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AMA submission to the Standing Committee on Community Affairs: Inquiry into the Medical Complaints Process in Australia

The Australian Medical Association (AMA) is the peak representative body of the medical profession. The AMA represents doctors in training, general practitioners, specialists and clinical academics across the spectrum of salaried doctors and private practitioners throughout Australia.

The AMA welcomes the opportunity to provide a submission to the Committee's inquiry into the medical complaints process in Australia.

One of the principal roles of the AMA is to protect the wellbeing of medical practitioners and promote and advance ethical behaviour of the medical profession. The AMA therefore views addressing bullying and harassment within the medical profession as one of its important roles.

The AMA believes that all doctors have the right to train and practice in a safe workplace free from bullying and harassment and holds a zero tolerance approach to all forms of bullying. The AMA notes reports that 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[1].

It is particularly important that the medical profession takes a leadership role in condemning bullying and harassment as and where it occurs.

Employers, medical colleges and other medical education providers have an important role to play in raising the awareness of and changing the culture that has allowed bullying and harassment to occur in the medical profession and health care sector. Well-thought-out and publicised policy in this area is important to foster a safe and healthy work and training environment, while maintaining appropriate standards of patient care[2].

[1] Australian Human Rights Commission. Workplace bullying: Violence, Harassment and Bullying Fact sheet. Available fromhttps://www.humanrights.gov.au/workplace-bullying-violence-harassment-and-bullying-fact-sheet
Scott J, Blanshard C, Child S. Workplace bullying of junior doctors: a cross sectional questionnaire survey. NZMJ Digest. 2008. Vol 121 No 1282: 13-15.
Scott K et al. 'Teaching by humiliation" and mistreatment of medical students in clinical rotations: a pilot study. Med J Aust 2015; 203(4): 185e.1-6.
EAG Report to RACS on discrimination, bullying and sexual harassment. September 2015.
[2] AMA Position Statement: *Workplace Bullying and Harrasment 2015*

The prevalence of bullying and harassment in Australia's medical profession

Evidence of the extent of discrimination, bullying and sexual harassment in the medical profession in Australia is very limited and we know that these are not issues limited to the medical profession. However, the AMA believes that doctors need to play a leadership role in addressing these issues and the AMA is coordinating action with medical colleges, employers, the Australian Salaried Medical Officers Federation and other stakeholders to gain agreement on and implement relevant policies and strategies to address bulling and harassment.

The most recent analysis of the prevalence of these issues is in the September 2015 Expert Advisory Group on Discrimination, Bullying and Sexual harassment *Report to the Royal Australasian College of Surgeons* (RACS). A survey commissioned by the Expert Advisory Group found that almost half of the 3500 surgeons and surgical trainees responding had experienced some form of bullying, harassment or discrimination. While this survey was restricted to the surgical specialty, anecdotal evidence and feedback from members would indicate that this experience is replicated in other medical specialties.

Despite medical schools, colleges and employers all having relevant policies in place, there is evidence that these are not well understood or well known. While the AMA has not surveyed all members, we do know from our 2014 survey of specialist trainees that general awareness of bullying and harassment policies across all colleges is low, with only 30 per cent of trainees reporting that they were aware of these.

Barriers, whether real or perceived, to medical practitioners reporting bullying and harassment

Research consistently indicates there are a number of factors which may increase the risk of workplace bullying and harassment occurring in the workplace.

- Presence of work stressors – high job demands, limited job control, organisational change, role conflict and ambiguity, job insecurity, an acceptance of unreasonable workplace behaviours or lack of behavioural standards, unreasonable expectations of clients or customers.
- Leadership styles – autocratic behaviour that is strict and directive and does not allow workers to be involved in decision making; or laissez faire behaviour where little or no guidance is provided to workers or responsibilities are inappropriately and informally delegated to subordinates.
- Systems of work – how work is organised, scheduled and managed, lack of resources, lack of training, poorly designed rostering, unreasonable performance measures or timeframes.
- Work relationships – poor communication, low levels of support or work group hostility.
- Workforce characteristics – groups of workers who are more at risk of being exposed to workplace bullying.

Declining job opportunities at the trainee level makes junior doctors particularly vulnerable and reluctant to complain about harassment and bullying. In some areas there remains a culture of intransigence that does not address bullying and harassment proactively. Individuals may remain silent about sexual harassment and there is a lack of trust/confidence that existing complaints processes at an institutional level offer a 'safe space' for complainants or that they will result in a fair and durable outcome. It must also be acknowledged that overwhelmingly this

sort of harassment is directed at women[3]. According to the Australian Human Rights Commission, 'sexual harassment disproportionately affects women with 1 in 5 experiencing sexual harassment in the workplace at some time. However, 1 in 20 men also report experiencing sexual harassment in the workplace'[4].

There is considerable distrust of managers by clinicians. The decreasing level of trust between clinical staff and their managers is in part due to the pressures that managers have to reach financial and performance goals without sufficient resources to provide for the needs on the ward. Public sector workplaces have changed markedly in recent years in response to globalisation and the business orientation of governments. Most notable in the public sector have been new forms of organisation, management and accountability and, as a corollary, multiple demands including tighter budgets and demands to generate new forms of income; thus the pressure on managers to meet multiple and competing requirements, the most important of which is clearly signalled as short-term financial gains which may put pressure on cohesion in the workplace.

This is compounded by the reality that many individuals are placed in leadership or supervisory roles with little or no training or support. Appropriate management and leadership training must be provided to those in managerial positions. Problems arise when managers are required to deal with complex situations involving conflict and unacceptable behaviours with little management or conflict resolution training.

Unclear policies and reporting structures are particularly problematic, with this being exacerbated by the lack of clarity that exists in relation to the role of medical colleges and employers in this area. 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.

Bystanders are silent

The discussion in relation to barriers to reporting also extends to the role of by-standers in so far as it affects their willingness to report unacceptable behaviour. There may be two different reasons bystanders do not speak up when witnessing unacceptable behaviour. The bystander may:

1) not recognise the behaviour as discrimination, bullying or sexual harassment; or
2) 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. Many of the barriers discussed above also discourage by-standers to make compliant or intervene in situations where they witness unacceptable behaviour.

In relation to the latter reason, it should be noted that this is more likely to reflect on processes at an institutional rather than system level.

[3] Sexual harassment: Serious business - Results of the AHRC 2008 Sexual Harassment National Telephone Survey.
[4] Australian Human Rights Commission, Guides, Sexual harrassment https://www.humanrights.gov.au/our-work/sex-discrimination/guides/sexual-harassment#fn1, accessed 13 April 2016

Gender inequality

Gender inequity has a proven causal relationship with the incidence of discrimination, bullying and sexual harassment of women. It is important that sexual harassment, discrimination and non-sexualised incivility is acknowledged as a manifestation of broader gender inequality.

Despite increased participation from women in the medical workforce, women are still under-represented in the upper tiers of leadership. If medicine is to continue to progress as a profession, the issue of gender inequality needs to be scrutinised more closely.

Factors that influence a woman's ability to enter and progress through some specialties include a proportionally lower number of women role models and mentors, long working hours and rigid training requirements that fail to recognise the needs for women to be able to balance work and family, and deep-seated cultural norms.

The role of AHPRA and the Medical Board of Australia in relation to bullying and harassment and the effectiveness of the National Law

The primary role of the MBA and AHPRA is public protection; ensuring Australians have access to safe, high quality health practitioners. The role incorporates a compliance function in order to address concerns about registered health practitioners. The MBA can investigate and take action about notifications that allege bullying and harassment by medical practitioners, where the conduct could potentially place the public at risk. However, it is often the case that inappropriate behaviour in the workplace is more effectively managed using local human resources policies and procedures.

The AMA works with the Medical Board of Australia (MBA) and AHPRA to improve the operation of the scheme from a medical practitioner's perspective, with the aim of streamlining notifications and investigation processes. The AMA acknowledges that AHPRA's performance has improved over recent years as the scheme has matured and AHPRA's processes have improved. In this respect, the time taken to close notifications in assessment has reduced from 142 days in 2013-14 to 73 days in 2014-15 and a process to progress aging notifications has resulted in investigations older than 12 months falling from 436 in 2013-14 to 360 in 2014-15[5].

The benefits of 'benchmarking' complaints about complication rates of particular medical practitioners against complication rates for the same procedure against other similarly qualified and experienced medical practitioners when assessing complaints

The AMA notes the guide to interpreting the terms of reference provided by the Committee secretariat on 15 March. The AMA's submission is addressed accordingly.

It is open to a National Board to consider a single notification or a group of notifications about a practitioner that suggest a pattern of conduct. When making a decision after assessing a notification, a National Board has to decide if it raises issues of professional misconduct, unprofessional conduct, unsatisfactory professional performance or impairment of a registered practitioner.

[5] AHPRA *Annual Report: AHPRA and National Boards 2014-15*, p 57

To do this, the National Board must consider what the appropriate standard of performance is for that practitioner within their particular setting. Effectively, the benchmark is the 'appropriate standard of performance'.

In making this assessment a National Board will give due consideration to the evidence presented in the notification. Every notification is managed individually. When multiple notifications are received about the same practitioner, these can be considered together by the Board. If there is a risk to public safety, immediate action can be taken.

Benchmarking can be complex and lead to perverse outcomes such as providing a disincentive for doctors to try new treatments, or self-protective practices such as not performing higher risk procedures because of the potential effect on outcome measures. There are other measures and standards of performance that the MBA may take into consideration as well as benchmarking. For example, the MBA will use the code of conduct *Good medical practice: a code of conduct for doctors in Australia* which is of particular relevance to issues of workplace behavior and conduct. The Committee would benefit from a detailed understanding of AHPRA's processes, including its use of notification data, to inform its deliberations on 'benchmarking'.

AHPRA's processes will be informed by the development of a National Restrictions Library that is being developed to:

- ensure consistent wording of restrictions that have the same intent;
- shape the recommendations that AHPRA staff make to the board;
- enable compliance with restrictions to be properly monitored and enforced; and
- provide a clear separation of the conditions on practice and the obligation on third parties involved in those conditions, e.g. supervision.

As the sophistication of AHPRA's data continues to mature consideration could be given to whether it could identify incidents of bullying and harassment or inform the way it is addressed. Any consideration of the way this data is used would need to be consistent with the responsibilities of AHPRA and the MBA, and the requirements under the Privacy Act as they are reflected in the National Law.

The desirability of requiring complainants to sign a declaration that their complaint is being made in good faith

The National Law protects practitioners, employers and education providers who make notifications in good faith under the National Law. 'Good faith' is not defined in the National Law so has its ordinary meaning of being well-intentioned or without malice. Section 237 provides protection from civil, criminal and administrative liability, including defamation, for people making notifications in good faith.

The AMA's position is that it is critical that health practitioners are not deterred from seeking early treatment for health conditions. Equally, medical practitioners should not be deterred from raising issues of bullying and harassment for any reason. Given that a significant number of notifications are made by practitioners, health complaints entities or other professionals such as the ombudsman and employers, introducing a requirement that a statement is signed that the complaint is made 'in good faith' is effectively challenging the professionalism of the these people.

A practitioner who is the subject of a notification will receive a copy of the complaint against them unless there is a good reason that informing the subject would put at risk the health or safety of a person, prejudice an investigation, place a person at risk of intimidation or affect the employment of an employee of a provider. This is a rare event.

Given the relative transparency of the notifications process the AMA questions how the inclusion of this requirement would improve the information available to AHPRA in making its assessment or have any material impact on the result.

AMA Recommendations

Cultural and systemic changes are required to tackle issues of bullying and harassment in the medical profession.

1. Achieving gender balance in senior roles

Studies have suggested that in work environments which are systemically male-dominated and privileged, it is important to provide explicitly articulated opportunities for women to collectively and democratically participate in order to challenge prevailing regimes of control and strive for a more inclusive environment. A self-regulation approach to achieving gender balance in senior roles could be adopted initially. Gender specific pressures need to be alleviated to ensure the roles can be fulfilled by women. Rather than simple policy statements on entitlements to flexible working arrangements, the solutions need to be practical.

2. Mentoring programs

Ensuring that all trainees have strong, supportive role models remains a challenge. Mentoring programs can play a positive role and should be encouraged.

3. Workplace Flexibility

Historically, the health system has not been good at providing flexible work places. Health service management and colleges need to work together to provide opportunities to improve flexibility in employment practices in order to encourage the full participation of all members of the medical workforce.

4. Training and Education

All medical practitioners at all stages of their career need to be up-skilled in performance management, communication techniques, providing assessment and feedback and remediation in order to better handle these issues when they arise and prevent issues escalating where possible.

Doctors at all stages in their career also require further and ongoing education about what bullying and sexual harassment looks like and how to make a complaint, and for those in management positions, how to investigate and manage a complaint. Managers and supervisors need to be aware of typical bullying and harassment behaviours that perpetuate an unhealthy culture and develop strategies to change these behaviours.

5. Improved policies and processes

Colleges must have robust and transparent policies and processes in place to tackle issues of bullying and harassment and play a leadership role in driving change. However, because of the reality that most medical training is delivered in public hospital settings, there is a real need for employers to work with the profession to address bullying and harassment, putting in place the right policies, process and culture. Reporting processes must offer a 'safe space' for complainants so that they can raise issues of bullying and harassment, free of shame, stigma or

repercussions. Employers also need to have good performance management processes in place to avoid reasonable management actions escalating into bullying complaints.

An impartial, external complaints handling mechanism is essential to allow victims and bystanders to report incidents outside the chain of command that is responsible for their career progression. Concurrent, ongoing support must accompany the complaint mechanism to prevent victimisation.

6. Data collection

The AMA believes that the implementation of a national training survey is needed to provide data about how training programs and locations are managing bullying and harassment well and where there is room for improvement.

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