16th February 2024

Dr Anne Tonkin
Chair
Medical Board of Australia

Dear Dr Tonkin

Thank you very much for the opportunity to make a submission regarding the Medical Training Survey.

I attach our submission here representing the collective views of the Advisory Board of A Better Culture, its reference groups and drawing on information gathered during stakeholder consultation on this issue.

Should you or the Steering Committee have any questions, please do not hesitate to contact Ms Komal Daredia, Project Manager, at kdaredia@abetterculture.org.au.

Sincerely

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A Better Culture

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Summary of Recommendations

1. That the Medical Board consider more targeted communications about the Survey to reach Health service and Hospital Boards, to build their understanding of the culture of their hospitals.
2. That the Board review its confidentiality and privacy assurances and ensure that these are consistently and repeatedly communicated, specifically highlighting that employers will not be able to identify respondents, and that individual data is not held by the Board and so cannot influence any decisions the Board may make about registration.
3. That the Board expand its exploration of Racism experienced and witnessed by trainees.
4. That the MTS creates clear and specific linkages between reported behaviors and “who was responsible”.
5. That all data from the MTS, in all reports, be presented with gender disaggregation, expressed as total, and with male, female and non-binary (where applicable) reported separately unless minimum data group sizes would be breached in so doing.
6. That the Board add a specific question/s about sexual harassment to the MTS dataset.

Introduction

A Better Culture was established under a grant from the Commonwealth to repurpose unspent funds form the Specialist Training Program, specifically to address findings reflective of workplace culture in the Medical Training Survey.

Accordingly, A Better Culture, through its reference groups, its affiliation with the Royal Australasian College of Medical Administrators and its multi-disciplinary Advisory Board has canvassed opinions on priorities for revisions to the Survey that would better support our work.

We acknowledge that the Survey has a much wider remit than workplace culture, and the guiding principles enunciated with the invitation to provide this feedback, and those principles have been considered in preparation thereof. We thank the Board for the opportunity to provide this submission.

We also acknowledge the value of a series of data points across time and are grateful to the Board for its commitment to this ongoing data collection. We welcome the demonstrated willingness to have the survey modernise by inclusion of new questions and retiring of old.

This submission proposed a number of additional items, but we also recognise that length and complexity of the survey are a relevant consideration. We do not believe it should be within our remit to recommend cessation of specific items that fall outside the scope of workplace culture, and so are not answering that part of the request for submissions, whilst recognising that this leaves the Board to juggle the potential of an ever-expanding survey.

We suggest that the Board could consider canvassing colleges and employers about impact of some questions - for example - Have the questions on additional workplace settings or years of registration ever contributed to a substantive change in training?

The social environment and norms are changing rapidly. The need to evolve is noted in the current Guiding Principles under the heading 'participation', but it is our view that improving the relevance of the survey, especially given a relatively young target population, is critical for improving participation.

One potential solution for the Board to consider could be to administer alternating versions of the survey (each set collected every 2nd year), or distribute 2 different versions randomly allocated, which, given the participation rate, would still be highly significant. These are matters for the Board to consider in the broader context of other stakeholder expectations.

We propose amendments that would create greater capacity to interpret actionable items and improve awareness and distribution of the survey. We have suggestions to reinforce confidentiality assurances, particularly in light of sensitive questions being included. Finally, we propose reporting of questions that align with 2 of the major strategic priorities defined in the A Better Culture Phase 2 workplan, namely gender and race perspectives.

Improving awareness and distribution of the Survey

Recommendation 1: That the Medical Board consider more targeted communications about the Survey to reach Health service and Hospital Boards, to build their understanding of the culture of their hospitals.

In our stakeholder liaison, we discovered that hospital or health service Boards may not be aware of the survey, and yet are in a strong position to initiate and monitor a response to any areas for improvement.

Indeed, the health services, as employers, have the primary obligation to address issues of discrimination, bullying and sexual harassment within their workplaces, and should be fully informed about its prevalence in hospitals.

We suggest that the Medical Board consider extending its communications to at least draw the attention of Health Service Boards to the existence of the Survey, and their ability to create reports from sites of interest. Whilst health service executives and departments may be aware of the survey, we have reason to believe that Boards may not be, and the health and safety of staff is at its core, a Board responsibility and a legal imperative.

This survey should be seen as complementary to their own internal surveys and provide a broader context for work that is done to create a safe workplace in these settings.

Confidentiality

Recommendation 2: That the Board review its confidentiality and privacy assurances and ensure that these are consistently and repeatedly communicated, specifically highlighting that employers will not be able to identify respondents, and that individual data is not held by the Board and so cannot influence any decisions the Board may make about registration.

There are some concerns that have been raised with A Better Culture about confidentiality – particularly from the International Medical Graduates (IMG) cohort. The most vulnerable practitioners, absent very clear and trustworthy communications to reassure, may succumb to the fear that adverse reports in the survey will rebound on them. We have had multiple IMG doctors confirm this perspective and draw it to the attention of the Board for consideration.

Race perspectives

Recommendation 3: That the Board expand its exploration of Racism experienced and witnessed by trainees.

1. **Direct questions on experiences of Racism and Bias**: While Q42a addresses experiences and witnessing of bullying, harassment, discrimination, and racism, it could be enhanced by directly asking about microaggressions, specific instances of favouritism, and bias due to country of origin or IMG status. This could include questions on:

    a. Specific experiences of racism or microaggressions in the workplace.
    b. Perceived bias in opportunities for training or advancement based on ethnic background, country of origin, or IMG status.

c. Experiences of favouritism affecting evaluations, rotations, or opportunities for learning.

2. **Support and Resources**: Questions about the availability of support and resources specifically aimed at addressing racism, discrimination, and microaggressions could be more prominent. Ask about awareness of, access to, and the effectiveness of these resources.
3. **Impact on Training and Well-being**: Include questions assessing how experiences of racism, discrimination, and bias have impacted not only the respondent's training experience (currently asked) but also their professional development and mental health. This will help gauge the severity of the issue and its implications on career progression, and its status as an issue of Occupational Health and Safety.

Actionable Data

Recommendation 4: That the MTS create clear and specific linkages between reported behaviours and "who was responsible".

In the current version of the MTS, a trainee may respond that they have experienced both racism and bullying. They are then asked to respond, "who was responsible", but are only asked once.

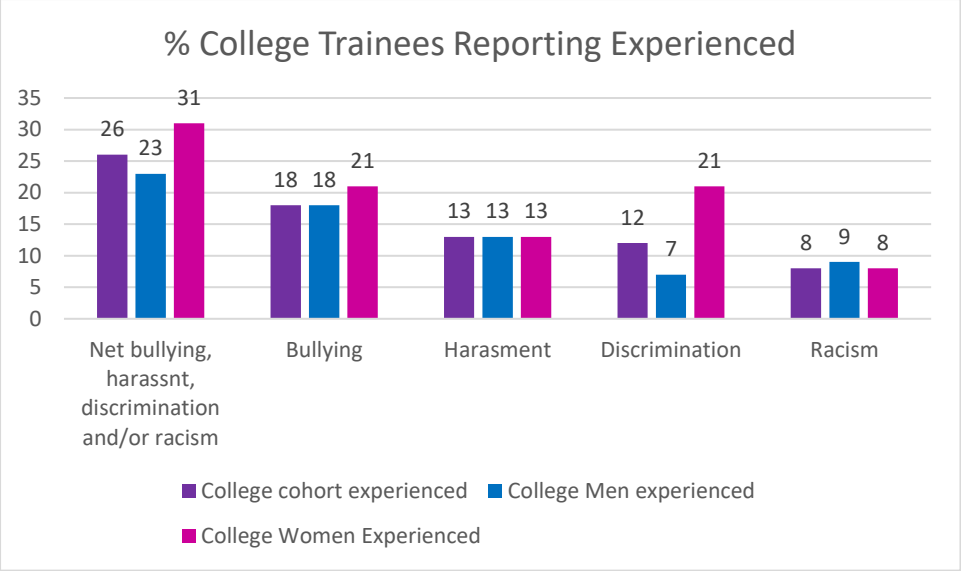
We have noted with concern the increased rate of reported adverse behaviours exhibited by patients. However, it is impossible to tell if this is bullying, racism, harassment or discrimination. Likewise, for example, if a trainee reported racism and bullying, but then indicated colleague and patient, there is no way to work out if both colleague and patient did both, or if the patient was responsible for racism and the colleague for bullying. Until we can get clarity on this data, the targeting of interventions will fail. We are recommending that the survey ask specifically about who was responsible for each separate behaviour. This will create a data set that is more actionable and relevant.

Gender Perspectives

Recommendation 5: That all data from the MTS, in all reports, be presented with gender disaggregation, expressed as total, and with male, female and non-binary (where applicable) reported separately unless minimum data group sizes would be breached in so doing.

At present, male vs female vs non-binary data is not included by default in any of the standardised reports, even though it is collected. Specific reports are generated for Aboriginal and Torres Strait Islander trainees, for International Medical Graduates but not for gender. This is inconsistent with Australia's commitment to gender equity, and with governmental policy for gender mainstreaming (that gender perspectives be incorporated into all policy making).

Furthermore, where one gender makes up a smaller proportion of trainees, (for example, women in RACS, Men in RANZCOG, and non-binary people in all) their experiences are rendered invisible, sublimated by the dominant experience of the main group. This is well demonstrated in, for example, data from the Royal Australasian College of Surgeons 2022 data, reproduced in the following graph:



IF one only compared women to the total – the net figure would be 31% of women vs 26% for all. It is only in direct comparison of the experience of men vs women that the disparity is starkly revealed.

It will require no further data collection for the Board to expand its reports in areas where gender is likely relevant to include this by default. Doing this for all reports would allow better understanding of intersectional inequity, allowing better understanding the experiences of those most at risk of discrimination, racism and harassment.

Recommendation 6: That the Board add a specific question/s about sexual harassment to the MTS dataset.

We understand that the Board's position has been that sexual harassment can be included by respondents in their response about harassment. We further understand that the matter has previously been considered and set aside due to concerns about complexity, safety of respondents and generating consensus on the issue.

For those reasons, our submission on the topic of sexual harassment is more detailed and draws on literature and other data sources, to emphasise that this position is grounded in research, policy and statute, and that sexual harassment within medicine has direct implications for protection of the public, the Board's core remit. We have included an appendix with a literature review on the topic in an effort to provide Board with a solid evidence base and present here a summary of our findings from the literature review and other policy documents and legal frameworks.

The distinction between harassment and sexual harassment lies in the nature and intent of behaviours, with harassment covering a broad spectrum of unwelcome conduct, while sexual harassment involves unwanted sexual behaviour. Despite these differences, confusion often arises due to gender biases and societal stereotypes. Various studies emphasize the systemic nature of sexual harassment, connecting it to broader issues like gender discrimination. Research reveals a widespread prevalence of sexual harassment in Australian workplaces, particularly in medical settings. Managing sexual harassment in healthcare faces challenges such as power dynamics, underreporting, and gender stereotypes. Reports indicate that victims often hesitate to come forward due to fear of repercussions and institutional barriers.

In Australia, legal frameworks distinguish between general harassment and sexual harassment, with recent amendments requiring organizations to actively address sexual harassment. We would particularly like to draw your attention to following:

- Section 28A of the Sex Discrimination Act 1984 (Cth) sees sexual harassment as any unwelcome sexual advance, request for sexual favours, or engagement in other unwelcome conduct of a sexual nature towards a person.
- The December 2022 amendment to the Sex Discrimination Act 1984 additionally requires a positive duty of organisations to eliminate, as far as possible, sexual harassment in connection with work.

Attitudes of A Better Culture Stakeholders to inclusion of a Sexual Harassment item/s on the MTS

We surveyed A Better Culture reference group participants (belonging to a diverse group of healthcare professionals) and RACMA members and Fellows.
95% of reference group respondents (n=90) and 90% of RACMA Members (n=75) responded "yes" to the simple question "Do you believe that the Medical Training Survey should include specific questions about sexual harassment".

Respondents in both surveys were asked if there were any risks that should be considered – and the predominant concern was one of triggering survivors and maintaining anonymity.

Suggested measures to additionally assure anonymity for accurate reporting include:

- An additional sentence giving this assurance immediately before the question.
- Making the sexual harassment questions optional
- Providing the survey through a third-party provider

Responses from A Better Culture and RACMA members repeatedly highlight the risk of re-trauma from reporting. This trauma takes two main forms: trauma from recounting the event, and trauma from lack of action after reporting. Measures to address this include.

- A trigger warning or explanation at the beginning of the survey to highlight the inclusion of sexual harassment questions- this avoids a feeling of being 'hijacked' on reaching the questions about sexual harassment after answering 40 prior questions.
- An additional brief trigger warning just prior to the sexual harassment questions
- An option to skip directly to the next section.
- A prominent 'hot button' on the sexual harassment question page that links to support as required, such as Converge or Drs4Drs.

Benefits of including questions about sexual Harassment:

The Board may be concerned that asking and reporting about sexual harassment could create a wave of adverse publicity for the profession. Against this, we propose the following considerations:

- By including sexual harassment in the survey, the MBA signals that it is a modern and responsive organization that is keeping pace with social and legislative change. Its continuing omission risks signalling the exact opposite. According to Cortina and Jagsi (2018) the inclusion of questions

about sexual harassment in medical board surveys serves as a crucial step in assessing the prevalence and impact of this issue within medical settings.

- The MTS, out of all the reporting pathways, has the potential to be one of the safest ways to report sexual harassment (if simple measures are taken) due to the independence of the MBA from employers and training colleges.
- The MTS is brought into alignment with good medical practice: a code of conduct for doctors in Australia, where in section 5.4 'Discrimination, bullying and sexual harassment', the subsection 5.4.9 'Appropriate information sharing, within the law, by all relevant parties such as employers and specialist medical colleges, to support effective resolution and remediation, when possible' is difficult to enact when the information is not even collected by the organization that produces and enforces the Code

'The best time to plant a tree was 30 years ago; the second-best time is today'. The absence of questions about sexual harassment is likely to become increasingly scrutinized over time. Introducing them now will contribute to normalization of the questions within the MTS, and additionally play a part in gradually fading the stigma that currently discourages many from reporting.

Conclusion

We are grateful to the Board for the opportunity to make a submission and assure our utmost collaboration to assist the Board in this process. The recommendations presented are based on the thorough stakeholder consultation that has been conducted by A Better Culture team in the year 2023.

It matters that doctors are experiencing personal harm in the workplace. We can choose to eliminate bullying, to stamp out all forms of harassment, to have zero tolerance for racism, and to wipe discrimination off the face of the profession. We seek Board's help in making that change by considering the recommendations presented in the submission.

Appendix A: Literature Review on Sexual Harassment

In light of growing awareness about sexual harassment, it becomes increasingly evident that healthcare environments are not exempt from its pervasive reach. Recent research highlights its prevalence across sectors, including healthcare, education, and workplaces. Hence, urgent action is needed to conduct thorough data collection efforts within Australian medical workplaces to fully grasp the extent of the issue. This literature review emphasizes the crucial need to prioritize sexual harassment in future surveys within Australian medical settings, emphasizing its significance in addressing this pressing concern.

Sexual Harassment vs Harassment

Confusion between harassment and sexual harassment is not uncommon, as both involve behaviours that create hostile or uncomfortable environments for individuals. However, the delineation lies in the nature and intent of the behaviours exhibited. Harassment encompasses a broad spectrum of unwelcome or offensive conduct, which may manifest in verbal, physical, or non-verbal forms. This can include derogatory remarks, intimidation tactics, or exclusionary practices aimed at undermining or marginalizing individuals (Taylor *et al*, 2018).

On the other hand, sexual harassment involves behaviour of a sexual nature that is unwanted or unwelcome, ranging from suggestive comments and gestures to explicit advances or demands for sexual favours. The defining factor in sexual harassment is the presence of sexualized conduct or language, which serves to objectify and demean individuals based on their gender or perceived sexuality (Quick *et al*, 2017).

Despite these distinctions, there is often confusion and conflation between harassment and sexual harassment with gender biases and societal stereotypes playing key roles in this according to Taylor *et al* (2018). However, owing to the pervasive nature of sexual harassment, the legal frameworks guiding workplace conduct in Australia provides separate definitions to general harassment and sexual harassment in relevant federal and state legislation. Similarly, prevalence surveys about disrespectful behaviours by professional colleges in Australia have included sexual harassment separate to general harassment.

The December 2022 amendment to the Sex Discrimination Act 1984 additionally requires a positive duty of organisations to eliminate, as far as possible, sexual harassment in connection with work. The MTS collecting prevalence data specific to sexual harassment would be part of demonstrating an effort to meet this positive duty (or at least track the effect of efforts to meet this positive duty, given the likely prevalence).

Sexual harassment is an issue of far greater impact than the sometimes-terrible impacts on the individuals who experience it. It remains highly topical and its importance in Australia is no less than that seen overseas. Its pervasive nature and individual as well as organizational impact underscore the urgent need for comprehensive measures to address and prevent it. This is why various surveys treat sexual harassment distinctively from general harassment in the workplace.

In the bid to provide a comprehensive definition to what constitutes sexual harassment, various studies have peered into the subject from diverse areas. Quick *etal* (2017) notes that defining what sexual harassment is remains a 'persistent problematic' area of understanding sexual harassment. Folke et al (2020) delve into the systemic nature of sexual harassment, linking it to broader issues such as gender discrimination in the labour market and framing it as a form of systemic trauma. Their insights underscore the interconnectedness of sexual harassment with larger societal structures and power dynamics. Cortina and Areguin (2021) on the other hand discuss the evolution of the understanding of sexual harassment,

to recognizing gender harassment as the most prevalent form. Gender harassment, rooted in contempt and aimed at degrading individuals based on their gender, highlights the broader context of sexism and discrimination within which sexual harassment operates. That is to say, persistence of sexual harassment in medicine is not a manifestation of sexual attraction, but a more sinister manifestation of gender power dynamics which may not be confined to colleagues, but risks contaminating treating relationships, and therefore, patient safety.

Section 28A of the Sex Discrimination Act 1984 (Cth) sees sexual harassment as any unwelcome sexual advance, request for sexual favours, or engagement in other unwelcome conduct of a sexual nature towards a person. This behaviour occurs in circumstances where it is possible that the person being harassed would feel offended, humiliated, or intimidated. Importantly, sexual harassment can manifest in subtle and implicit ways, not just explicit actions. It further emphasises that sexual harassment encompasses various behaviours, including staring or leering, making suggestive comments or jokes, displaying sexually explicit materials such as posters or magazines, engaging in stalking behaviour, and sending sexually explicit emails or text messages. Additionally, unwelcome touching is also considered a form of sexual harassment. According to Crebbin etal (2015), “sexual harassment may include, but is not limited to 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”.

These behaviours, whether overt or covert, contribute to creating a hostile or intimidating environment for the individual experiencing them and are therefore deemed unlawful under the Sex Discrimination Act.

Research by the Australian Human Rights Commission (AHRC) indicates that sexual harassment is widespread in Australia. According to their national survey, "Respect@Work", released in 2020, 39% of women and 26% of men experienced sexual harassment in the workplace within the past five years. (Australian Human Rights Commission, 2020). In medical workplaces, including hospitals and surgical training programs, sexual harassment remains a significant concern. Stone et al. (2019) conducted a narrative study focused on the impact of sexual harassment and assault perpetrated by doctors in medical workplaces, specifically within hospital training programs. Six Australian women doctors shared personal accounts of their experiences, revealing long-term personal and professional consequences. Three key phases were identified: prelude, assault, limbo, exposure, and aftermath. Many participants did not report the abuse, and those who sought legal recourse faced challenges to their personal well-being and professional standing. Similarly, Liang et al. (2019) through a qualitative study involving 12 women who had departed from medical training from various Australian regions offer insights into the reasons behind women leaving surgical training, with discrimination being a significant factor. To offer more perspectives, the study references Hill et al. (2014), suggesting that women may engage and ‘pretend to enjoy’ sexualized banter in surgery rooms to establish safety and credibility in a male dominated environment.

In another study, Crebbin, et al (2015) investigated the prevalence of discrimination, bullying, and sexual harassment in surgery in Australia and New Zealand. Two quantitative surveys were conducted: one among Royal Australasian College of Surgeons (RACS) members and another among hospitals, medical institutions, and related organizations. With a 47% (3516 respondents) response rate in this study, findings showed that nearly half 49.2% (1516 respondents) of the surveyed individuals reported experiencing one or more of the behaviours with 7% reporting sexual harassment specifically. This prevalence was consistent across all surgical specialties. In a similar survey, Venkatesh et al (2016) through an online survey of trainees in the College of Intensive Care Medicine of Australia and New Zealand found the

prevalence of bullying, discrimination and sexual harassment. 3% of the respondents specifically reported sexual harassment with women reporting a greater prevalence. A more recent study by Parke et al (2023) carried out an online survey of intensive care unit nurses on the prevalence of bullying, discrimination and sexual harassment. 1.9% of the respondents reported the prevalence of sexual harassment. In this study, 34.6% of the respondents reported that the perpetrators were patients. Majority of the respondents 66% owing to lack of confidence in addressing the behaviours did not report these incidents.

Managing sexual harassment in healthcare settings in Australia is fraught with challenges stemming from power dynamics, underreporting, gender stereotypes, lack of awareness and training, complex reporting procedures among other things. According to McDonald and Charlesworth (2019) and McDermott (2020), despite the prevalence of sexual harassment in Australian workplaces, it is often underreported. North (2016) concludes that this is particularly true about men dominated workplaces. Institutional and departmental barriers, especially prevalent in STEM disciplines, further exacerbate this underreporting (Aguilar & Baek, 2020). Victims who do report sexual harassment may encounter bias and discrimination, potentially leading to negative employment outcomes (Hart, 2019).

Furthermore, these cases are underreported due to a lack of understanding of what constitutes harassment. According to Carstensen (2016) and Wamoyi (2021) the lack of consensus on the definition of sexual harassment, compounded by gender differences in interpretation, adds complexity to the issue. This lack of understanding can further stem from societal norms that normalize certain forms of misconduct (Kiguwa et al, 2015), and fear of repercussions for reporting sexual harassment. Additionally, victims may hesitate to come forward due to feelings of shame, embarrassment, or self-blame, particularly if the harassment involves subtle or ambiguous behaviours.

Birinxhikaj, et al (2017) in their study concluded that Victims respond to harassment by attempting to escape the environment, seeking counselling, or reporting the incident. However, reporting was the least likely outcome, sometimes due to financial dependence on their job. One of the respondents in Llewellyn (2018) study of bullying and sexual harassment of junior doctors in New South Wales and ACT noted that.

> *"I brought it (the harassment) up briefly at an exit interview at the end of the term which was run by a consultant unrelated to the team. He laughed it off and said I was on a surgical team, so misogyny was to be expected to some extent. ... consultants/registrar making obscene/crude remarks but always justifying by saying, it's a joke, don't report".*

Similarly, Colenbrander *et al* (2020) in their study titled "if you can't make it, you're not tough enough to do medicine" conducted semi-structured in-depth interviews with recently graduated medical students from Sydney based medical schools on bullying and harassment and how hierarchies affect reporting of these incidents. Findings suggested a problematic culture of 'power imbalance' which deterred reporting of incidents of harassment. Participants disclosed their inability to report issues due to the hierarchy in place and among other things described senior doctors as 'sexist'. One of the respondents noted that

> *'No matter how valid your complaint is, hospital management, I think, will tend to see you as the person who is a bit of a troublemaker, or caused a fuss… There might be retribution.'*

The prominence of sexual harassment discourse is indicated by the continued measure of it separately, in many medical training college surveys, even when other measures were aggregated for reasons of feasibility, for example during COVID (RACS 2021 survey). Omission of matching data in the MTS makes data correlation impossible, and hampers collaborative work to address the problem, and the ability and

willingness of colleges to ask this question, and have it answered by their own trainees, sets a precedent that demonstrates that it can be done.

The MTS, due to its ability to aggregate across multiple specialties and sites, may be the *only* way for some doctors to safely report sexual harassment, especially those from smaller specialties or isolated sites. The psychological benefit of being able to report, even in this small way, must be considered against the perceived silencing by continuing to omit sexual harassment.

Furthermore, data collected in the MTS could assist in making the case for better institutional structures to report, and support survivors. The ongoing omission of sexual harassment sends a message, albeit unintentional, that sexual harassment is less important than bullying or racism.

In healthcare organizations, the impact of sexual harassment extends beyond individual victims to affect organizational culture and patient care. A culture that tolerates or ignores harassment erodes trust, cohesion, and morale among staff. This can lead to increased absenteeism, decreased productivity, and higher turnover rates. Moreover, harassment can undermine patient safety and quality of care by compromising communication, teamwork, and clinical judgment (Walton 2015). Healthcare professionals experiencing harassment may become disengaged, leading to diminished clinical performance and compromised patient outcomes.

Sexual harassment is a multifaceted issue that must be explored if we are truly seeking gender equity in health workforce, and in delivery and experience of healthcare, and this aligns with the MTS's guiding principle of quality improvement.

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