

Chapter 3

Bullying and harassment in the medical profession

3.1 While the focus of this inquiry was on the use of the medical complaints process as a tool of bullying and harassment within the medical profession, the committee also received a large number of submissions outlining broader concerns with the prevalence of bullying and harassment in Australia's medical profession. As discussed in the first chapter, this level of bullying and harassment presents a considerable risk to members of the health care sector, but also to the Australian public as a whole, and for that reason the committee is concerned by the evidence it has received.

3.2 This chapter discusses not just the prevalence and forms of bullying and harassment evident in the medical profession, but the real and perceived barriers to reporting these behaviours. It also examines responses to address bullying and harassment from the medical sector, including medical boards, government, colleges and hospitals. These responses emphasise the need for a cross-sector, coordinated approach to addressing these issues.

Prevalence of bullying and harassment

3.3 In their submissions to this inquiry, medical administrators and colleges emphasised that they take a 'zero-tolerance' approach to all forms of bullying and harassment.¹ However, as recent research has demonstrated, and as was further illustrated by evidence submitted to this inquiry, bullying and harassment remains prevalent within the medical profession.

3.4 Within the profession itself, there is general recognition that bullying and harassment is a significant problem. For example, the AMA acknowledges that recent reports indicate:

... the hierarchical nature of medicine, gender and cultural stereotypes, power imbalance inherent in medical training, and the competitive nature of practice and training has engendered a culture of bullying and harassment that has, over time, become pervasive and institutionalised in some areas of medicine.²

3.5 Mr John Biviano of the Royal Australasian College of Surgeons (RACS) made a similar point:

1 See, for example: Australasian College for Emergency Medicine, *Submission 4*, p. 1; Australian and New Zealand College of Anaesthetists, *Submission 5*, p. 2; Royal Australasian College of Medical Administrators, *Submission 18*, pp 1–2; Royal Australian and New Zealand College of Psychiatrists, *Submission 19*, p. 1; Royal Australian and New Zealand College of Radiologists, *Submission 20*, p. 1.

2 Australian Medical Association (AMA), *Submission 9*, p. 1.

The college, or RACS as it is typically known, acknowledges that there is no doubt that bullying and harassment occurs in the surgical workplace and takes very seriously the subject of this inquiry.³

3.6 Dr Catherine Yelland of the Royal Australasian College of Physicians (RACP) concurred, noting that:

We regard bullying and harassment as unacceptable, and the college has no tolerance of these behaviours.

[...]

There is significant evidence in Australia and overseas that bullying and harassment are a problem across all healthcare professions. We can provide more detail if required. We regularly survey trainees, seeking feedback on the quality of their training, supervision and support. We may include questions on bullying and harassment in the future.⁴

3.7 The Royal Australasian College of Medical Administrators' Professor Gavin Frost likewise expressed concern about the prevalence of bullying and harassment and reiterated the College's policies against such behaviours:

As with my colleagues, our college has zero tolerance for harassment and bullying of any kind and our policies and procedures clearly set that out.⁵

3.8 The peak representative group for doctors, the Australian Medical Association, argued that:

... all doctors have the right to train and practice in a safe workplace free from bullying and harassment and [the AMA] holds a zero tolerance approach to all forms of bullying.⁶

3.9 Despite the consensus that bullying and harassment is unacceptable, there is concern that the actual prevalence of such behaviour is unknown or underreported. The Australian Nursing and Midwifery Federation (ANMF), for instance, noted that it is difficult to quantify the prevalence of bullying and harassment in the nursing and midwifery profession due to a lack of national data. However, the ANMF referred to recent research and submissions from organisations within the nursing and midwifery profession that all indicated 'significant levels' of bullying and harassment.⁷

3.10 The committee particularly notes the 2015 report by the Expert Advisory Group to the Royal Australasian College of Surgeons (RACS), which highlights the wide-reaching prevalence and negative impacts of bullying and harassment in the

3 Mr John Biviano, Director, Fellowship and Standards, Royal Australasian College of Surgeons, *Committee Hansard*, 1 November 2016, p. 41.

4 Dr Catherine Yelland, President, Royal Australasian College of Physicians, *Committee Hansard*, 1 November 2016, p. 42, 43.

5 Professor Gavin Frost, Dean of Fellowship Education, Royal Australasian College of Medical Administrators, *Committee Hansard*, 1 November 2016, p. 43.

6 Australian Medical Association (AMA), *Submission 9*, p. 1.

7 Australian Nursing and Midwifery Federation, *Submission 99*, p. 2.

surgical profession. The key findings of this report are referenced throughout this chapter and summarised in **Box 3.1**.

Box 3.1 – Royal Australasian College of Surgeons – Expert Advisory Group on discrimination, bullying and sexual harassment

In March 2015, the Royal Australasian College of Surgeons (RACS) established an Expert Advisory Group to investigate the prevalence of discrimination, bullying and harassment within the surgical profession. The EAG consultations included over 3,500 participants including fellows, trainees and international medical graduates, as well as over 100 hospitals.

Key findings of the Expert Advisory Group's final report to RACS include:

- **49 per cent** of fellows, trainees and international medical graduates report being subjected to discrimination, bullying or sexual harassment;
- **54 per cent** of trainees and 45 per cent of fellows less than 10 years post-fellowship report being subjected to bullying;
- **71 per cent** of hospitals reported discrimination, bullying or sexual harassment in their hospital in the last five years, with bullying the most frequently reported issue;
- **39 per cent** of fellows, trainees and international medical graduates report bullying, **18 per cent** report discrimination, **19 per cent** report workplace harassment and **7 per cent** sexual harassment;
- the problems exist across all surgical specialties; and
- senior surgeons and surgical consultants are reported as the primary source of these problems.

Source: Royal Australasian College of Surgeons, *Submission 113*, p. 2.

Definitions

3.11 For the purpose of this inquiry, the committee refers to bullying and harassment as defined by the RACS Expert Advisory Group.⁸ **Box 3.2** outlines these key definitions.

8 These definitions are also used by the AMA in its position statement on bullying and harassment. See: Australian Medical Association, *Position Statement – Workplace Bullying and Harassment*, 3 December 2015, <https://ama.com.au/position-statement/workplace-bullying-and-harassment> (accessed 9 November 2016).

Box 3.2 – Definitions of bullying and harassment**Bullying**

Bullying is unreasonable and inappropriate behaviour that creates a risk to health and safety. It is behaviour that is repeated over time or occurs as part of a pattern of behaviour. Such behaviour intimidates, offends, degrades, insults or humiliates. It can include psychological, social, and physical bullying.

Harassment

Harassment is unwanted, unwelcome or uninvited behaviour that makes a person feel humiliated, intimidated or offended. Harassment can include racial hatred and vilification, be related to a disability, or the victimisation of a person who has made a complaint.

Source: Expert Advisory Group on discrimination, bullying and sexual harassment, *Report to the Royal Australasian College of Surgeons*, 28 September 2015, Appendix 1, p. 19, <http://www.surgeons.org/about-respect/what-we-have-done/building-respect.-improving-patient-safety/expert-advisory-group/> (accessed 9 November 2016).

3.12 Anecdotal evidence from submitters and witnesses to this inquiry supports the findings of the Expert Advisory Group report that bullying and harassment is a significant problem in the medical profession, across a range of specialities.

3.13 In many instances, this can be seen as a cultural problem within the profession; the committee notes considerable evidence suggesting that particular groups – including medical students and junior doctors, women and doctors of Indigenous or non-English speaking backgrounds – are more likely to be the subject of bullying and harassment.

3.14 Examples of the different types of bullying and harassment raised by submitters and witnesses are outlined below.

Medical and nursing students and trainees

3.15 The committee heard that many medical and nursing students and trainees experience a particular form of bullying and harassment during training. Submitters described either being a trainee or observing a trainee being bullied and harassed during clinical placements. In some instances, this resulted in the trainee either:

- being failed in assessments;
- transferring mid-placement to another hospital and thus delaying completion of their placement; or
- quitting their specialist training programs.

3.16 The Australian Medical Students' Association (AMSA) noted that bullying and harassment is widespread in medical education and includes 'teaching by humiliation' as well as 'derogatory remarks, inappropriate humour, ignoring students and setting impossible tasks or deadlines'.⁹

9 Australian Medical Students' Association (AMSA), *Submission 10*, p. 2.

3.17 AMSA drew the committee's attention to a recent study of medical students in Sydney and Melbourne published in the *Medical Journal of Australia* that indicated that 74.0 per cent of medical students had experienced teaching by humiliation, and 83.6 per cent had witnessed it.¹⁰

3.18 Some confidential submitters to this inquiry particularly noted that, as trainees or junior doctors, they had particular concerns about making a complaint about this bullying since it would have a negative impact on their future career. This issue will be further discussed below as a barrier to reporting bullying and harassment.

Sexual harassment and discrimination

3.19 The committee is concerned by the reported prevalence of sexual harassment in the medical profession, perpetrated particularly against female doctors, students and trainees. **Box 3.3** outlines the definition of sexual harassment defined by RACS.

Box 3.3 – Sexual harassment

Sexual harassment is defined as unwelcome sexual advances, request for sexual favours and other unwelcome conduct of a sexual nature, by which a reasonable person would be offended, humiliated or intimidated. Sexual harassment may include, but is not limited to: leering; displays of sexually suggestive pictures, videos, audio tapes, emails & blogs, etc., books or objects; 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.

Source: Expert Advisory Group on discrimination, bullying and sexual harassment, *Report to the Royal Australasian College of Surgeons*, 28 September 2015, Appendix 1, p. 19, <http://www.surgeons.org/about-respect/what-we-have-done/building-respect,-improving-patient-safety/expert-advisory-group/> (accessed 9 November 2016).

3.20 Miss Elise Buisson, President of AMSA, described to the committee one example of sexual harassment experienced by female medical trainees:

...a student reported to me that they were sitting in surgical grand rounds, so that is when all the surgeons in the hospital come together and have an educational meeting. Someone presents some research to them. A trainee doctor stood up, gave an absolutely outstanding presentation—they had put a lot of work into it—and a quite established male surgeon was very loudly interrupting her as she went on, saying, 'My, my, my! Haven't they let you out of the kitchen a lot this month!' and various other statements about her being female ... He laughed, and everyone laughed, and the head of surgery at a medical school in that city was sitting in the room and did nothing, as did everybody else.¹¹

10 Scott K, Caldwell P, Barnes E, Barrett J, "'Teaching by humiliation' and mistreatment of medical students in clinical rotations: a pilot study', *Medical Journal of Australia*, vol. 203, no. 4, 17 August 2016. See: AMSA, *Submission 10*, p. 3.

11 Miss Elise Buisson, President, Australian Medical Students' Association, *Committee Hansard*, 1 November 2016, pp 25–26.

3.21 AMSA drew the committee's attention to a recent survey by the Australian Medical Association Western Australia which found that sexual harassment is 'endemic' across WA Health and Medicine. The survey found that 31 per cent of the 950 respondents had experienced sexual harassment in the workplace, including whilst applying for a job or training program. Of those reporting sexual harassment, 81 per cent were women.¹²

Racial discrimination

3.22 Alongside sexual harassment and discrimination, recent reports have suggested that racial discrimination remains a problem in the medical profession.

3.23 The committee heard that Aboriginal and Torres Strait Islander doctors and students experience racial discrimination as part of their training and practice.

3.24 The Australian Indigenous Doctors' Association (AIDA) told the committee that results of a recent survey, *Bullying, Racism and Lateral Violence in the workplace*, indicated almost all members reported having witnessed bullying in their workplace, and over half reported having witnessed racism at least once a week.¹³ Examples of racism included:

... doubting members' status as Aboriginal and Torres Strait Islander, experiences of 'unrelenting and systematic bullying', being belittled and shamed, and verbal racist abuse'.¹⁴

3.25 AIDA submitted that bullying and harassment 'often in the form of racist remarks or behaviour', together with inadequate reporting mechanisms:

... create a culturally unsafe work environment, lacking in respect and support, and create a barrier for Indigenous medical students and doctors to pursue and persist on their medical career.¹⁵

3.26 The Expert Advisory Group final report to RACS found that 27 per cent of international medical graduates reported either racial or sexual discrimination.¹⁶

3.27 In its 2012 inquiry into registration processes and support for overseas trained doctors, the House of Representatives Standing Committee on Health and Ageing heard that international medical graduates reported bullying and harassment as they

12 See: Australia Medical Association WA, 'Shattering the silence', *Medicus*, 18 April 2016, p. 22, <http://www.amawa.com.au/wp-content/uploads/2016/04/Cover-18-April-2016.pdf> (accessed 9 November 2016).

13 Dr Benjamin Armstrong, Board Director, Australian Indigenous Doctors' Association (AIDA), *Committee Hansard*, 1 November 2016, p. 31.

14 AIDA, *Submission 8*, p. 3.

15 AIDA, *Submission 8*, p. 1.

16 Expert Advisory Group on discrimination, bullying and sexual harassment, *Report to the Royal Australasian College of Surgeons*, 28 September 2015, p. 4, <https://www.surgeons.org/about-respect/what-we-have-done/building-respect,-improving-patient-safety/expert-advisory-group/> (accessed 7 November 2016).

worked through accreditation and registration.¹⁷ Its final report, *Lost in the Labyrinth*, recommended that:

... the Medical Board of Australia extend the obligations it applies to employers, supervisors and international medical graduates in its *Guidelines – Supervised practice for limited registration* to include a commitment to adhere to transparent processes and appropriate standards of professional behaviour that are in accordance with workplace bullying and harassment policies.¹⁸

3.28 As of November 2016, the government had not responded to this report.¹⁹

3.29 While it was not a major theme of this inquiry, several confidential submitters noted their own experiences of race-based bullying and harassment.

Media and social media

3.30 Following on from the use of the medical complaints process as a tool of bullying and harassment, as discussed in the previous chapter, some submitters noted that they had been subject to a further level of bullying and harassment when the details of complaints made against them were given to the media, or disseminated via social media.

3.31 Submitters state in these instances, the media often report false allegations, doing irreparable damage to their reputation. Others claim they have been cyberbullied through social media.

3.32 For example, Dr Gary Fettke explained to the committee that during his investigation by AHPRA, he became aware that the person who lodged the notification against him had also been posting what he characterised as 'defamatory material on a social media hate site'.²⁰

Patients and families

3.33 The committee received a small number of submissions from patients or their families who reported that they had been bullied and harassed by medical professionals. Most of these submitters have made complaints to AHPRA and were unsatisfied with AHPRA's response.

3.34 Submitters expressed concern that bullying and harassment between medical practitioners may impact on patients. For example, the Health Care Consumers Association expressed concern that:

17 House of Representatives Standing Committee on Health and Ageing, *Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors*, March 2012, p. 189.

18 House of Representatives Standing Committee on Health and Ageing, *Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors*, March 2012, p. 194.

19 *Notice Paper*, 21 November 2016, House of Representatives, p. 60.

20 Dr Gary Fettke, *Committee Hansard*, 1 November 2016, p. 19.

...a culture that accepts and condones bullying is not conducive to good patient care and must be addressed. Further, where a culture condones bullying in the staff, there is evidence that this can reduce empathy towards patients and can led [sic] to disrespect and bullying of patients.²¹

3.35 Several confidential submitters argued that the lack of focus on bullying's impact on patient safety means that there is not appropriate recognition of the problem or clear lines for patients and members of the public to report bullying and harassment by medical practitioners. These submitters expressed concern that their complaints were not taken seriously.

3.36 Some confidential submitters noted that questioning any aspect of their treatment resulted in bullying and harassment and in some cases this affected their ability to receive further treatment. Conversely, other patients discussed their problems receiving treatment because their doctor had their practice restricted because of a vexatious complaint.

Committee view

3.37 The committee expresses deep concern about the reported prevalence of bullying and harassment in the medical profession and reiterates that bullying and harassment in any workplace is unacceptable and must not be tolerated.

3.38 The committee notes that evidence from submissions supports recent research that highlights the prevalence of bullying and harassment across different specialities.

3.39 The committee recognises that bullying and harassment in the medical profession pose threats to public safety and patient wellbeing, and for that additional reason is particularly concerned by the prevalence of bullying and harassment in the medical profession.

Barriers to reporting bullying and harassment

3.40 Submitters and witnesses identified two key barriers to reporting bullying and harassment in the medical profession related to:

- lack of clarity and trust in the reporting process; and
- cultural issues within the medical profession.

Process issues

Clarity of existing reporting mechanisms

3.41 The committee heard that there is a lack of clarity and awareness in the medical profession of the appropriate mechanisms for reporting bullying and harassment. Submitters highlighted that processes for making complaints, or for subsequently addressing complaints, are not well understood. For example, the AMA noted in its submission that a 2014 survey of specialist trainees found that general

21 Health Care Consumers Association, *Submission 16*, p. 12.

awareness of bullying and harassment policies across all colleges is low, with only 30 per cent reporting that they are aware of these.²²

3.42 The committee notes that confusion about the complaints process was one of key findings of the Expert Advisory Group in its report to RACS, particularly:

... with a lack of coordination or clarity about where to lodge a complaint or how to raise an issue (between the College, employers and, for students, universities), if one were brave enough to do so.²³

3.43 Mr John Biviano from RACS told the committee the existing complaints mechanisms lack coordination across the sector:

... the oversight of health professions is complex and difficult to navigate. It involves medical colleges, health departments, hospitals and regulators, including the Medical Board of Australia and AHPRA. There is a clear lack of coordination between these bodies and fragmentation of the system.²⁴

Trust in existing complaints processes

3.44 Submitters expressed a lack of trust in the complaints system's ability to produce a fair outcome, suggesting that this may discourage victims from reporting bullying and harassment. For example, AIDA's survey of its membership found that the majority of members:

... reported that policies and procedures were in place at their workplace but stated that they did not believe that victims or perpetrators were adequately supported by the existing policies and procedures, suggesting a lack of confidence, particularly in complaints procedures and the actual application of existing policies.²⁵

3.45 Similarly, the Australian College of Emergency Medicine argued that:

... medical practitioners are less likely to make a report if they are not confident that the issue will be dealt with in a way that will bring about meaningful and positive outcomes, and/or if they believe that their day-to-day lives in the workplace will be impacted upon negatively as a result of making a report.²⁶

3.46 The Royal Australian and New Zealand College of Psychiatrists (RANZCP) also submitted that many workplaces that do not have appropriate processes for reporting bullying:

22 AMA, *Submission 9*, p. 2.

23 See: Expert Advisory Group on discrimination, bullying and sexual harassment, *Report to the Royal Australasian College of Surgeons*, 28 September 2015, p. 11, <https://www.surgeons.org/about-respect/what-we-have-done/building-respect,-improving-patient-safety/expert-advisory-group/> (accessed 7 November 2016).

24 Mr John Biviano, Director, Fellowship and Standards, Royal Australasian College of Surgeons, *Committee Hansard*, 1 November 2016, p. 42.

25 Australian Indigenous Doctors' Association, *Submission 8*, p. 3.

26 Australasian College of Emergency Medicine, *Submission 4*, p. 1.

... a key question is how the relevant workplace deals with bullying and harassment claims and how it conducts and resolves investigations into these claims. If appropriate and supportive mechanisms are not in place, this represents a clear barrier to medical practitioners reporting bullying and harassment.²⁷

3.47 The committee notes that the Expert Advisory Group to RACS also found:

... there is a lack of trust and confidence in the people handling complaints and the processes in place at the College and across the health sector. There is confusion about processes that are often legalistic and narrowly defined; and a demonstrable lack of consequences for perpetrators.²⁸

3.48 Despite the recent media and public attention on bullying and harassment within the medical profession, the committee notes that awareness amongst practitioners of the existing policies and procedures is not high. While it is evident that some work has been done to improve this, it is clear that this remains a problem requiring the attention of medical colleges, workplaces and medical schools.

Cultural issues

3.49 The committee was particularly concerned by evidence that suggests that the culture of the medical profession does not support the reporting of bullying and harassment.

Accepted culture of bullying

3.50 Submitters and witnesses suggested that in some sections of the medical profession, bullying is accepted as part of the workplace culture. For example, beyondblue submitted that recent research indicates that there is some concern that:

... there may be a "culture" that allows bullying and harassment to occur within the medical profession, and that this may be a transgenerational phenomenon ingrained in the profession.²⁹

3.51 The committee notes that submissions to this inquiry support the findings of the Expert Advisory Group's report to RACS which found that in relation to the surgical profession, 'bullying has become normalised as a culturally accepted behaviour' and issues of discrimination, bullying and sexual harassment are:

... enmeshed with questions about the culture of surgical practice, as well as the culture of medicine and the healthcare sector more widely.³⁰

27 RANCP, *Submission 19*, pp 1–2.

28 Expert Advisory Group on discrimination, bullying and sexual harassment, *Report to the Royal Australasian College of Surgeons*, 28 September 2015, p. 5, <http://www.surgeons.org/about-respect/what-we-have-done/building-respect,-improving-patient-safety/expert-advisory-group/> (accessed 9 November 2016).

29 Beyondblue, *Submission 11*, p. 17.

30 Expert Advisory Group on discrimination, bullying and sexual harassment, *Report to the Royal Australasian College of Surgeons*, 28 September 2015, p. 7.

3.52 The committee heard that the culture of bullying particularly affects medical students and trainees. AMSA highlighted that a recent study of mistreatment of medical students indicated that 50 per cent of students had come to believe that mistreatment is 'necessary and beneficial for learning'.³¹ Similar findings were reported by the Victorian Auditor-General, which noted a high degree of acceptance of bullying and harassment among junior doctors:

Such behaviour was explained as a 'training technique' that helped motivate them to work harder, or as unfortunate but an inevitable rite of passage and part of the 'old-school way'.³²

Fear of repercussions

3.53 One of the key barriers to reporting instances of bullying and harassment reported by submitters and witnesses was fear of negative repercussions from making a complaint. Many submitters were concerned that making a complaint against a senior colleague would adversely affect their future career. Others expressed a fear of reprisals against them for making a complaint at their workplace against a colleague. As discussed in chapter 2, confidential submitters who have suffered bullying or harassment are also concerned that the retaliation would take the form of a vexatious notification being lodged against them.

3.54 For example, Dr Artiene Tatian from AIDA told the committee that a survey of its members found that over half did not report bullying and harassment due to a fear of negative repercussions.³³ Dr Ben Armstrong from AIDA also told the committee that for the 40 per cent of members who had initiated some sort of complaint reconciliation, the vast majority were ignored or not actioned and 'they often had negative repercussions, which discouraged them from making further complaints'.³⁴

3.55 The committee heard that fear of negative repercussions are particularly acute among students and trainees who are concerned about the impact of making a complaint on their career progression. Miss Elise Buisson from AMSA told the committee, that often students are advised not to make reports, due to possible negative impacts on their careers:

Even very well-meaning clinicians or faculty members will advise you not to report certain things: 'Look, it's probably not that bad. If you are to do it, it's going to have a really negative effect on your career.' And if someone

31 Scott K, Caldwell P, Barnes E, Barrett J, "'Teaching by humiliation" and mistreatment of medical students in clinical rotations: a pilot study', *Medical Journal of Australia*, vol. 203, no. 4, 17 August 2016. See: AMSA, *Submission 10*, p. 3.

32 Victorian Auditor-General, *Bullying and Harassment in the Health Sector*, March 2016, p. 19, http://www.audit.vic.gov.au/reports_and_publications/latest_reports/2015-16/20160323-bullying.aspx (accessed 9 November 2016).

33 Dr Artiene Tatian, Board Director, AIDA, *Committee Hansard*, 1 November 2016, p. 33.

34 Dr Benjamin Armstrong, Board Director, AIDA, *Committee Hansard*, 1 November 2016, p. 33.

was to come to me and say, 'Should I report X', I would find it very difficult to know what is the best course of action for them.³⁵

3.56 Similarly, the Royal Australasian College of Medical Administrators argued that concern for career progression is the paramount reason why complaints about bullying and harassment are often not lodged:

The key barrier for medical practitioners taking action is the belief that it will adversely affect future career options. This is supported by the survey undertaken by RACMA in 2015 on bullying, harassment and discrimination and consultations with RACMA's membership. Additionally reasons cited are the perceived stress associated with filing a complaint and enduring an investigation, and the perception there is potential for victimisation as a result of raising the matter.³⁶

Silence of by-standers

3.57 The committee heard that the combination of process and cultural issues contributes to an environment where those by-standers who witness bullying and harassment are not supported to report the behaviour. The AMA submitted that there may be two different reasons why by-standers do not speak up when witnessing 'unacceptable behaviour', they may:

- not recognise the behaviour as discrimination, bullying or sexual harassment; or
- harbour distrust in the complaint mechanism – that the complaint will not be taken seriously, that someone else's word will be taken over theirs, that victimisation will ensue, or that it would ultimately not be in the best interests of the victim to raise it.³⁷

3.58 The 'silence of by-standers' was identified by the Expert Advisory Group to RACS as a 'critical issue', which:

... stems from fear of reprisal, fear of 'making it worse', concerns about their position or right to raise an issue given hierarchical structures and power differences; prominent people are perpetrators, bullies are seen as untouchable.³⁸

Gender inequality and cultural diversity

3.59 The committee also heard that gender inequality presents barriers for reporting bullying and harassment, particularly for women. The AMA pointed out that:

Gender inequity has a proven causal relationship with the incidence of discrimination, bullying and sexual harassment of women. It is important

35 Miss Elise Buisson, President, AMSA, *Committee Hansard*, 1 November 2016, p. 27.

36 Royal Australasian College of Medical Administrators, *Submission 18*, p. 2.

37 AMA, *Submission 9*, p. 3.

38 Expert Advisory Group on discrimination, bullying and sexual harassment, *Report to the Royal Australasian College of Surgeons*, 28 September 2015, p. 8.

that sexual harassment, discrimination and non-sexualised incivility is acknowledged as a manifestation of broader gender inequality.³⁹

3.60 The Expert Advisory Group also highlighted that lack of cultural diversity, together with gender inequality, contribute to a workplace culture that does not support the reporting of bullying and harassment:

Gender inequity and limited cultural diversity also featured as both cause and effect in relation to culture. Both were seen to enable the continuation of the dominant surgical culture and were a consequence of it.⁴⁰

Addressing bullying and harassment

3.61 Submitters and witnesses highlighted that addressing bullying and harassment in the medical profession will require a cross-sector approach, including government, medical boards, AHPRA, hospitals and speciality colleges. Some of the approaches to addressing bullying and harassment undertaken so far are outlined below.

Medical boards and AHPRA

3.62 Submitters highlighted that the formal medical complaints process administered by AHPRA and the Medical Board of Australia (MBA) and Nursing and Midwifery Board of Australia (NMBA) is just one mechanism for addressing bullying and harassment. As discussed in chapter 2, the key focus of the formal AHPRA complaints process is patient safety.

3.63 AHPRA, the MBA and the NMBA acknowledged that they have an important role to play in addressing bullying and harassment:

Bullying and harassment can be very damaging to the people who are subject to these behaviours and to the safety of patients. There is no place for these behaviours in the Australian medical, nursing, midwifery or registered health practitioner workforce. Through our role in the national regulation of health practitioners, we are committed to playing our part in supporting the health and well-being of medical practitioners, nurses and midwives and ending discrimination, bullying and harassment.⁴¹

3.64 However, the MBA, NMBA and AHPRA emphasised that:

Not all allegations of bullying and harassment that involve medical practitioners, nurses or midwives are appropriate for action by the MBA or NMBA as the threshold for regulatory action may not be met.⁴²

3.65 Dr Joanna Flynn, Chair of the MBA, told the committee that in most cases, AHPRA and the boards are not the most appropriate place to address discrimination, bullying and harassment:

39 AMA, *Submission 9*, p. 4.

40 Expert Advisory Group on discrimination, bullying and sexual harassment, *Report to the Royal Australasian College of Surgeons*, 28 September 2015, p. 8.

41 MBA, NMBA and AHPRA, *Submission 21*, p. 1.

42 MBA, NMBA and AHPRA, *Submission 21*, p. 4.

... the boards are not the appropriate first point of call for most matters in relation to bullying, which ought to be dealt with locally and investigated locally. Most problems should be solved close to the source of they can.⁴³

3.66 Dr Flynn emphasised that:

While the Medical Board and Nursing and Midwifery Board and AHPRA have important roles to play, the medical complaints process and our regulation of health practitioners will not, on its own, address bullying and harassment and deliver the change in culture that we seek. That is why we work in partnership with the professions, employers, colleges, health departments and other health complaints bodies to help end bullying and harassment.⁴⁴

3.67 Similarly, the ANMF commented that AHPRA:

... are unlikely to be able to deal with reporting of bullying in a useful manner, particularly in dealing with the underlying issues which are usually organisational, rather than individual. A report to AHPRA actually negates the occupational health and safety nature of bullying, and the need for a risk management approach to be implemented, as well as investigating the root cause of the issue.⁴⁵

Codes of conduct

3.68 The MBA, NMBA and AHPRA noted that one of their key roles is to provide guidance on what is expected of registered practitioners through a code of conduct:

Such guidance sets out the principles that characterise good practice and makes explicit the standards of ethical and professional conduct expected by their professional peers and the community.⁴⁶

3.69 The MBA pointed to its publication, *Good Medical Practice: A Code of Conduct for Doctors*, which was developed to guide doctors in their professional practice and roles, and set 'clear expectations on medical practitioners to act and communicate respectfully to both patients and colleagues'.⁴⁷

3.70 The NMBA noted that the *Codes of Professional Conduct for midwives and nurses* is currently under review, and expects to conduct a public consultation on the revised codes in early 2017.⁴⁸

43 Dr Joanna Flynn, Chair, Medical Board of Australia, *Committee Hansard*, 1 November 2016, p. 61.

44 Dr Joanna Flynn, Chair, Medical Board of Australia, *Committee Hansard*, 1 November 2016, p. 53.

45 ANMF, *Submission 99*, p. 3.

46 MBA, NMBA and AHPRA, *Submission 21*, p. 3.

47 MBA, NMBA and AHPRA, *Submission 21*, p. 3.

48 The NMBA notes that its analysis of notifications made between 2010 and 2015 identified that 'aggression' and 'bullying' were two of the largest categories of notifications. A focus of the review process is 'ensuring that the revised codes address these issues and set clear requirements for expected behaviours'. See: MBA, NMBA and AHPRA, *Submission 21*, p. 3.

3.71 Some submitters suggested that one way that AHPRA and the boards could assist in addressing bullying and harassment is through the codes of conduct they administer. The Australian Dental Association (ADA) recommended that the Code of Conduct for registered health professionals 'should be strengthened to reinforce the overall duty of care of health professionals, particularly those in employer positions, to ensure the safety of their colleagues, staff and patients'.⁴⁹

3.72 Beyondblue recommended that responses to bullying and harassment levels should be part of a broader focus on mental health, recognising the substantial impact on mental health that workplace bullying and harassment have. Beyondblue suggested that action on bullying and harassment should be based on a culture of 'respectful relationships' and recommended that reference to 'respectful relationships' be incorporated in the code of conduct administered by the MBA and those of the individual colleges.⁵⁰

3.73 The Australian Indigenous Doctors' Association recommended that a key measure to reduce the levels of bullying and harassment in the medical profession would be to mandate cultural safety training for all employees in the health sector.⁵¹

Speciality colleges

3.74 Following the release of the Expert Advisory Group's report to RACS in 2015, the committee heard that all speciality colleges have undertaken reviews of their reporting and complaints mechanisms. The Committee of Presidents of Medical Colleges stated that:

All specialist Medical Colleges are fully committed to fulfilling their obligations to eliminate or minimise the risk of bullying. Each has undertaken a system review to ensure appropriate policies and procedures are in place to manage complaints relating to bullying, which also includes regular compliance checks to ensure policies and procedures are up-to-date and staff are provided with information and training.⁵²

3.75 In particular, the committee heard that RACS has dedicated 'enormous resources' to responding to the Expert Advisory Group report through its November 2015 action plan, *Building respect, improving patient safety*.⁵³ Mr John Biviano from RACS told the committee that the key actions taken by RACS to date as part of the action plan include:

49 Australian Dental Association, *Submission 6*, p. 2.

50 Beyondblue, *Submission 11*, p. 3.

51 Australian Indigenous Doctors' Association, *Submission 8*, p. 4.

52 Committee of Presidents of Medical Colleges, *Submission 14*, p. 1.

53 See: *Building Respect, Improving Patient Safety*, RACS Action Plan on Discrimination, Bullying and Sexual Harassment in the Practice of Surgery, tabled by Royal Australasian College of Surgeons, at Sydney public hearing 1 November 2016, http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MedicalComplaints45/Additional_Documents (accessed 14 November 2016).

- working with health departments and hospitals to develop strategies to address discrimination, bullying and sexual harassment, including developing memorandums of understanding between RACS and hospitals;⁵⁴
- introducing mandated courses for surgeons involved in education on 'basic adult education principles', building awareness of discrimination, bullying and harassment, and skills for supervisors; and
- devoting more resources to complaints management, including a centralised database and process to resolve complaints.⁵⁵

3.76 The committee heard that while RACS is leading the colleges in addressing these issues, other colleges are also seeking to address bullying and harassment. The Committee of Presidents of Medical Colleges (CPMC) noted that:

... all specialist Medical Colleges have subsequently undertaken assessment processes to recommend actions their individual College could take directly and in partnership with hospitals and employers to mitigate and prevent such behaviours from occurring.⁵⁶

3.77 A number of colleges made submissions to the inquiry outlining the specific measures they have taken to address bullying and harassment. For example, Mr John Ilott noted that the Australian and New Zealand College of Anaesthetists (ANZCA) has:

... strengthened the internal professional conduct framework. We have also established a centralised complaints-handling process, which is for complaints to the college. While our education program has not been as extensive as that of RACS, we acknowledge the generosity of RACS in providing much of the material that they developed at their own cost, which has been made available to other colleges.⁵⁷

3.78 Similarly, the Royal Australasian College of Physicians (RACP) set up working party in 2015 to 'further ensure our current systems, policies, procedures and practices were robust'.⁵⁸ Mrs Linda Smith, Chief Executive Officer of RACP told the committee that some of the changes introduced as a result include:

- improved compulsory supervisor training workshops;
- education leadership and supervisor support that allows identification of inappropriate supervisor behaviour and a process of working with supervisors to change behaviour;

54 RACS provided the committee with a draft MOU as part of its submission. See: RACS, *Submission 113, Attachment 1*.

55 Mr John Biviano, Director, Fellowship and Standards, Royal Australasian College of Surgeons, *Committee Hansard*, 1 November 2016, p. 44.

56 Committee of Presidents of Medical Colleges, *Submission 14*, p. 2.

57 Mr John Ilott, *Committee Hansard*, 1 November 2016, p. 44.

58 Dr Catherine Yelland, *Committee Hansard*, 1 November 2016, p. 42.

- producing 'Creating a safe culture', a new e-learning resource for fellows, plus online curated learning collections on bullying and harassment;
- extensive assessment of the resources provided by other colleges; and
- implemented a 24/7 confidential online support service for fellows and trainees that is not just limited to problems they may be having in the workplace.⁵⁹

3.79 However, the committee also heard concerns about the efficacy of these measures by colleges, and whether they are in fact having any real impact on reducing bullying and harassment. For example, Miss Elise Buisson from AMSA told the committee:

I do think there has been significant change, but I do not think it has been all surgeons. And I think that change has been focused within the College of Surgeons because the other colleges have not had that same pressure applied to them. We have developed this kind of media idea that it is the surgeons who are particularly at fault, whereas I think there are quite a lot of poorly behaving doctors who are not surgeons who are getting away with it just fine. There absolutely are some surgeons who are still behaving badly, but I do think it is substantially less than it was a year-and-a-half ago. Whether that change will be sustained for another 18 months or the 18 months after that I am a little less certain of.⁶⁰

3.80 Similarly, Dr Michael Mansfield, discussing the increase in bullying he has seen throughout his career, described the professional colleges as 'impotent, with respect to any meaningful action, despite the window-dressing'.⁶¹

Need for greater coordination

3.81 Evidence to the committee highlights the need for coordination across the medical sector to address bullying and harassment.⁶² Beyondblue submitted that:

Action on bullying and harassment is everyone's responsibility. Governments have a role through enacting legislation and funding relevant programs. Statutory authorities have a role in overseeing adherence to legislation through education, investigation of complaints, and the enforcement of laws and penalties. Employers are required by law to create an environment that protects the health and safety of their staff. Employees are obliged to follow the law and the lawful directions of their employers.⁶³

3.82 Evidence from the speciality colleges highlights that addressing bullying and harassment requires cooperation with hospitals and employers. The Australasian College of Emergency Medicine (ACEM) argued that:

59 Mrs Linda Smith, *Committee Hansard*, 1 November 2016, pp 44–45.

60 Miss Elise Buisson, President, AMSA, *Committee Hansard*, 1 November 2016, pp 26–27.

61 Dr Michael Mansfield, *Committee Hansard*, 1 November 2016, p. 12.

62 Australian Dental Association, *Submission 6*, p. 2.

63 Beyondblue, *Submission 11*, p. 2.

In order to address the culture of bullying, ACEM considers that hospital management or executives, as well as hospital governing bodies, must be held accountable for the culture of the organisations that they lead. Through addressing bullying issues associated with those who are responsible for establishing the culture of a workplace, positive changes for those working at all levels within the hospital could be achieved.⁶⁴

3.83 Similarly, the CPMC submitted that 'while all Colleges are making a considerable effort to improve processes they cannot do it alone and there needs to be agreed principles between all parties'.⁶⁵ Mr Biviano from RACS told the committee:

... the responsibility to end a culture of bullying and harassment does not reside with any one individual or entity. Employers, hospitals, governments, health professionals, industrial associations, regulators and other partners in the health sector must all commit to sustained action. While each of these groups can and should develop individual solutions, at the core of the issue is the need for cooperation and collaboration across the health sector.⁶⁶

3.84 Mr John Ilott, CEO of ANZCA, told the committee that:

Lasting improvements can only be achieved with the cooperation of the health services in both private hospitals and public hospitals.⁶⁷

3.85 A number of submitters suggested that better sector-wide coordination is an important step to address the lack of clarity and trust in existing reporting mechanisms. The AMA submitted that:

Greater cooperation between employers and colleges with respect to the development and implementation of bullying and harassment policies and in relation to complaints handling would be beneficial to all parties involved. The current environment discourages effective compliance both with respect to the development of well understood and effective policies, as well as in relation to having accessible and trusted complaints mechanisms.⁶⁸

3.86 As part of this coordination, RANZCP suggests that:

... there should be further practitioner education in regards to bullying and harassment as practitioners are often confused about what should be reported to AHPRA and what should be reported to their workplace.⁶⁹

64 Australasian College of Emergency Medicine, *Submission 4*, p. 2.

65 Committee of Presidents of Medical Colleges, *Submission 14*, p. 1.

66 Mr John Biviano, Director, Fellowship and Standards, Royal Australasian College of Surgeons, *Committee Hansard*, 1 November 2016, p. 42.

67 Mr John Ilott, Chief Executive Officer, Australian and New Zealand College of Anaesthetists, *Committee Hansard*, 1 November 2016, p. 43.

68 AMA, *Submission 9*, p. 3.

69 RANZCP, *Submission 19*, p. 2.

3.87 Similarly, the ANMF noted that its policy statement on bullying and harassment asserts that 'the first level for raising a bullying complaint is within the workplace'. When this fails, nurses and midwives are advised to report the bullying to a range of state and territory based authorities, such as Occupational Health and Safety Regulators.⁷⁰

3.88 In 2016, the Victorian Auditor-General conducted an audit of four public health services to assess their effectiveness in managing the risk of bullying and harassment in the workplace. The Auditor-General's report into *Bullying and Harassment in the Health Sector* found that the leadership of health sector agencies 'do not give sufficient priority and commitment to reducing bullying and harassment within their organisations' and that the health sector is 'unable to demonstrate that it has effective controls in place to prevent or reduce inappropriate behaviour, including bullying and harassment'.⁷¹

3.89 The Victorian Auditor-General made a number of recommendations for health sector agencies, WorkSafe, the Victorian Public Sector Commission and the Department of Health and Human Services to better address:

- early intervention mechanisms to address bullying and harassment;
- management of formal complaints; and
- collaboration between agencies that have a role in the safety culture of the health sector.⁷²

Committee view

3.90 The committee acknowledges the work undertaken across the medical sector, particularly by colleges, to address bullying and harassment. The professional colleges are uniquely placed to respond to the medical profession's concerning record of tolerating or ignoring bullying and harassment.

3.91 However, the committee notes that while work is being done, a genuine change in the way the profession responds to incidents of bullying and harassment remains to be seen. Substantial and lasting change is the only metric on which such efforts will be assessed.

3.92 The committee is pleased to see increased recognition that supports further work to encourage cooperation and coordination across the sector to eliminate bullying and harassment and remove any barriers to making complaints.

70 ANMF, *Submission 99*, p. 3.

71 Victorian Auditor-General, *Bullying and Harassment in the Health Sector*, March 2016, p. x, http://www.audit.vic.gov.au/reports_and_publications/latest_reports/2015-16/20160323-bullying.aspx (accessed 9 November 2016).

72 Victorian Auditor-General, *Bullying and Harassment in the Health Sector*, March 2016, p. xiii–xv, http://www.audit.vic.gov.au/reports_and_publications/latest_reports/2015-16/20160323-bullying.aspx (accessed 9 November 2016).

