



**ST VINCENT'S
HEALTH AUSTRALIA**

UNDER THE STEWARDSHIP OF MARY AIKENHEAD MINISTRIES

Expert Advisory Group on

Discrimination, bullying and sexual harassment

Advising the Royal Australasian College of Surgeons

St Vincent's Health Australia (SVHA) Issues Paper Response

Disclaimer: St Vincent's Health Australia (SVHA)'s submission contains detail which has been provided to us anecdotally from employees operating within the Australia hospital and healthcare sector both in and outside of SVHA's facilities. It represents the collective views of a range of individuals under the SVHA umbrella and is based on their experiences in a variety of health care and hospital settings, including St Vincent's. The submission is intended to contribute to the bank of knowledge regarding the extent of and possible solutions to the issue of bullying, discrimination and sexual harassment (BDSH) in the healthcare and hospital sector. The response does not represent the culture and working environment within SVHA facilities and services but is offered as a general representation of the Australian healthcare and hospital sector.

Overarching Statement

St Vincent's Health Australia (SVHA) is the nation's largest Catholic not-for-profit health and aged care provider. We are a clinical, research and education leader working in private hospitals, public hospitals and aged care services in New South Wales, Victoria and Queensland. St Vincent's Health Australia operates more than 2,500 hospital beds, 1,100 aged care places, employs over 17,000 staff, works with over 2,500 medical practitioners and draws on the talents of over 1,300 generous volunteers.

It is absolutely crucial that all Australians, enjoy a work environment free from implicit or explicit behaviour used to control, influence or affect a person's well-being in a negative manner. As an employer of 17,000 staff in hospitals and Aged Care facilities Australia-wide, SVHA has a responsibility under Work Health and Safety and anti-discrimination law to provide a safe workplace.

However, SVHA also believes that they have a moral imperative to treat employees in a way which is in line with our values as an organisation: *Compassion, Justice, Integrity and Excellence*.

It is a legal and moral responsibility SVHA take very seriously and we see no place for discrimination, bullying or sexual harassment in the practice of surgery or in any modern workplace.

SVHA holds the view that the behaviours discussed within this paper pose a real and present danger to patient safety and health outcomes that can only be addressed by the removal of bullying/discrimination and sexual harassment in the surgical workplace and outlines further evidence to support this view within the following submission. SVHA believes that bullying, discrimination and sexual harassment is occurring within parts of the health care sector are bordering on archaic and would not be tolerated in any other industry.

SVHA is encouraged by the fact that the Expert Advisory Group (EAG) advising the Royal Australasian College of Surgeons (RACS) has been appointed and stakeholder comment and solutions sought to this increasingly important issue. This means that the too-long hidden problem of bullying, discrimination and sexual-harassment (BDSH) in the workplace is being acknowledged and exposed. The issue of BDSH in the workplace has now been escalated into public consciousness and the RACS appears ready to take this issue more seriously than it has done in the past.

As a healthcare provider responsible for a large group of hospitals spanning the private and public sectors, SVHA would be interested in partnering with RACS to develop a strategic framework to bridge the communication and accountability divide between hospitals and the College.

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1. Organisational Culture

a. Problems persists despite the legal, policy and standards framework

i. Do surgeons know where the line is, and still cross it?

It is difficult to know for sure if bullies always recognise when they are bullying. When they have “crossed the line”.

It is also important, particularly in light of the hierarchical nature of the medical profession and surgical environment, that there is fundamental distinction between bullying, which is inherently undermining and corrosive, and constructive supervision, which is developmental and supportive.¹ Ideally, a balance must be sought where constructive criticism is not viewed as bullying and where bullying is outlawed.

Bullying is a complex phenomenon and is not always easy to discern **why** someone might bully. Suffice to say, it is SVHA’s view that it appears to stem from both individual characteristics and systemic issues.

A combination of inherent stresses of dealing with high stakes, high emotion situations, coupled with work place stress and fatigue coupled with personal characteristics such as self-centredness, immaturity, or defensiveness can make someone more prone to bully. Systemic factors somewhat unique to the healthcare environment may exacerbate the issue of bullying including the pressures of audited clinical outcomes, cost containment and embedded power inequalities in medical hierarchies.

¹ Mistry, M & Latoo, J., “Bullying: A Growing Workplace Menace” (2009) British Journal of Medical Practitioners Vol 2(1), 23-26, p. 23.

ii. Are surgeon's aware of the relevant professional and educational standards? If so, why do some ignore them?

Anecdotally SVHA is aware that bullying and sexual harassment do exist within hospitals, including our own, despite the large majority of these healthcare facilities providing clear instruction on how individuals must behave and how to escalate an issue of suspected bullying. While formal systems are in place in hospitals for educating and escalating inappropriate behaviors, these systems have a tendency to be viewed as a 'tick the box' exercise in terms of 'non clinical' training responsibilities.

A comprehensive policy is worthless without a culture that believes in and supports it and recommends steps employees need to consider.² Moreover, there is a history of tolerance and inaction in regards to intimidating and disruptive behaviours in healthcare organisation that fail to adequately address unprofessional behaviour through policies and procedures.³

SVHA suggests that a powerful way to increase awareness of bullying and anti-discrimination is to communicate the evidence-based risks to patient safety which occur as a result of bullying and abusive behaviour. Research clearly demonstrates that intimidating and disruptive behaviour can foster medical errors⁴⁵⁶

iii. What else needs to be done to increase awareness of the law and standards?

SVHA is supportive of a workplace environment which fosters respect and openly and transparently communicates a need to speak up if an example of bullying or anti-discriminatory behaviours is observed or felt. This means that the onus and responsibility for speaking up is shifted from the victim to every employee. It is the type of individual accountability that it nicely articulated by Lieutenant-General David Morrison, Former Chief of Army, when he states in his well-known speech, "The standard you walk past is the standard you accept. That goes for all of us, but especially those who by their rank have a leadership role."

Hospitals should facilitate a culture whereby all members of staff are encouraged to actively report an incidence of bullying. This is important as often the observers of the bullying may outnumber the bully and victims and can act collectively to redirect the dynamic of a situation and/or avert a bullying incident.

Therefore, it is the role of institutions and colleges to facilitate effective and safe reporting through protected and accessible communications.

SVHA is wholly supportive of the anti-bullying mindset adopted at Vanderbilt University, Nashville, TE, USA and urge the Australasian College of Surgeons to consider it among best

² Heenan R. How to beat the workplace bully. *Heath Service Journal*. 12th February 2009: 25-27/

³ Porto, G and Lauve, R: Disruptive Behaviour: A Persistent threat to patient safety. *Patient Safety and Quality Healthcare*, July/August 2006. Available online: <http://psqh.com/julaug06/disruptive.html> (accessed July 10, 2015)

⁴ Rosenstein, AH and O'Daniel, M: Disruptive behaviour and Clinical Outcomes: Perception of nurses and physicians. *American Journal of Nursing*, 2005, 105, 1, 54-64

⁵ Institute for Safe Medication Practices: Survey on workplace intimidation. 2003. Available online: <https://ismp.org/Survey/surveyresults/Survey0311.asp> (accessed July 10, 2015)

⁶ Morissey J: Encyclopedia of errors; Growing database of medication errors allows hospitals to compare their track records with facilities nationwide in a non-punitive setting. *Modern Healthcare*, March 24, 2003, 33 (12): 40, 42

practice examples in reshaping the behaviour of the Australian medical community where anti-bullying recommendations are concerned.

According to Gerald Hickson, M.D., Associate Dean for Clinical Affairs and Director of the Center for Patient and Professional Advocacy, Vanderbilt University, “If healthcare organisations encourage patients and families to speak up, their observation and complaints, if recorded and fed back to organisational leadership, can serve as part of an (anonymous) surveillance system to identify behaviors by members of the health care team that create unnecessary risk.”

According to a SVHA survey conducted as part of the independent Expert Advisory Group (EAG) review, one of the key factors contributing to discrimination in the workplace is an acceptance of the existing culture by senior staff. This can be as overt as the senior staff, including surgeons, participating in acts of bullying themselves, through to more subtle acceptance of the situation through their silence in the presence of a colleague being bullied.

Surgeons taking the lead and immediately addressing inappropriate comments and behaviour is cited as having the most powerful influence in driving cultural change according to the same survey.

iv. What else needs to be done to ensure compliance with them?

SVHA supports the following recommendations to ensure compliance to bullying, anti-discrimination and sexual harassment including:

- A culture change mindset within the RACS assessments so performance behaviours are considered as important as technical competency and poor behaviour as much a risk to patient safety as technical incompetence.
- Clear leadership standards in all Codes of Conduct that define acceptable and unacceptable behaviour. These should be developed with input by leaders themselves, ensuring consistency with employee contracts and relevant by-laws.
- Independent members of RACS Review Committees who are prepared to revoke clinicians right to practice for breaches of human rights as much as failing in the delivery of health services.
- Training hospital-wide on professional and respectful behaviour, in part conducted by the clinical leaders themselves.
- Holding individuals accountable for behaviour via improved performance management structures including 360 reviews (include as part of registrars assessment) and fellowship conditions tied to performance behaviours.
- Process for circulating performance reviews to key hospital personnel if ongoing negative performance behaviours observed and cited.
- Holding up examples of respectful, collaborative behaviour (among junior and senior staff) and reward this type of behaviour in College leadership and awards.
- Leadership training for senior staff who are held accountable for modelling standards of behaviours.
- Immediate and definitive action by senior clinicians at the point of impact of inappropriate types of behaviour.

- Surveillance and reporting systems for unprofessional behaviours: this can be anonymous and victims and observers of bullying encouraged to report without fear of 'retaliation' or a 'whistle blower' response.
- Reinforcing performance management skills to facilitate documentation of actions to address bullying behaviour in the hope that 'repeat offenders' can be disciplined in an appropriate manner. (ie. escalation of disciplinary action for repeat behaviour).

1. Organisational Change

b. Are we teaching the right skills?

i. Are surgical trainees well enough informed about appropriate behaviour in the workplace and given the skills to deal with the inappropriate behaviour of others? If not, what other training do they need?

SVHA is of the view that whilst our hospitals have the relevant policies and processes in place they are not always considered relevant or meaningful to medical professionals and that adherence (or otherwise) to the policies will not impact their ability to progress in their professional career. In part, this could be because policies are not developed in consultation with the hospital leadership nor publicly endorsed by senior clinicians who are respected for their performance behaviours.

Hospitals are observed rewarding senior medical staff with positions of influence irrespective of their performance behaviours thus sending a message to junior doctors and registrars that the policies are rhetoric, or worse still, that you need to behave in an overly directive, defensive manner to get promoted into the senior positions. Are we rewarding and propagating bad behaviour and breeding bullies as well.

Strengthening the link between the Royal Australasian College of Surgeons (RACS) and hospitals in terms of their zero tolerance approach to bullying will be an important behaviour change strategy. As outlined earlier in this submission, SVHA is interested in a piloting such strategic links with RACS.

These type of links will demonstrate a collective alignment on the policies, make clear the repercussions and hold up cases of positive and negative behaviours to educate and inform.

Clinical and non-clinical staff need to be trained in the process of active debriefing of surgical teams when instances of poor behaviour occur and to highlight the ramifications to patient safety.

ii. Why isn't training changing the behaviour in the workplace?

Behaviour change will occur when junior doctors observe their clinical mentors leading the fight against bullying, being actively involved in developed policy's and protocols, educating their colleagues on these protocols and when employees are rewarded for positive workplace behaviour as well as for their clinical prowess.

Not reprimanding poor behaviour in senior staff, gives tacit approval and trainees are then encourage to model the behaviour they observe.

iii. How can the link between patient safety and behaviour be made clearer?

There is clear evidence that demonstrates that intimidating and disruptive behaviour may result in medical error, (Rosenstein, Morrissey) however this link is not well recognised by surgeons as a performance risk to themselves and their surgical team.

A structured performance management system which holds all employees to account in observing the correct performance behaviours as strongly as they do clinical training is key to the reform.

- All employees should be educated on the impact to patients of workplace bullying: a person centred care approach.
- A clear process model should exist for reporting inappropriate behaviour in the operating theatre and a review of the procedure to highlight how it may have risked patient outcomes irrespective of whether medical error occurred as a result.

This patient safety centred approach will only be effective if led and cascaded from respected senior clinical staff and administrative leadership to junior doctors and registrars.

iv. How helpful is this link in preventing discrimination, bullying and sexual harassment?

SVHA considers the increased risk to patient safety that occurs when bullying behaviour occurs is central to the strategy of addressing bullying among our surgical workforce.

The majority of health professionals enter their chosen discipline for altruistic reasons and have a strong interest in caring for and helping others. The large majority who continue to maintain high level of professionalism need to actively take a “no tolerance” approach to those few who behave in a way in which they put patient safety at risk. A “no tolerance” approach to patient safety risk already exists in hospitals across Australia although it is often focussed on clinical standards rather than personal behaviours. By normalising bullying as a risk behaviour similar to failing to wash hands or failing to take a proper patient history will promote the adverse and undesirable aspects of bullying in relation to the patient.

2. The Culture of Surgery

a. Gender inequity

i. What else can be done to address gender inequity/Is there a link between gender inequality and discrimination?

There is a large amount of evidence pointing to gender inequality in medicine. What is occurring within our hospitals walls to account for such a dramatic drop from the 52% of women studying medicine to just 14% who continue on to a speciality.

The gender wage gap for medical practitioners is, as of August 2014, 30.7% and the national average across all professions sits at an all-time high of 18%. This presents a problem for the future of the medical profession. The workplace is no longer filled with career men and ‘stay-at-home’ wives. The medical workplace will reach a 1:1 women to men ratio in 2020 and the number of men who intend to share childrearing responsibility is increasing.⁷

The medical profession needs to change to meet the demand of the changing face of its employee workforce.

⁷ Workplace gender equality agency. Gender pay gap statistics [Internet]. 2014 p. 1-12. Available from: <https://www.wgea.gov.au/sites/default>

True equalising opportunity for all needs to be identified in Codes of Practice and modelled in practice at all levels of medical fraternity and endorsed by mentors and senior medical workforce. RACS must ensure that gender equity solutions look beyond maternity and childcare allowances and address the other key workplace factors which are keeping young women from joining and/or completing surgical training.

ii. How can the College and employers address gender inequity?

SVHA is very pleased to see the RACS Expert Advisory Group has been appointed to review the issue of BDSH among the surgical workforce.

This move in itself is an acknowledgement that there is a problem which exists and that no member of any profession is above or 'outside the law' nor is any position of employment too stressful that bullying is acceptable.

SVHA believes it is pivotal for surgeons who set a positive behavioural example are rewarded for exhibiting strong professional behaviours and RACS and institutions be aligned, on paper and publicly, in their stance on gender inequality.

2. The Culture of Surgery

b. The boy's club

i. What is it about surgery that contributes to discrimination?

SVHA believes that it is a combination of character traits and systemic environmental factors that can lead to examples of direct or indirect examples of discrimination.

Surgeons are statistically more likely to be white males who have the type of personality, innately or via training or both, which is decisive, directive, confident. This set of personality traits can be very important in a stressful surgical environment where quick decisions and backing ones decisions is key and a good number of strong surgeons possess these personality traits. It is also this set of personality traits which are most frequently modelled in surgical teams and are aligned with alpha male personalities.

Junior doctors, male and female will then self-assess as to whether they fit the desired personality type. It is at this point that a large number of women actively exclude themselves from being a surgeon.

The data clearly shows that diversity in the workplace builds strength and productivity and it is this range of personality types which must be extolled within a surgical environment.

Those surgeons with an ability to stay calm under pressure, to nurture their teams, fostering learning agility and growth both technically and behaviourally. These traits are equally powerful tools in surgery and should not be perceived as weaknesses. There needs to be a greater recognition that an excellent surgeon is not defined by a single set of personality criteria.

Research demonstrates that when women display characteristics that are more typically correlated with male personality traits – decisiveness, directness – they are negatively correlated for workplace likeability and such women can be viewed as pushy or overly ambitious. Yet these traits are applauded in males as being necessary and demonstrating mental 'toughness'. It is a difficult paradox for those employees who sit 'outside the square' – culturally or from a gender perspective.

ii. What will it take for this to change?

SVHA recommends there are a range of initiatives that RACS should promote, including:

- Listen, really listen to the stories, whether anonymous or otherwise and provide a 'safe environment' to report, investigate and reprimand.
- Empower and reward a diverse model of surgery, all genders, and diverse cultural backgrounds – open up people's imagination as to what a surgeon is.
- Reward those many surgeons, male and female, who are respectful and not subject to gender bias – hold these surgeons up as mentor's, both formally and informally.
- Introduce mandatory training of surgical supervisors – this may be difficult as they are voluntary positions but they have to be educated and approachable to trainees without fear that it will affect their assessments.
- Establish a formal mechanism by which complaints can be channelled through the College. Enhance awareness of this 'review' channel and have senior well-regarded surgeons reinforce its value so trainees and juniors are not intimidated to use the channel. Anonymous reporting will be an important aspect to this system.

iii. Apprenticeship model

Key mentoring relationship/s are necessary for surgical training and can have a profound influence on the development of attitudes and behaviours. This close modelling and mimicking of someone who is a successful surgeon is one of the most important influences over an impressionable and ambitious trainee as these mentors represent an end point of what they want to become.

If trainees are immersed in an environment of gender discrimination or bullying, this will be normalised and even become desired as a model of success. This peer and supervisor level is the nexus of where interventions need to happen, not at a policy level.

2. The Culture of Surgery

c. Problems are worse in procedural specialities

i. Why are these problems worse in procedural specialities?

- As trainees have increased dependence on close consultant supervision and regulation and signoff of technical skills, mentors can have a profound effect, positively or negatively, on their trainee staff.
- An environment of increased stress can be seen to exacerbate examples of discrimination.

ii. Are surgeons trained well enough to manage stress of job?

- NO, many surgeons will not attend training on offer as there is a systemic view that being a strong surgeon requires a self-sufficiency and mental 'toughness' and that anything less demonstrates unsuitability.
- Within an entrenched male-dominated surgical culture, admitting to being stressed equates to admitting failure or technical incompetency.
- This creates an extremely difficult environment for surgeons to feel comfortable accepting help.
- Poor stress management can manifest in a surgeon internalising the concerns or externalising them on others

iii. Has inappropriate behaviour been normalised

- In a lot of cases YES. Inappropriate behaviour is so common it has been synonymous with a number of surgeons, with some even using it as a “badge of honour” as a marker of being “in control”. Throwing equipment in the operating theatre, shouting at junior doctors and making sexist remarks about female colleagues have all been cited as examples of BDSH which are currently occurring in the hospital environment.
- The high-stress, unique ‘life-death’ nature of surgery has been used as an excuse for bad behaviour as has the physical divide of the operating room from the rest of the hospital. This geographic isolation has bestowed an air of independence from the behavioural expectations of a “normal” workplace.

3. Bystanders are silent

i. What stops bystanders speaking up when they hear about or witness discrimination etc.

Disruptive behaviours can often go unreported and therefore unaddressed, for a number of reasons.

- Fear of retaliation and stigma associated with being a ‘whistle blower’ or worse, being singled out from their peers as a “troublemaker” with potentially dire career consequences.
- Whether the person is a witness or the victim, a concern that their own reputation and/or career will be tarnished as a result.
- A resignation that there will not be any repercussions should an incident be reported – that nothing will change, especially when involving a key person of influence with their hospital or College.
- If the bully is a senior clinician and a prominent person within the hospital or institution they can be viewed as ‘untouchable’.
- All of the above are the result of a current system which fails to adequately support victims and witnesses in their reporting of incidents and then not sufficiently reprimanding those ‘bullies’ in the medical profession. It is also evident of a system that does not ensure Codes, standards and policies are applicable to all – to every individual within the hospital.

ii. What is the culture of surgery which makes these issues someone else’s job or responsibility to fix?

- Institutions either lack the performance management framework or do not utilise the existing performance management framework to identify, review and act on alleged disruptive behaviour.
- Senior clinicians are not adequately trained in performance management. It is challenging for leaders to model and exhibit expertise in a process for managing performance behaviours when they are not experts themselves.
- With an embedded performance management infrastructure there is a resignation that it is impossible to fire someone even if they are a ‘repeat offender’.
- An attitude among senior clinicians of ‘I am here to do my job’, it is up to hospital to provide the infrastructure. In part the infrastructure relies on senior clinicians to mentor and model belief in the ‘system’ for it to gain traction.

- Institutions may feel they are at risk (rightly or wrongly) of unfair dismissal accusations and may be vulnerable at law.
- Organisations feel the reputational risk of negative publicity surrounding BDSH claims, especially given the issue of bullying has become a more public issue.
- Ultimately the lack of formal structures and belief in the system all create an environment of risk - for all medical practitioners and administrators within an institution. They simply don't feel confident they have the tools and the culture to adequately address bullying, anti-discrimination and sexual harassment (BDSH) in their place of work.
- Any behaviour that impairs the health care team's ability to function well creates risk.

iii. **What actions can be taken by individuals, teams and organisations?**

- A culture shift of respect for all led by well-respected senior clinical staff within institutions who are renowned for their professional behaviour.
- Culture shift formalised with new organisational performance management framework rolled out across institutions and training with leadership from strong clinical mentors.
- In policy and in practice culture shift creates a safe environment for individuals to speak out and also a culture of respect and accountability backed up by actions for those who do not conform.
- Peer accountability is key, policies are impotent without the right culture and peers setting the standard regardless of their level is critical. SVHA is supportive of the "red flag" system in the aviation industry where employees can easily and safely identify where they see boundaries are starting to be crossed.
- Real time accountability, not laughing at the joke on the ward round but standing up and making it known consultant to consultant that that is unacceptable.
- Follow up the open secrets. The people *everybody* knows about in terms of bad behaviour and don't wait for a complaint to come to you but go out and seek them. SVHA is supportive of the introduction of random workplace audits of staff awareness of and compliance with reporting requirements.
- Anonymous reporting to hospital and College will help facilitate the rapid change required to stamp out bullying. Appropriate analysis of such complaints can establish data trends which in turn drive targeted actions.

4. Complaints

a. Under-reporting

i. What prevents people from complaining about DBSH

- See also section 3i.
- The perceived risk of stigma of reporting an incident of DBSH is REAL. There exists an inherent reliance on clinical hierarchy for training references, assessments and job recommendations and even referrals down the track in private practice. Calling out a clinical mentor can very well be "career suicide."
- David vs Goliath mentality is well entrenched within institutions. A victim of DBSH might 'win the battle' through reporting, the bully might get a rap over the knuckles, but the war for prestigious jobs is fought in an tightly controlled internal world not bound by any formal policies or procedures.

- Reputation and word of mouth is everything. It is easy to cast doubt on people's ability without blatant libel. A 'whistle-blower' or complainant may simply become unpalatable to institutions and miss out on any jobs and these same people often influence referral bases and accreditation in private practice.
- ii. How does power imbalance between perpetrator and victim impact on this?**
- It is pivotal. The power imbalance spans the professional / specialist group or training scheme as detailed above but is also critical in the hospital environment as well. The perpetrator might be a key hospital identity, a leader on which a hospital's reputation or research money is built. So it can feel like they are the untouchables that no one can impugn or that their accusation may not be believed.
 - Accusers can become "black balled". Suddenly a promising trainee's assessment reports start to slip and it is impossible for an outside adjudicator to know if they are truly a good trainee or if it was manufactured. The exclusivity of the club is their defence.
 - This snowball effect can affect a person's peer support network; others may want to support the victim or the victim's version of events but cannot take the risk for their own jobs and reputations.
- iii. What confidence is there in existing complaints pathways – in hospitals and college?**
- Generally, there is very little confidence in existing complaints pathways and they do not reflect the reality of a clinical institution.
 - There is a perception that policies exist for accreditation purposes.
 - As a result there is reticence and intimidation about engaging with the 'pathways.' A feeling that to report an incident will be confronting and not lead to a satisfying outcome nor change in the longer term.
 - Also key is there is no connection or communication between hospital and RACS, so that if a doctor makes a complaint to the hospital and they investigate it, there is currently no agreement to share knowledge or notify the college. This is key in that many fellows would be far more concerned about college accountability and a threat to fellowship than about a formal warning from a hospital.
 - Privacy laws may add complexity to the process but these laws need to be understood and navigated in order for a system overhaul to be successful.
- iv. How does lack of awareness about how to make a complaint and to whom make an impact on making a complaint?**
- At a public hospital level there are a number of avenues which exist for junior doctors to make a complaint, they can vary from pastoral care staff, supervisors, sympathetic consultants and medical workforce. It is often led by relationships and who they are most comfortable speaking to.
 - Junior doctors typically would have an awareness from their non-clinical hospital orientation training that policies exist but they would be unlikely to access such policies directly but may access a trusted colleague instead.
 - Improved communication about RACS and its policies will need to occur as currently few junior doctors would have any knowledge of RACS policy, or know where to find it.
 - Opportunity exists to broaden and change the view of what RACS stands for, to make them a more approachable, support network based organisation who has the broader interests of the medical profession front and centre of their remit.

- The framework of the RACS training scheme reinforces the vulnerability especially of registrars. They are very dependent on surgeons to help them pass their assessments and develop their professional profile, reputation and skillset. Everything from organising the right fellowship at the right place like Harvard, to organising a job as a consultant hangs on the senior members of the profession.

v. How are the problems different for each bullying, discrimination and SH?

Bullying

- Is seen as part of what toughens you up for the life as a surgeon – it's almost an informal rite of passage deemed necessary to navigate if you want to become a successful surgeon.
- Toughness is modelled as “the right stuff”. There is an inherent belief that if I want to make it as a surgeon this is who I have to be and then this belief is propagated to the next generation.
- The result – a breeding ground for bullies. Victims learn to see it as a deficiency in them, not discrimination.
- Without an effective anti-bullying framework, this cycle will continue to thrive in our hospital system - supported and encouraged.

Discrimination;

- Discrimination refers to prejudicial actions or omissions based on gender or race or others qualities.
- The surgical environment can be viewed as being dictated by and geared towards rewarding qualities more typically seen among male surgical staff. Attributes such as decisiveness, dominance, bold and self-confidence. At the same time these surgeons may also be micro managing, autocratic, impatient and demanding and people classically dislike reporting to them or teaming with them. Yet the latter negative qualities are rarely singled out or reprimanded in a surgical environment.
- There is little encouragement of diversity in surgery – of other successful type of surgeons for trainees to aspire to. Women in surgery and those surgeons of a different race speak of feeling the pressure to conform to the surgeon stereotype to be taken seriously in their chosen profession.

Sexual harassment

- A common theme of sexual harassment is an acceptance that the jokes, snide remarks, or raised eyebrows are all part of navigating a male dominated profession.
- If you take offense or complain, or report, you “can’t take a joke” or are “too sensitive”, all the opposite traits of what is regarded as necessary to make a good surgeon. Worse, you see women laughing along at the jokes – again conforming to what is considered ‘acceptable behaviour.’

4. Complaints

b. Fear of Reprisal

i. How does fear of reprisal stop people making complaints?

- It can be paralysing to young doctors to initiate a complaint as their ability to progress in their careers is so closely dependant on senior clinicians. Often they consider career their mid and long term opportunities and progression more important than making a complaint that they perceive make not make a difference. They may also feel that the process of making a complaint is too hard – and it's very often and lose-lose outcome. A combination of fear and hopelessness.
- Young doctors start to believe they need to be tougher to survive a career in surgery, they toughen up and accept the disruptive behaviour so they can appear to be made of the 'the right stuff' for surgery.

ii. What would change that? What can the college do?

- Appropriately utilised anonymous reporting as used by Vanderbilt University Medical Center where trends in complaints are investigated and acted on (see earlier in submission).
- Show leadership in making people accountable regardless of who they are and what they represent within the hospital or college hierarchy instead of rewarding those who demonstrate bullying.
- True "zero tolerance" must be seen and not just heard and modelled by respected senior clinical staff in addition to hospital administrators
- In the longer term following up people who leave training, following up the careers of those who have complained and listening to their stories.
- Must be some communication or agreement between College and employers to allow the College to be represented in investigations or be aware of complaints. Change to the conditions of a fellowship should be introduced if someone is found guilty and mandatory retraining required. Surgeons cannot afford to lose their fellowship and the College should leverage that in bringing an end to this behaviour.

4. Complaints

c. Response to complaints

i. How effectively do organisations use the powers they have to try and sanction behaviour

- These questions have been addressed in Sections 1a.iii and 1b.i.
- Employees are often not adequately trained in performance management with little guidance as to how to have "difficult conversations".
- Often there is a reticence to report the actions of a colleague who may have been a clinical mentor for some time. This action could be seen as wanting to impugn the reputation of a friend and it is frowned upon by the profession.
- Institutions have policies in place but these are not viewed as being in touch with a clinical environment and more an administrative necessity, are not frequently utilised and not perceived as a channel for sanctioning behaviour and contributing to long term behaviour change.

li/iii. Do existing, complaints management and appeals processes allow for fair and equitable treatment?

By definition, most complaints are between parties who are not equal in the hierarchy and it is the challenge for organisations to treat them as equal. But even if this can be achieved within the hospital context when extrapolated to the college context it is almost impossible to equalise the status of parties. The registrar training program means the trainee always has a reputational vulnerability which will almost certainly be impacted irrespective of the outcome.

Fair & equitable management (to both parties) of a complaint requires a process with adherence to sound justice principles such as the right to be heard and natural justice.

iv/v/vi. Is there enough transparency when sanction are imposed? How effectively are these sanction follow up? What do you think would be effective in generating lasting behaviour change in terms of sanction imposed?

These questions have been addressed in sections 1 a. iii and iv and section 2 a. i.

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