia asked its members about their experiences of sexual harassment. Of 950 respondents, 31 per cent had experienced sexual harassment in the workplace, including whilst applying for a job or training program[1]. Eighty-one percent of those reporting sexual harassment in the workplace were women[2]. Data about the prevalence of bullying, discrimination and sexual harassment among trainees and fellows of the college of intensive care medicine of Australia and New Zealand similarly demonstrates that female-identifying people are almost three times more likely to report being subject to sexual harassment[3]

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[1] Australia Medical Association WA (2016), 'Shattering the silence', *Medicus*, 18 April 2016, p. 22, http://www.amawa.com.au/wp-content/uploads/2016/04/Cover-18-April-2016.pdf

[2] ibid

[3] Venkatesh, B; Corke, C; Raper, R et al, (2016) Prevalence of bullying, discrimination and sexual harassment among trainees and fellows of the college of intensive care medicine of Australia and New Zealand. Critical Care and Resuscitation, Vol. 18, No. 4, 230-234.

. Among respondents to a 2016-2017 survey of junior medical doctors in New South Wales, 22.7% of females reported experiencing sexual harassment, in comparison to 4.7% of males[4].

Australian data suggests that the most prevalent perpetrators of sexual harassment against members of the medical profession are other members of the health profession - followed by patients.

Nature of Sexual Harassment as experienced by medical professionals

Medical professionals experience sexual harassment in multiple forms. These include but are not limited to:

- Unwanted physical contact;
- Suggestive comments or jokes;
- Insults or taunts based on sex;
- Intrusive questioning relating to an individual's personal life, domestic circumstances or body;
- Requests for dates and personal contact information
- Requests or pressure for sexual favours, including in exchange for academic preferencing or career support;
- Molestation, indecent exposure, indecent assault, sexual assault or rape.

Perhaps the best characterised and widely publicised example of sexual harassment in the Australian Medical Workforce is that of Victorian surgical trainee Dr Caroline Tan[5]. Dr Tan was assaulted by a male clinical supervisor, who kissed her, groped her and propositioned her for sex. After reporting the perpetrator, Dr Tan was victim to a suite of efforts made to undermine her credibility. Despite her strong academic and professional reputation, Dr Tan was ultimately pushed to leave Melbourne and pursue her career in New Zealand. Dr Tan's case has been considered a descriptive example of both the competitive and hierarchical elements of the medical profession perpetuate a tolerance of inappropriate behaviour, and also the possible consequences of speaking out in such environments.

The most common experience of sexual harassment described by women in Science, Technology, Engineering and Medicine is "*gender harassment"*, which encompasses a suite of behaviours communicating that women do not belong or do not merit respect[6]. Unwanted sexual attention and

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[4] Llewellyn, A., Karageorge, A., Nash, L., Li, W., & Neuen, D. (2018). Bullying and sexual harassment of junior doctors in New South Wales, Australia: rate and reporting outcomes. *Australian health review*.
[5] The Age, (2015). Surgeon Caroline Tan breaks silence over sexual harrassment in hospitals https://www.theage.com.au/national/victoria/surgeon-caroline-tan-breaks-silence-over-sexual-harassment-in-hospitals-20150311-141hfi.html
[6] National Academies of Sciences, Engineering, and Medicine. (2018). *Sexual Harassment of Women: Climate, Culture, and Consequences in Academic Sciences, Engineering, and Medicine*. Washington, DC: The National Academies Press. doi: 10.17226/24994.

coercion at work are thought to be inextricable from cultural norms which allow ongoing questioning of the role of women in certain professional capacities.

Examples of sexual harassment are frequent in conversations with Australian medical professionals. As part of preparation for this submission Level sought permission to share with the committee examples of sexual harassment as experienced by its supporters. The following anecdotes are illustrative of the nature of sexual harassment as experienced in the Australian medical workplace.

- One junior doctor reported of her time as a student: *" In theatre with a surgeon in a small country town I was questioned about my 'love life' by the male surgeon who was supposed to be my academic mentor for the day, and told to expect that I would go through my 'slut phase' before falling into a long term relationship. The theatre list was prolonged by the complexity of some of the cases. When asked if I wanted to stay for the remainder of the cases I replied 'I'm easy, I can stay to help'. The surgeon turned my words around to say 'Oh you're easy? Perhaps we should go for a drink after we leave then!'. The next day another doctor in an educational role at that health service asked me how my day with the aforementioned surgeon had been - pre-empting that I might have found my interactions uncomfortable based on previous reports of students and junior medical staff. In discussion about how to respond to the surgeon's inappropriate behaviour I was cautioned to think carefully about the repercussions of publicly criticising him lest that particular surgeon have any say in my career progression"*
- A final year medical student reflected of her time on a particular medical team - she would be asked by her male consultant why she hadn't baked for the team that week - and felt chastised for not contributing to the wellbeing of the team by not bringing baked goods to work. No other junior medical staff on that team (all male) nor the male medical student who preceded her on that team had ever been asked to bake.
- A report of time as a student in a surgical theatre detailed a surgeon shaving the hair of a patient before a procedure (which is standard practice in some operations to enable sterile access to particular areas of the body). The surgeon picked up the handful of pubic hair and walked past two male medical students towards the one female student, positing the pubic hair in her hands and stating "*there you go, a present*".
- A female GP who felt forced to leave her clinic described her experience. "*I was asked to consider being a partner [of the GP practice], and started discussions with the youngest (male) partner. I started noticing that ... business meetings became more of a pretense to discuss his emotional feelings towards me. He started asking me for lunch on a daily basis, and sending me multiple messages a day, mostly beginning with the pretext of business, but then becomes messages that made me (and my husband) uncomfortable with. I [gave] him 2 warnings, which he apologized for, but then he kept up the same behaviour after his apologies. He [set] up another lunch meeting with me to 'discuss the contract', and during that meeting questioned me about my marriage and relationship with me husband. I ended the meeting and stopped working at the clinic... I initially brushed off his behaviour because I was really interested in finally getting the opportunity for business ownership. However, now that the clinic is unable to provide me with*

a safe working environment, I am forced to leave the workplace while this male partner is still working there under the protection of the business (because he is part of the business).“

The above examples of both verbal and non-verbal behaviours, which convey objectification or reinforce beliefs about the second-class status of members of one gender, are emblematic of widespread practices in the medical workforce. Experiences of direct physical and sexual assault also occur in medicine. In 2015 the Royal Austalisian College of Surgeons asked members to describe their experiences of bullying, sexual harassment and discrimination in the workplace. Among respondents reporting sexual harassment, 9% described aggression or physical abuse, and 12% described inappropriate physical contact[7].

Consequences of Sexual Harassment as experienced by medical professionals

Sexual harassment negatively affects the psychological and physical health of those who experience it, and can impede professional achievements and continuation. Importantly, these consequences are not confined to the direct target of the harassment in question - but have significant implications for witnesses of sexual harassment. Observations of workplaces have suggested that the ambient level of sexual harassment in a workgroup - defined by the frequency of direct or indirect exposure to sexually harassing behaviour - has diffuse consequences for both women and men within an organisation [8].

The physical and psychological implications of sexual harassment are well documented in academic literature. The most frequently reported psychological outcomes for people who experience sexual harassment are symptoms of depression, stress and anxiety[9]. Women exposed to gender harassment have been shown to have cardiac and vascular activity that is a manifestation of physical stress that places them at risk of long-term health problems[10].

Professional implications of experiencing sexual harassment include declines in job satisfaction, organisational withdrawal (including absenteeism, tardiness and use of sick leave), frequency of thoughts about resigning, job stress, productivity and performance decline. The impact of sexual harassment on educational outcomes cannot be underestimated - impacting self esteem, academic engagement and motivation[11]. American data regarding the implications of sexual harassment of medical students demonstrated that, experience of gender based discrimination or sexual harassment was a factor in

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[7] Expert Advisory Group advising the Royal Australasian College of Surgeons Discrimination (2015). Bullying and Sexual Harassment Prevalence Survey. https://www.surgeons.org/media/22045682/PrevalenceSurvey_Summary-of-Facts_FINAL.pdf

[8] NASEM (2018).

[9] *Ibid.*

[10] Schneider, KT., Tomaka, J., and Palacios, R. (2001). Women’s cognitive, affective, and physiological reactions to a male coworker’s sexist behavior. *Journal of Applied Social Psychology*, 31(10), 1995–2018. https://doi.org/10.1111/j.1559-1816.2001.tb00161.x.

[11] NASEM (2018).

choice of medical specialty or ongoing training location for 34.9% of medical students[12]. Female identifying students were twice as likely to attribute some part of their career choice to experiences of gender discrimination and sexual harassment[13].

The negative effects of sexual harassment are compounded for those who experience intersectionalities of belonging to multiple minorities - be they gender- or sexuality-based, or related to ethnicity, culture or education level[14].

Behaviours such as sexual harassment of medical practitioners pose a threat to patient safety and well-being[15]. The negative implications of sexual harassment on the wellbeing of medical staff might lead to an increase in the rate of accidents and medical errors in the workplace. The concentration of experiences of sexual harassment among junior doctors is of particular concern in light of the structure of health care systems in which junior-most medical staff are often at the front line of treating and managing patients[16].

Drivers of Sexual Harassment as experienced by medical professionals

Sexual harassment as experienced by medical professionals is thought to persist in a climate of gender inequity, where inappropriate conduct has long been normalised, and where entrenched hierarchies protect offenders from complaint or consequence.

Gender Inequity

As outlined in the Level Medicine 2017 Submission to the Parliamentary Enquiry on Gender segregation in the workplace and its impact on women's economic equality, 2017, the factors that contribute to persistent gender inequity in the medical workplace are multifactorial;

- Female doctors are disproportionately concentrated in lower-earning and less prestigious specialities.
- Within the same specialties — such as general practice — women earn less than their male counterparts.

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[12] Stratton TD, McLaughlin MA, Witte FM, Fosson SE, Nora LM. (2005) Does students' exposure to gender discrimination and sexual harassment in medical school affect specialty choice and residency program selection? *Academic Medicine.* 80(4):400-408.
[13] *Ibid.*
[14] NASEM (2018).
[15] Westbrook, J., Sunderland, N., Atkinson, V., & Jones, C. (2018). Endemic unprofessional behaviour in health care: The mandate for a change in approach *Medical Journal of Australia* doi:10.5694/mja17.01261
[16] Samsudin, ES., Isahak, M. & Rampal, S. (2018) The prevalence, risk factors and outcomes of workplace bullying among junior doctors: a systematic review, *European Journal of Work and Organizational Psychology,* 27:6, 700-718, DOI: 10.1080/1359432X.2018.1502171

- A number of structural and cultural barriers to change, including training pathways that do not currently accommodate parents and caregivers, gendered norms within specialties, and gender-based discrimination.
- Persistent imbalances exist within the gender distribution in managerial positions in hospital services
- Entrenched cultural perceptions that leadership and teaching roles remain male-dominated, particularly in the more prestigious specialties[17]

Prevalence of bullying/harassment

The prevalence of bullying and harassment in the medical profession has been well documented, and recognised by a 2016 Senate inquiry to present *"a considerable risk to members of the health care sector, but also to the Australian public as a whole," [18]* .

A 2015 survey of 3516 surgical Fellows, trainees and international medical graduates and found that 49% affiliated with the Royal Australasian College of Surgeons had been subjected to discrimination, bullying, harassment or sexual harassment[19] . 2016-2017 data from a cohort of junior doctors in New South Wales demonstrated that over half of doctors surveyed experienced bullying[20]. 2017 survey results from the Australasian College for Emergency Medicine demonstrate that 34% of respondents had experienced bullying, 21.7% discrimination, 16.1% harassment and 6.2% sexual harassment[21] . The true prevalence is likely to be significantly underestimated, with widespread under-reporting.

Organisational culture

The 2016 Senate Inquiry into the Medical complaints process detailed evidence that suggested bullying and harassment are normalised, transgenerational practices in many areas of medicine. In 2013, a cohort of medical students in Melbourne told researchers that practices of humiliation and harassment are a

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[17] Level Medicine (2017). *Gender segregation in the workplace and its impact on women's economic equality - Submission to the Senate Standing Committees on Finance and Public Administration* http://levelmedicine.org.au/our-work/advocacy/gender-segregation-and-womens-economic-equality/

[18] Senate Standing Committee on Community Affairs (2016). *Medical complaints process in Australia*. Canberra: Parliament of Australia; https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MedicalComplaints45/Report

[19] Royal Australasian College of Surgeons (2015). *Expert Advisory Group advising the Royal Australasian College of Surgeons: discrimination, bullying and sexual harassment prevalence survey*. Melbourne: RACS. https://surgeons.org/media/22045682/PrevalenceSurvey_Summary-of-Facts_FINAL.pdf

[20] Llewellyn, A., et al (2018).

[21] Australasian College for Emergency Medicine (2017). ACEM to tackle bullying and harassment. Melbourne, ACEM: https://acem.org.au/News/Aug-2017/ACEM-to-tackle-bullying-and-harassment

traditional practice in the culture of medicine and medical education, and an accepted way of enculturating the young, helping them to "toughen up" for medical practice[22].

The elements of organisational culture that contribute to the ongoing perpetuation of harassment are complex and enmeshed, but include;

- The widespread "patronage" system of training, whereby medical trainees depend on a small group of powerful senior colleagues for entry into training, assessment, job opportunities and career progression.
- A lack of trust in the confidentiality and procedural fairness in reporting pathways contributes to apprehension about reporting incidents. Many medical professionals undertake a mix of clinical and administrative work in healthcare institutions - and health services can be experienced as small, interwoven networks in which anonymity and confidentiality are difficult to maintain.
- Fear of negative repercussions for reporting unacceptable workplace behaviours such as harassment
- A practice of standing by silently when witnessing unacceptable behaviour, which tacitly accepts and normalises instances of harassment

The cultural climate that enables ongoing harassment also acts to prevent complaints by victims of behaviour such as sexual harassment. Thematic analysis of reasons for not reporting or taking action on bullying or harassment illustrated that junior doctors are reluctant to speak out, not only for fear of reprisal, but also because they do not believe it is worth doing so in the context of perceived inefficiencies of current reporting systems[23]. Other contributors to silence on behalf of targets of sexual harassment in the medical workforce include;

- A dependence on advisors and mentors for career advancement,
- A system of meritocracy which requires high levels of productivity and robs individuals of the time for self-care such as reporting of harassment
- The male-dominated culture of some fields which can be perceived as inhospitable to concerns regarding wellbeing
- The close-knit nature of many medical networks, in which rumors and accusations are difficult to contain[24]

Measures to Address Sexual Harassment as experienced by medical professionals

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[22] Scott, K. M., Caldwell, P. H., Barnes, E. H., & Barrett, J. (2015). Teaching by humiliation" and mistreatment of medical students in clinical rotations: a pilot study. *Med J Aust*, *203*(4), 185e.
[23] Llewellyn, A., et al (2018).
[24] NASEM, (2018).

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Level endorses the findings of previous inquiries with pertinence to gender inequity and bullying within the workplace - which are contributing factors to the ongoing perpetuation of sexual harassment in the medical workforce. We would like to draw the Commission's attention to the 2016 Senate Inquiry into the Medical complaints process and the 2017 Parliamentary Enquiry on Gender segregation in the workplace and its impact on women's economic equality as examples of consultation processes which have culminated in suggestions for pathways to address drivers of sexual harassment.

Level would like to suggest the following measures which might be included in a suite of actions to address sexual harassment as experienced by medical professionals;

- In order to accurately depict the scope and consequences of harassment and its driving factors in the medical workforce, it is imperative that we have better data. Workplaces should be required to to thoroughly and repeatedly measure the nature, prevalence, and severity of harassment and discrimination - and its antecedents such a wage inequality and representation in managerial positions.
- Sound complaint mechanism that protects complainants from career repercussions. Level endorses the comprehensive recommendations of the 2016 Senate Inquiry into the Medical complaints process in Australia, which outline steps to achieve a co-ordinated, system wide response to harassment in the medical workplace [25]
- It is imperative that we publically recognise and support individuals and employers who promote respectful work environments.
- Ongoing efforts to revise organisational systems and structures to value diversity, inclusion and respect should be supported.
- Medical schools and training programs should be required to embed diversity and inclusion training in their curricula.
- Broader societal efforts to address the drivers of consequences of gender inequity and promote respectful relationships in all domains of society will assist in re-shaping the context in which sexual harassment continues to be perpetuated in the workplace

Submission prepared by G FitzGerald on behalf of Level Medicine. Level would like to thank the members of the Australian medical workforce who bravely shared their experiences of sexual harassment in the workplace to inform the preparation of this submission.

[25] Senate Standing Committee on Community Affairs (2016). *Medical complaints process in Australia*. Canberra: Parliament of Australia; https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MedicalComplaints45/Report