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ASMOF Sexual Harassment and Gender Equity Survey:

Doctors-in-Training Report

Introduction

In February 2019 ASMOF conducted an online survey of members in NSW on *Sexual Harassment and Gender Equity in Medicine*. This survey was intended to inform our submission to the Australian Human Rights Commission's Inquiry into Sexual Harassment in the workplace, as well as to guide ASMOF's ongoing advocacy to improve workplace conditions for our members. The survey was focused on doctors' views and suggestions for how their workplace could be improved to address sexual harassment and better promote gender equity.

70 Doctors-in-Training (DiTs) responded to the survey, representing 23% of total survey respondents. Most DiTs who responded to the survey were female (54 respondents), 14 were male and 2 self-described their gender.

This report explores DiT specific findings and views on improving responses to sexual harassment and gender inequity. Where relevant, responses from DiTs are compared to those of the 170 senior doctors who completed the survey, the vast majority of whom were staff specialists (148).

Please note that due to small survey numbers this is a non-representative sample, and there is a likelihood of self-selection bias. Survey results, including quantitative results relating to prevalence and nature of sexual harassment, should therefore be interpreted with caution.

Despite the limitations in the data, the results of ASMOF's survey provide insights into DiT experiences and indicate areas worthy of further exploration and discussion.

The results indicate that DiTs may be particularly vulnerable to sexual harassment in the workplace, and face significant challenges in addressing sexual harassment. Addressing the safety of DiTs must be a priority in efforts to reduce sexual harassment.

Additionally, most DiTs do not believe their workplace champions gender equity, and could be doing much more to support them in balancing their paid work and training requirements with caring responsibilities. DiTs have made a range of suggestions for how this situation could be improve, primarily through:

- Greater access to flexible training and work;
- strong leadership including more women in leadership positions; and
- better parental leave provisions.

1. Sexual Harassment

Prevalence

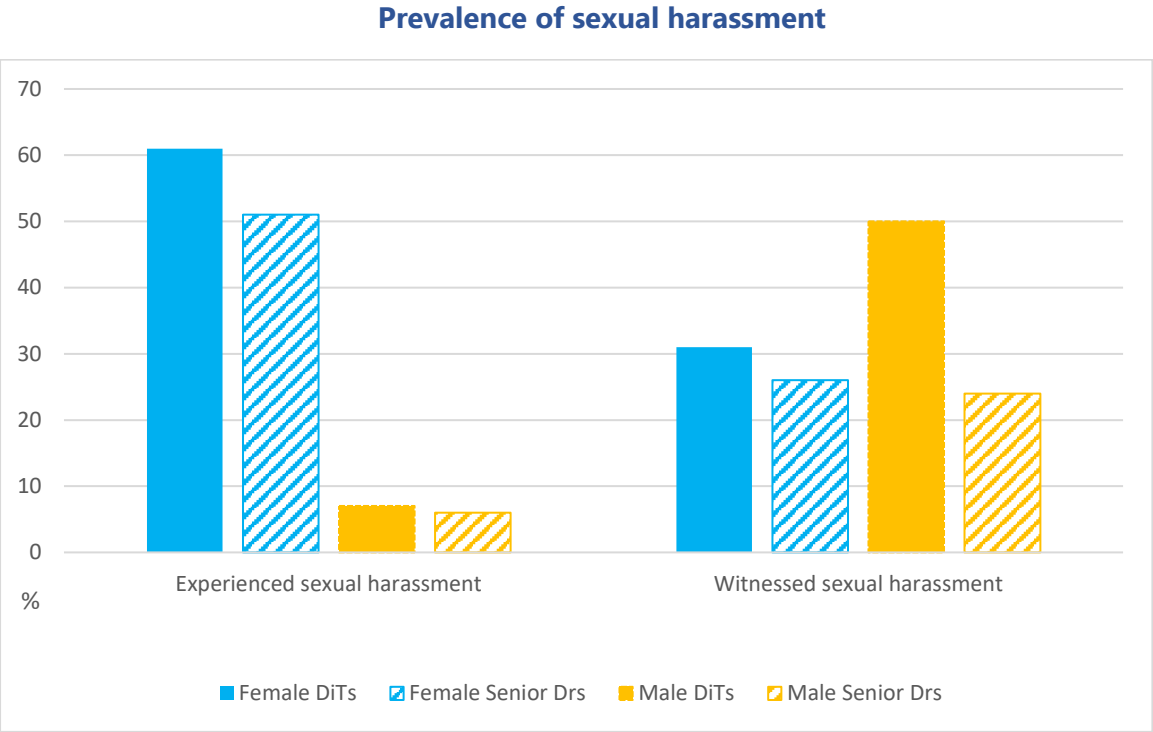
Sexual harassment can be defined as:

> 'any unwanted or unwelcome sexual behaviour, which makes a person feel offended, humiliated or intimidated. Sexual harassment is not interaction, flirtation or friendship which is mutual or consensual.' (Australian Human Rights Commission)

ASMOF findings affirm that sexual harassment is far too commonly experienced by doctors. The majority of female DiTs who responded to the survey reported that they were sexual harassment in their workplace (61%), and almost a third of female DiTs had witnessed sexual harassment occurring.

A small proportion of male DiTs reported that they had been sexually harassed, however half had witnessed it occurring in their workplace.

These figures are higher than those of senior doctors as reflected in the table below. Half of senior female doctors reported that they had been sexually harassed, and a quarter of senior doctors had witnessed harassment occurring.



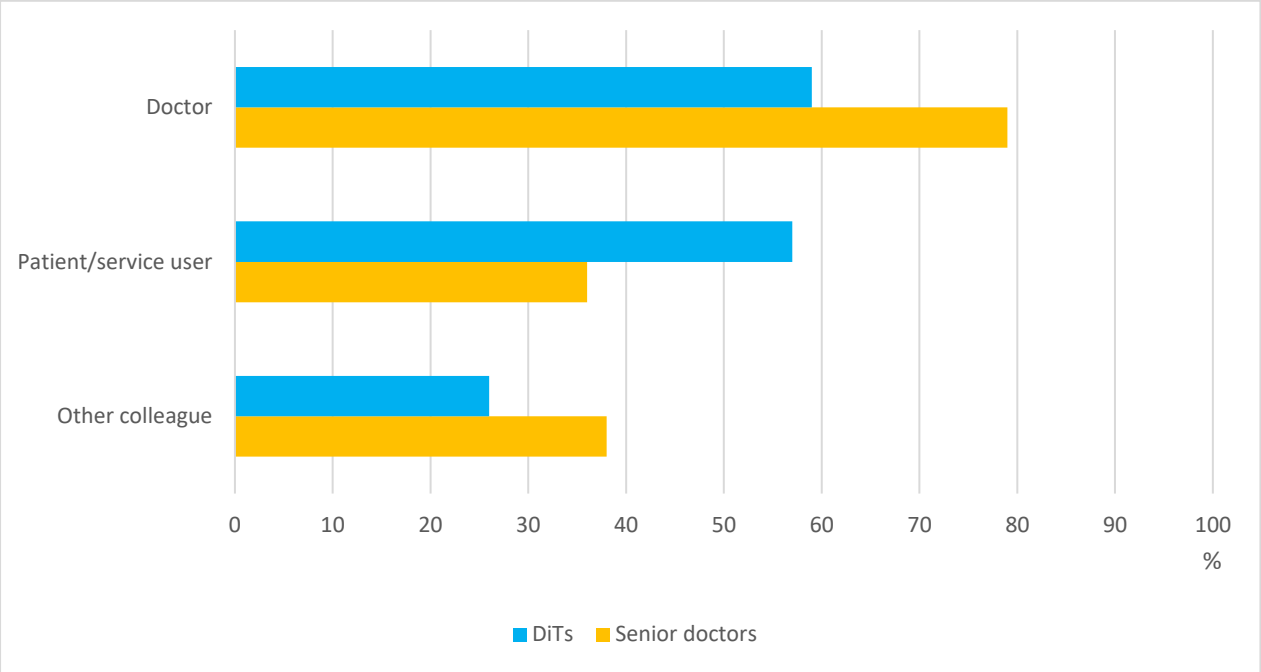
The increased risks to DiTs was a consistent theme throughout the survey data, and was identified as a concern by both senior doctors as well as DiTs themselves.

Perpetrators of harassment

Overall, doctors most commonly reported that the perpetrator of sexual harassment (that they experienced themselves and/or witnessed) were fellow doctors (70%). However a significant proportion identified a patient or service user as perpetrating sexual harassment, and a further third identified another colleague as a perpetrator.

DiTs were much more likely than senior doctors to report that patients and service users had perpetrated harassment, and identified them as being responsible for sexual harassment almost equally to their fellow doctors:

Perpetrators of sexual harassment in doctors' workplaces

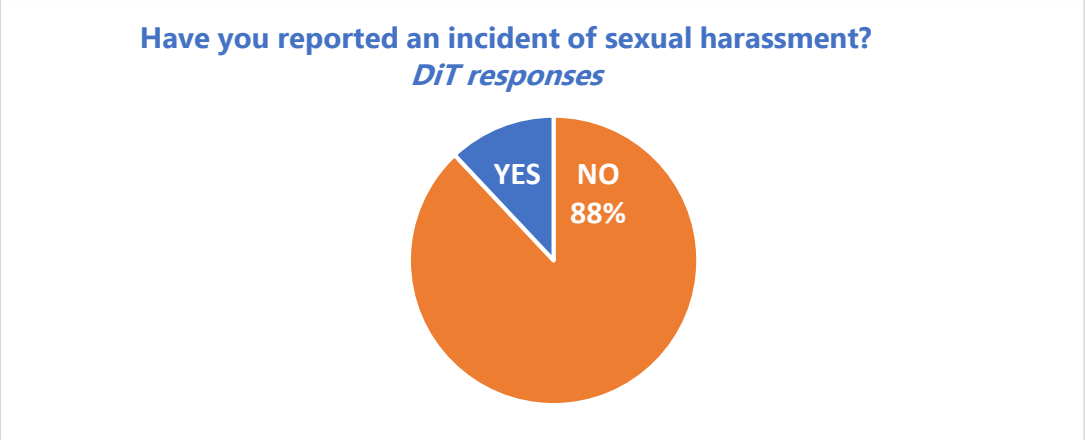


This highlights the need for responses to adequately address both peer to peer and third party sexual harassment in health services.

Reporting and complaints

The internal and external processes around reporting sexual harassment and outcomes for doctors are of a significant concern for ASMOF. Previous research has indicated that there are a wide range of barriers to doctors reporting sexual harassment. The Australian Human Rights Commission has noted that recipients of harassment may downplay harassment and feel that their experience was not serious enough to complain about. Barriers typically experienced by doctors include fear of affecting career options, loss of reputation, and the stress associated with formal complaints and investigation.[i]

ASMOF's survey found that the vast majority of DiTs who had experienced sexual harassment did not report it.



Similarly, only 4% of DiTs who witnessed sexual harassment stated that they reported the incident.

Doctors comments in ASMOF's survey highlight the power dynamics at play in the health workplace and the fear surrounding reporting. A theme which was frequently raised by doctors was the impact reporting could have on doctor's careers and many of the comments confirmed that this particularly affect DiTS, who are at the early stages of their career, and are heavily dependent on their supervisors to progress their careers.

'most won't report because the ones doing it are high up and more powerful'

'My harassment occurred as an RMO [Resident Medical Officer], which is a very vulnerable position as you rely on supervisors reports to progress and also have to work in the department.'

'let's face it- there is usually a power imbalance directed to a younger and professionally more vulnerable person wrt [with regards to] harassment.'

'Sexual harassment and bullying is not taken seriously by the hospital as they know JMOs will be rotating out reasonably quickly, which solves the problem from the hospital admin perspective.'

'More complaints may be forthcoming if no consequences truly came with reporting (ie no career or reputational loss could be guaranteed for the complainant)'

'Create a culture where trainees don't fear for their careers if they speak up'

'The problem is that it's often supervisors and thus there is implications for progression if

For those DiTs who did report an incident of sexual harassment – only one reported that they were 'partially' satisfied and the rest of the responses were negative.

'My DPET + head of department blamed my work performance and told me the harassment was due to my "passive" personality'

These findings are supported by Llewellyn et. al's analysis of bullying and sexual harassment amongst junior doctors found that complaints were often dismissed, behaviours were blamed on the sensitivity of the complainant, and/or senior medical staff member took not action after the complaint was made.[ii] Junior doctors were deterred by these experiences, and from reporting incidents of bullying or harassment again in the future.

Managing harassment from patients when doctors have a duty to provide health care was also perceived as challenging, and an area in which DiTs may feel powerless.

> 'supposed to be reported to line managers but if a patient assaults you in clinic, what are they really going to do.'

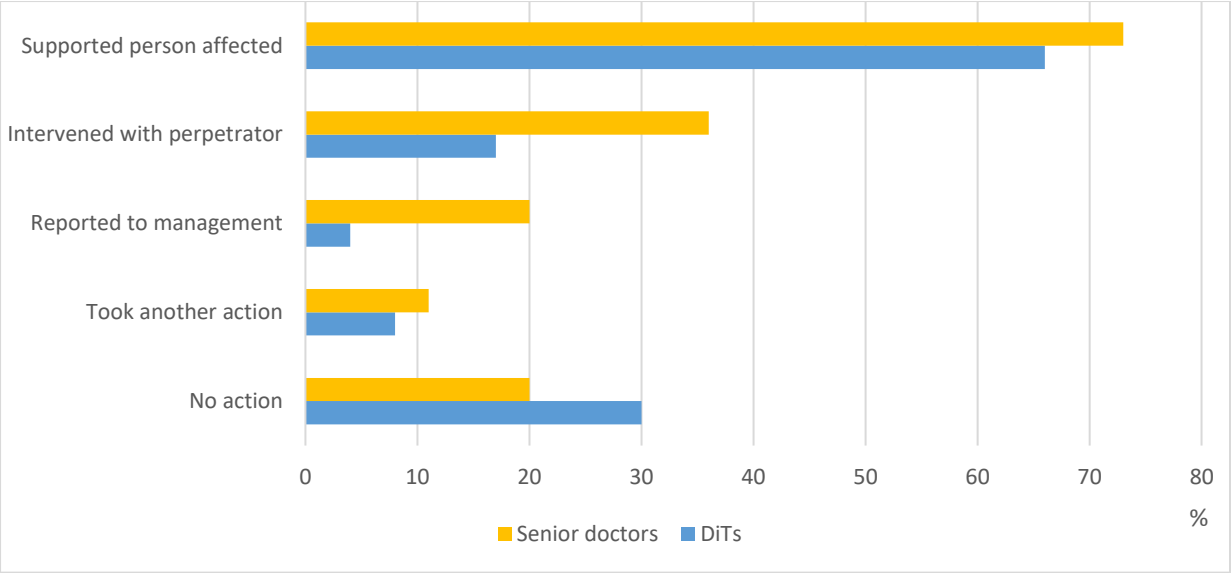
Bystander actions

The Commission's research has found that 40% of workplace sexual harassment incidents were witnessed by someone else, and these witnesses will typically not intervene.

ASMOF's survey with NSW members found that doctors who reported that they had witnessed sexual harassment often do take some form of action, typically by providing support to the person affected. The next most common action was direct intervention with the perpetrator, with just over a quarter of doctors taking this action. However it appears that DiTs may be less likely than senior doctors to have taken these actions when they have witnessed sexual harassment.

More than half of DiTs who witnessed sexual harassment provided support to the person affected (66%). DiTs who witnessed sexual harassment were less likely than other doctors to directly intervene with the perpetrator. Slightly less than a third of respondents (31%) did not take any action.

Actions taken by doctors who witnessed sexual harassment



The same factors which contribute to low levels of reporting may also influence DiTs responses when witnessing sexual harassment.

Culture of medicine

Commentators have noted that medical environment carries particular risks due to a hierarchical structure, male dominance in senior positions, and a system of training which leaves junior doctors dependent on powerful senior colleagues to progress their career.[iii]

Whilst there are a variety of workplace cultures across Australia, this structure continues to reproduce power imbalances which sees DiTs at particularly at risk due to their employment on fixed term contracts, frequent rotation, and a fiercely competitive environment in which trainee positions are highly sought after.

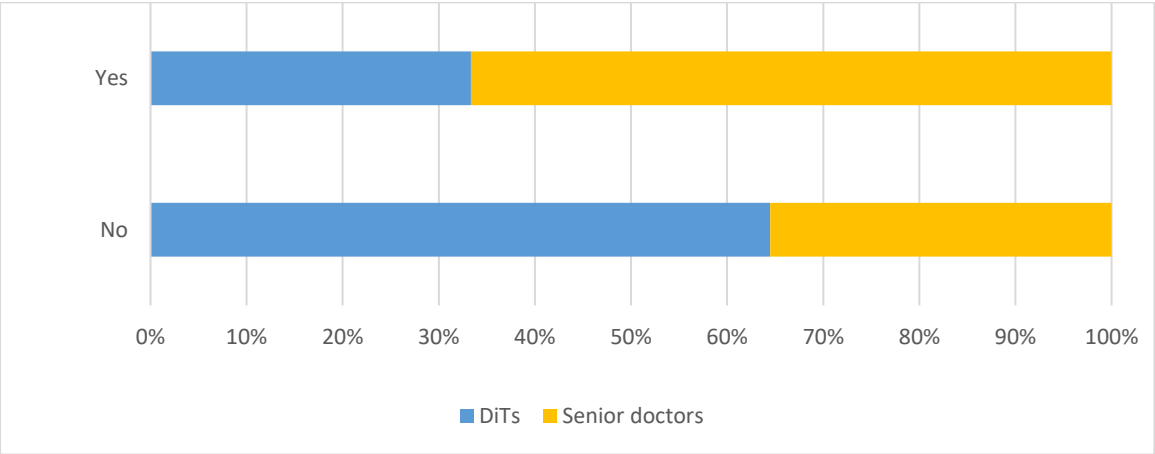
Comments from doctors indicate that in many workplaces, a cultural shift will be required to reduce the incidence of sexual harassment.

> 'It is still a problem. I have been a doctor for over 25 years and while things are better for my young colleagues than they were for me it is unacceptable that this still happens.'
>
> 'Change the whole culture to respect doctors, particularly respect female and junior doctors'
>
> 'Medicine is behind the eight ball with these 2 issues [sexual harassment and gender equity] and it is present to a significant level in this workplace. This needs to change'

Employer initiatives

ASMOF asked doctors in NSW whether they were aware of initiatives or policies in their workplace which address sexual harassment. As the graph below indicates, DiTs were significantly less likely than senior doctors to know about initiatives or policies in their workplace addressing sexual harassment, with the majority (69%) being unaware of such policies.

Q. Are you aware of initiatives or policies in your workplace/s which address sexual harassment?



Respondents most commonly stated that they were aware that there was a policy generally rather than providing details, and respondents referred to policy rather than initiatives.

Improving workplace responses

DiTs shared a range of suggestions for how sexual harassment could be better addressed in the workplace.

Policy and Education

Typically DiTs wanted more awareness, knowledge and information as to what sexual harassment is, and how to address sexual harassment. DiTs identified that strong policies were needed to address sexual harassment. Some doctors articulated that these be 'no tolerance' or 'zero tolerance' policies which were clear that sexual harassment was prohibited.

> 'Empowering JMOs with knowledge about how to speak up and approach this'.
>
> 'As a junior doctor was never informed for the line re: sexual harassment from a patient and what to do.'
>
> 'Have a visible code of conduct of what constitutes inappropriate behaviour e.g. the definition like at the beginning of this survey'
>
> 'Ensure good understanding of what sexual harassment is, what expectations are, and what avenues for reporting are in place as well as consequences.'
>
> 'Workshop explaining specifically how to lodge a complaint and how outcomes will be transparent. Providing strategies to doctors of all genders on how to address sexual harassment from colleagues and patients.'
>
> 'Have a clear policy of zero tolerance and consequences explained, all discussed at orientation'

Reporting

DiTs also wanted improved internal reporting pathways which are clear and known to staff, confidential and independent from their career progression. Some DiTs believed there should be an option for anonymous reporting.

> 'Actually protect the complainants confidentiality.'
>
> 'There needs to be an independent third party to deal with JMO concerns and a mandatory reporting system in place for those who harass or bully'
>
> 'We need someone else to act as an advocate on our behalf, our progression is too closely related to the perpetrators. This the incentive to stay silent is too great.'
>
> 'make line of report clearer provide objective members of staff who are not involved in employment process.'
>
> 'Anonymous reporting. The problem is that it's often supervisors and thus there is is implications for progression if you speak up.'
>
> 'A person to report the incident to who is not directly supervising you'
>
> 'Have a confidential hotline'

Management of perpetrators

Another consistent theme that emerged from responses was that there should be consequences for perpetrators of sexual harassment, regardless of whether they were senior staff or patients.

> ‘Actual consequences for those who sexually harass staff, regardless of the 'rank' of those involved.’
>
> ‘making sure offenders get appropriate sanctions’
>
> ‘Actively enforce a high consequence no tolerance policy, particularly with senior members of staff’
>
> ‘Openly discipline those who have been convicted, i.e. greater credibility given to repercussions.’
>
> ‘Take punitive actions against offenders. Set the example, make it known that it will not be tolerated.’
>
> ‘Patients are threatened with not being able to continue care if they harass staff, but this is not actually what happens. Perhaps legal action (i.e. police) against abusive patients? I've seen many patients expose themselves to nurses, or say lewd things, and still have to receive care.’
>
> ‘Need to take firm stance , as these would be criminal offence if occur in community and perpetrator not as a patient.’
>
> ‘more transparency regarding outcomes for perpetrators’
>
> ‘Repercussions for perpetrators, regular meetings with managers to address behaviour’

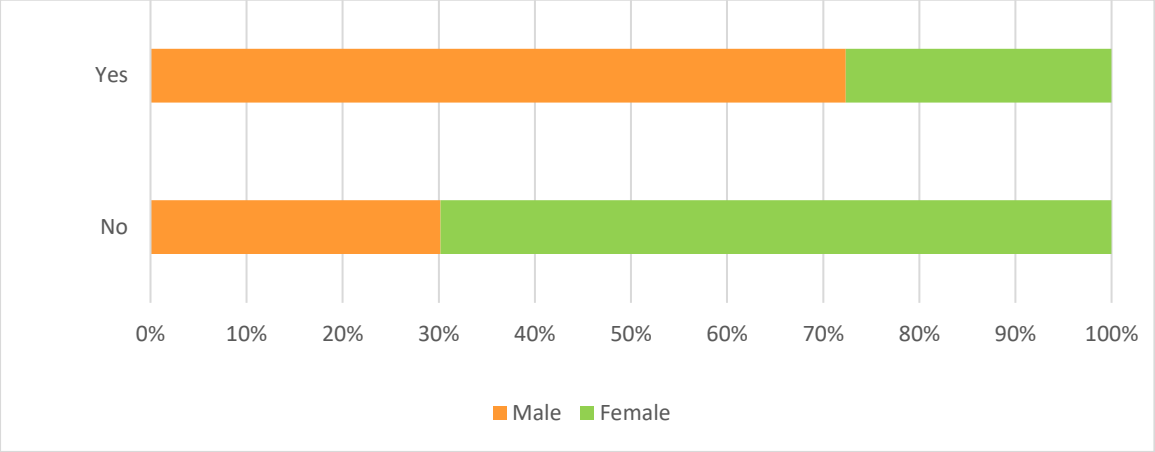
Cultural change

DiTs also referred to the need for broader cultural change in order to prevent sexual harassment from occurring.

> ‘much of it is engrained sexist culture and difficult to tackle’
>
> ‘changing the culture surrounding women in the medical workforce.’
>
> ‘change the culture in medicine and society make it acceptable to talk about’

2. Gender equity

ASMOF also surveyed doctors on gender equity more broadly in their workplace. ASMOF asked respondents if they believed that their employer actively promoted gender equity. Female doctors (both DiTs and Seniors) were far more likely to report that their employer did not support gender equity:



Survey responses on gender equity reveal that sex-based discrimination continues to occur, and that there are significant challenges for doctors in balancing their work with parenting and caring responsibilities which must be urgently addressed.

> 'Very male dominant department and female trainees often belittled and not given the same training opportunities. They are given leeway in terms of having children but are punished for the privilege by not getting the same opportunities and expected to be grateful'
>
> 'Change is happening too slowly. Too much lip service. Not enough action. Tired of the excuses.'

ASMOF also asked doctors what their employer could to improve gender equity.

Flexibility & part-time work

Almost half (47%) of DiTs who suggested improvements in their workplace mentioned flexibility in their response. This most commonly referred to the need for greater flexibility in training, as well as the capacity to do part-time hours.

'yes to flexible training schemes (eg part time training), such as enforcing mandatory number of trainee positions be part time. Individuals find it extremely hard to negotiate flexible or part time hours as that's seen as a "cop out".'

'Much much more flexible training. Certain areas (e.g. most of critical care specialties) lend themselves very well to flexible hours / part-time hours, but last year of all the anaesthetics / ICU registrar positions advertised in NSW only 2 said they would consider part-time hours (not saying other positions wouldn't / didn't, but only 2 clearly stated in the position description that they would consider applications for less than full-time applications). And if you want to work part-time you are often limited in that you are almost expected to find the person to fill the other half of your job (which is great if you have a friend who also wants to work part time in the same role at the same hospital - but most of us don't have that friend!) '

'Flexible training for both men and women so both can participate in parenting and caring roles outside of work. '

'Option of paid paternity leave and part time work for men as well as maternity leave and part time work for women.'

'Easier access to job share arrangements for men and women. Clearly stating that such flexible arrangements will not adversely affect progression through training I.e. Opportunities at next recruitment round .'

'Flexibility in job sharing and actively encouraging this'

Leadership

A quarter of DiTs referred to leadership in their responses, most commonly that there should be more women in leadership positions. Some DiTs drew attention to the importance of all leaders supporting equity.

'I feel with good leadership and setting an example of what is acceptable the culture of medicine can change.'

'More females in leadership positions, female mentors'

'Interviews/ position descriptions for senior positions should include and awareness of equity issues and how they would address them.'

'Actively train female doctors to make successful applications for jobs in leadership positions.'

'just seeing more women in mgmt / leadership roles within the hospital would be helpful - when you don't see anyone like you in senior roles it becomes hard to see that you can ever get there.'

'More females in positions of seniority..once the management is a little more equal the rest will likely follow'

'Sponsorship or awards for leaders promoting gender equity.'

Parental Leave

Another concern identified by DiTs was access to parental leave, with respondents keen to ensure that men were able to access adequate leave to share parenting duties with their partner.

> 'Giving men same amount of paternity leave.'
>
> 'Longer paternity leave is important, including to address barriers to women entering certain specialities - in dual doctor families, it's necessitated the female takes an extended break from training, whilst there is no opportunity for the male to take more than 2 weeks (!) after the baby is born to assist, be a parent, etc.'
>
> 'Give equal duration paternity leave at least 10 weeks so that male employees have an opportunity to become fathers and so that young men and young women represent equal financial risks with respect to child bearing… Equality in the workplace will never exist until men are forced to assume equality at home.'
>
> 'Equal parental leave no matter of gender of the primary care giver.'
>
> 'All departments in the hospital system should contribute to the total cost of parental leave for the hospital. That way employing predominantly male trainees would not give departments financial benefit.'

[i] Best Practice Australia (2015) 'Bullying and Sexual Harassment Prevalence Survey: Summary of Facts', Research commissioned by: The Expert Advisory Group Advising the Royal Australasian College of Surgeons, available at https://www.surgeons.org/media/22045682/PrevalenceSurvey_Summary-of-Facts_FINAL.pdf.
[ii] Llewellyn A, Karageorge A, Nash L, Li Wg, Neuen D (2018) Bullying and sexual harassment of junior doctors in New South Wales, Australia: rate and reporting outcomes. Australian Health Review.
[iii] Mathews B and Bismark , 'Sexual harassment in the medical profession: legal and ethical responsibilities' Med J Aust 2015; 203 (4): 189-192. || doi: 10.5694/mja15.00336