



Australian Salaried Medical Officers' Federation

Level 3, Suite 46, 330 Wattle Street  
Ultimo NSW 2007  
Telephone 9212 6900 Facsimile 9212 6911 Email  
[asmof@asmof.org.au](mailto:asmof@asmof.org.au)

## Australian Salaried Medical Officers' Federation Submission: National Inquiry into Sexual Harassment in the Workplace

### Introduction

The Australian Salaried Medical Officers' Federation (ASMOF) is the Doctors' Union, representing over 12,000 Registered Medical Practitioners including Staff Specialists, Post Graduate Fellows, Clinical Academics, Career Medical Officers and Doctors in Training including Interns, Resident Medical Officers and Registrars who are directly employed in the Public Hospital system, Affiliated Health Facilities, Private Hospitals and in Community Health.

ASMOF would like to thank the Australian Human Rights Commission for the opportunity to respond to the National Inquiry into Sexual Harassment in the Workplace, and for the Sex Discrimination Commissioner's ongoing leadership on the prevention of sexual harassment and sex-based discrimination. The Commission's own research has revealed that sexual harassment is widespread in Australian workplaces, with 39% of women and 26% of men having experienced sexual harassment at work in the past 5 years.

In 2015 the high-profile comments of Australian surgeon Dr Gabrielle McMullin lifted the lid on sexual harassment in medicine, and drew attention to an entrenched culture of sexism that limited opportunities for female surgeons. Her comments raised awareness and prompted a range of positive actions, particularly from the Royal Australasian College of Surgeons, however ASMOF believes that further actions and widespread reform is necessary to tackle the persistent problem of harassment in the workplace. We welcome this Inquiry as an opportunity to advocate for these reforms, and we believe that specific actions targeting medicine and health services more broadly will be a necessary outcome of this Inquiry.

In order to better understand the nature of sexual harassment experienced by doctors, ASMOF surveyed our members in NSW on sexual harassment and gender equity. Our findings affirm that sexual harassment is far too commonly experienced by doctors, with an alarming 55% of female doctors reporting that they had experienced sexual harassment in their workplace. This submission will report the full findings of this survey, which provides new insights into sexual harassment in medicine.

The findings also 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. Gender inequities are a key driver of sexual harassment and ASMOF would like to see the Commission give consideration to how these inequities can be reduced for Australia's medical workforce.

The Australian Council of Trade Unions (ACTU) and other stakeholders have drawn attention to the failure of Australia's current regulatory framework to ensure that Australian workplaces are safe, equitable and harassment-free. ASMOF supports their calls to reform the legislation, including Work Health and Safety legislation, the *Sex Discrimination Act 1984* and the *Fair Work Act 2009*. We believe that strengthened legislation and improved workplace conditions are urgently needed.

In addition to legislative change, ASMOF suggests that a broader cultural shift is needed in order to reduce the occurrence of sexual harassment and promote gender equity in their workplace. We have therefore detailed a range of proactive measures, informed by doctors, which we believe must be comprehensively implemented in order to ensure that all doctors are respected, valued and have the same opportunities to progress their career.

### **Summary of Recommendations**

1. Reform the legal framework (including the *Sex Discrimination Act 1984*, *Fair Work Act 2009* and WHS legislation) and resource regulators, as per ACTU's recommendations, to ensure sexual harassment and gender inequities are actively addressed in doctors' workplaces.
2. Embed doctors' rights to a harassment free workplace and equitable conditions within their industrial agreements, as outlined in ASMOF and AMA's Bargaining Framework.
3. Initiate a comprehensive, multi-pronged approach to addressing all forms of sexual harassment in health services which is tailored to our medical workforce. This should incorporate the following key measures:
  - Strong leadership and support for future female leaders
  - Education and awareness which includes bystander education
  - Safe, transparent and independent internal reporting mechanisms with meaningful action following identified misconduct
  - Clear guidelines and policy

Thank you for considering our recommendations, and if you would like any further detail about our survey findings or any aspect of this submission, please contact Carolina Simpson, Policy Officer, ■

Yours sincerely,



Professor Geoff Dobb  
President, ASMOF

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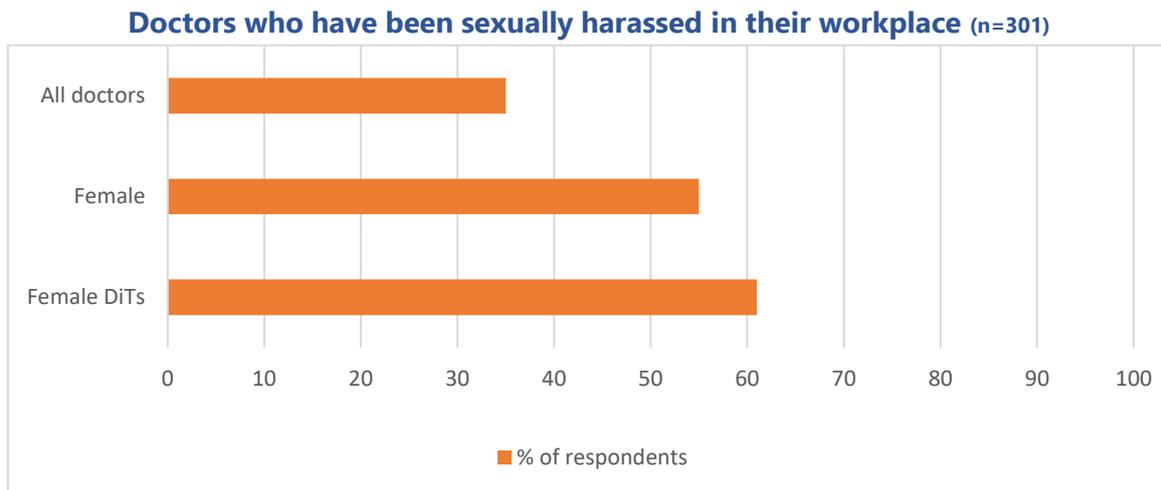
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# 1. Sexual harassment in medicine

## Prevalence and nature

In February 2019 ASMOF conducted an online survey of members in NSW on *Sexual Harassment and Gender Equity in Medicine*. Most respondents who identified their position were Staff Specialists (62%) or Doctors in Training (DiTs)/Junior Medical Officers (JMOS) (29%), with other respondents including Clinical Academics and Career Medical Officers. ASMOF members work across a range of fields and in NSW our members predominantly work in public hospitals. Many of our members work across different sites and will have more than one workplace.

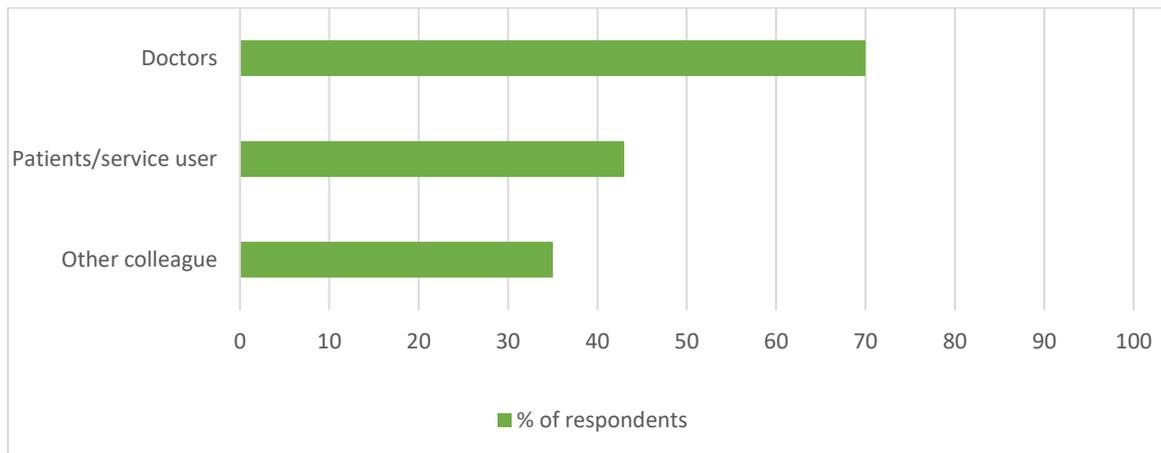
Of the 301 doctors who responded to survey, just over a third reported that they had experienced sexual harassment in their workplace. Over half of female doctors had experienced sexual harassment in their workplace, compared with 6% of male doctors. Female Doctors in Training were even more likely to have experienced sexual harassment, and the increased risks to DiTs was a consistent theme throughout the survey data.



Many doctors also reported that they had witnessed sexual harassment occurring in their workplace (29%), with no variation by gender. Doctors in Training were more likely to report that they had witnessed sexual harassment occurring in their workplace (34%).

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

## Perpetrators of sexual harassment in doctor's workplaces



Although our survey was relatively small and represents a fraction of our membership, our findings are supported by other Australian research addressing sexual harassment in medicine. In 2016 the Australian Medical Association WA conducted a survey with responses from 950 medical practitioners and medical students. This survey of doctors showed 31% had experienced sexual harassment in the workplace, and 44% of female doctors had been sexually harassed.<sup>i</sup>

The Royal Australasian College of Surgeons (RACS) 2015 survey of 3516 Surgeons found of the 560 respondents who identified as female, 30% were subject to sexual harassment, compared to 2% of male respondents. In 90% of responses a male was identified as being responsible for the sexual harassment.<sup>ii</sup>

In the RACS survey respondents were asked to describe the what they experienced. The most commonly reported type of sexual harassment reported was sexual innuendo/propositioning (54%). Sexually explicit or offensive jokes, unwelcome sexual flirtations, inappropriate physical contact and questions or insinuations about my sexual or private life were also commonly reported.<sup>iii</sup>

ASMOF's survey and other research has been limited in identifying the experiences of doctors who identify as LGBTIQ, who may be particularly vulnerable to harassment.

### Reporting and complaints

The internal and external processes around reporting sexual harassment and outcomes for doctors are of a significant concern for ASMOF.

ASMOF's survey found that the vast majority of doctors who had experienced sexual harassment did not report it (84%). Similarly, only 12% of witnesses to sexual harassment stated that they reported the incident. RACS 2015 survey found that only 9% of those who experienced sexual harassment brought it to the attention of their supervisor or manager.<sup>iv</sup>

There are a wide range of barriers to doctors reporting sexual harassment. The 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.<sup>v</sup>

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 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'

'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 . At least that was my experience. I felt I had too much to lose after working so hard for so long....'

'assurance that by reporting it one is not jeopardizing ones career'

'Whistleblowers in health often lose their jobs'.

'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 you speak up.'

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

'It's difficult because the majority of perpetrators are patients who have some reason to be a bit disinhibited. It is still gross and makes me feel uncomfortable but I'm not sure anything can be done about it'

'It's difficult when it's a patient doing it.'

Unfortunately, even when doctors do report their experiences of being sexually harassed in their workplace, there is no guarantee that there will be a fair outcome. Most respondents to ASMOF's survey who reported sexual harassment were not satisfied with the outcome, and comments indicate that the process was unfair and often resulted in further victimisation.

'I was told that I was being hysterical'

'It was excruciating and such a long winded process I would not do it again. I would just call the behaviour out on the spot.'

'hospital did nothing about the abusive...environment.'

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 no action after the complaint was made.<sup>vi</sup> Junior doctors were deterred by these experiences, and from reporting incidents of bullying or harassment again in the future.

### **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.<sup>vii</sup>

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

'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.'

Comments from doctors indicate that in many workplaces, a cultural shift will be required to reduce the incidence of sexual harassment. Addressing the safety of Doctors in Training must also be a priority in efforts to reduce sexual harassment, which will involve a collaborative effort between employers and education and training providers including Specialist Colleges.

'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'

'In my department I am unaware of sexual harassment as a significant issue. We have a culture of inclusion and gender equality'

## 2. Gender equity in medicine

In considering sexual harassment in the workplace, we must also be careful not to overlook women's non-sexual experiences of being undermined at work. Whilst improvements have been made slowly over the past decades, the medical profession continues to disadvantage female doctors, and has frequently fallen behind modern expectations that doctors should be able to balance family commitments with their medical practice. This is reflected in many of the comments made by doctors in ASMOF's survey, many of which suggest that medicine is lagging behind other sectors:

'I think there needs to be a real culture shift and although there has been some improvement in the last 20 years, there is a long way to go.'

'Medicine can still be very archaic. Training programs that rely on archaic single-income families with a partner who is at home is not possible in the modern day...programs that punish people for pregnancy or child-care duties are bad for men AND women.'

'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'

'The health service seems to be doing absolutely nothing to address this imbalance - unlike most industries across the world.'

'There is a lot of gender-based discrimination going on in departments across the country although a lot of it may not qualify as sexual harassment. I have experienced and witnessed this in many departments I have worked in NSW and interstate. Unnecessary comments regarding pregnancy or even ostracisation during pregnancy. This behaviour does not only come from men but in several instances also from female staff specialists. There seems to be a prevalent view that women with families who work part-time are not contributing enough to the advancement of medicine and as one person put it "are only doing it for the money". During the child-bearing years women are still seen as a burden in some departments. some male consultants openly state they won't employ a female advanced trainee.'

'In the field of cardiology, the proportion of training positions offered to female candidates is far less than the proportion of applicants who are female. In addition, there are some hospitals that have NEVER in their history, hired a female candidate.'

'The issue of gender equality and sexual harassment has been reinforced in the surgical training circuit. Please do not forget that physicians (particularly procedural based) and other specialties suffer this, such as gastroenterology and cardiology.'

Attempts to shift the culture of medical workplaces to reduce sexual harassment must also look at the related issue of gender-based discrimination and gender inequity. Supporting doctors to combine parenting and caring roles with work are a crucial element of this change.

### **Flexible work/training arrangements**

The ACTU have noted that Australia is one of the most unequal countries in the world in regards to men's and women's sharing of unpaid domestic and care work.<sup>viii</sup> Flexible work arrangements are unavailable for many doctors, and doctors frequently recommended that such arrangements were needed to improve gender equity and working conditions for all doctors.

'Part time mum needs more support such as flexible hours, work from remote site setup, less meeting after hours, opportunity to be in managerial role'

'more flexible with job sharing, don't penalise mothers who cannot commit to long hours like their male counterparts may be able to'

'flexible work place is best for men and women'

'Flexibility in job sharing and actively encouraging this.'

Flexibility in training programs was very frequently recommended by doctors, and many doctors stated that training colleges needed to tackle this issue alongside employers.

'Specialist College training programs are extremely difficult to navigate whilst being pregnant and having young children. Only lip—service is paid to flexibility in training. I was expressly told by a member of a selection panel that 'you'd better not get pregnant if we accept you onto our training program'. Specialty training program requirements were a big factor in my decision to have only 1 child. It is very difficult to gain selection onto a competitive training program if one is obviously pregnant at the interview. Training programs that require rotations to distant cities are extremely problematic for mothers of young children.'

'Flexible training in specialties is a must. GP program is the only program I am aware can be done part time.'

'Flexible training is very important, for both female and male trainees'.

'think flexible surgical training would help to allow opportunities for a more gender balanced proportion of leaders in this area of specialty'

'Reward those sites that have a history of providing flexible training positions.'

### **Access to leave entitlements**

Another concern identified by doctors 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.

'Encouragement for male staff to take and use effectively paternal leave without real or perceived penalties to their positions and advancement prospects. That would help balance the view that "women just take more time off" for child rearing.'

'Giving men same amount of paternity leave.'

'Both my wife and I are doctors, but my career is built around the assumption that it will be my wife that takes time off. I can't access more than a few weeks of paid paternity leave - what if it was me that wanted to be primary caregiver? Why should only my wife be able to take leave? Surely, at the very least we could split the entitlement.'

'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.'

'Need better working rights. Still hard to get maternity leave and part-time work...need to look at shared parental leave.'

Some doctors spoke of challenges in accessing basic leave entitlements as parents.

'There is an expectation that we do not take sick/carers leave to care for young, sick children, even though we are entitled to it, and one has more than enough leave entitlement to cover. We are encouraged to find alternative care for my children, and it was frowned upon when one does take leave for this purpose.'

### **Pregnancy**

Respondents also spoke of challenges and discrimination experienced in pregnancy.

'Discrimination in pregnancy also an issue. All staff should be aware of fair work laws relating to pregnancy - ie that you cannot treat a pregnant colleague any differently in a negative way'

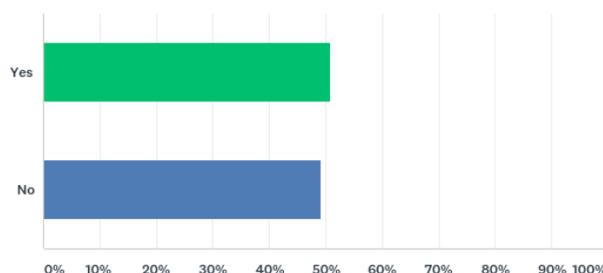
'adjustment of working hours for pregnant women (I was expected to work 24hr shifts up to 36 weeks of pregnancy).'

### 3. Employer actions & obligations

#### Current initiatives

When ASMOF asked doctors in NSW whether they were aware of initiatives or policies in their workplace which address sexual harassment, they were almost evenly split:

Q12 Are you aware of initiatives or policies in your workplace/s which address sexual harassment?



When questioned further about the specific initiatives and policies, responses were mixed. Some doctors detailed positive and proactive approaches to sexual harassment in their workplace:

'My current workplaces have clear protocols and policies in place and regular education sessions'

'we have mandatory annual training on acceptable behaviour in the workplace.'

'Identified senior colleagues who are safe contacts for those more junior who have experienced sexual harassment'

'Both LHD [Local Health District] and university policies to educate people as to the nature of sexual harassment and people to contact if you experience this'

'the staff is oriented about it at the beginning of term. there is online policy, contact details on intranet educating and providing support'

Respondents most commonly referred to policies rather than initiatives, and some mentioned education. The most commonly named were:

- Code of conduct
- Bullying and harassment policies or other local health policies
- Online training
- Medical College policies

Other respondents were unsure of details of policies and initiatives, or expressed cynicism as to their impact or effectiveness.

'Don't know - only know that there are supposed to be some.'

'I know there is a policy but I didn't think it was going to be implemented or taken seriously.'

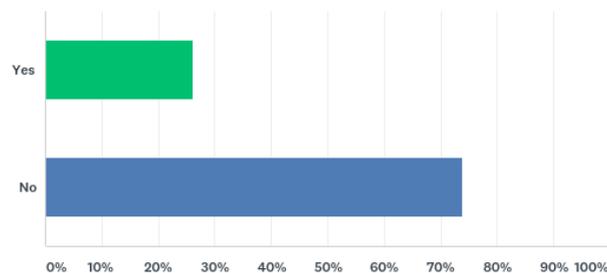
'supposedly zero tolerance; incidents can be reported to manager and HR'

'There is a stated commitment including in the form of policy documents but that is as far as it goes. When it comes to implementation the perpetrators are protected either because they have friends in high places or because of the organisations wants to protect its reputation/doesnt want to deal with it.'

Considering that half of doctors are not aware of *any* policies or initiatives around sexual harassment, it is clear that there is room to improve workplace responses to harassment.

ASMOF also surveyed doctors on whether they believed their employer promoted gender equity, and over half answered 'no' (57%). This figure jumped to 74% for female respondents:

Q16 Does your employer actively promote gender equity for female doctors?



Comments from doctors detailed in Section 2 suggest there are a range of improvements employers can make to promote gender equity.

### Work Health and Safety legislation

The responsibilities of health services in creating a safe workplace are guided by WHS legislation, which promotes a risk management approach. Whilst this submission will not detail the impact of sexual harassment, the health impacts have been well identified in other submissions, and can persist for many years after the harassment occurred.

Sexual harassment represents a significant risk to health and safety, but it is currently inadequately considered and addressed under this legislation. The ACTU has noted that Australia's national approach to WHS compliance and enforcement in relation to psychosocial hazards, including sexual harassment, needs an urgent review. The Final Report of the *Review of the model Work Health and Safety laws* has also recommended reform on these hazards, with Marie Boland stating:

‘To date, where there has been a focus on psychological health as a WHS issue, it has tended to be linked to widely recognised and acknowledged psychosocial hazards such as bullying and harassment. However, this has too often led to the individualisation of these complaints, their diversion into grievance processes and the removal of the original basis for the complaint from any assessment of the broader WHS organisational safety culture.’<sup>ix</sup>

The Report has recommended that the model WHS Regulations are amended to deal with psychosocial risks associated with psychological injury.

The high prevalence of sexual harassment in health services is posing a significant health risk to our medical workforce. ASMOF therefore supports Unions calls to:

- amend the Model Work Health and Safety Regulations and Codes of Practice to include an obligation to provide a work environment free from violence and harassment, including sexual harassment.
- appropriately resource WHS regulators to actively enforce this law
- Empower Unions to investigate breaches of this law.

#### ***Sex Discrimination Act 1984***

In order to address sexual harassment in the workplace, the *Sex Discrimination Act 1984* (SDA) establishes a complaint process that places the onus on individuals to report harassment so that further action can be taken. Stakeholders have drawn attention to limitations this complaints system, noting that it burdens the person who has been sexually harassed and risks being re-traumatised through the complaints system, can be costly to take a complaint beyond conciliation to court, and is slow and time consuming.

Considering that most doctors are, often justifiably, reluctant to report incidences of sexual harassment, it is crucial that employers take an active stance in preventing sexual harassment and promoting safe workplaces in health services. The current, individualised system places too much emphasis on individuals reporting their harassment, and too little on proactive and preventative approaches.

In consideration of the limited utilisation of the SDA in its current form ASMOF supports the ACTU’s call for anti-discrimination legislation to be amended to place a positive duty on employers and other service providers to eliminate sex discrimination and sexual harassment and promote gender equity.

Bearing in mind that a significant proportion of harassment is perpetrated by patients in health services, we also support the recommendation that anti-discrimination legislation be amended to make it clear that employers are also liable for third party harassment of their employees, and provide guidance and resources about how to prevent and respond to third party harassment.

#### ***Fair Work Act 2009***

The ACTU has noted that the *Fair Work Act 2009* (FWA) has failed to keep pace with changing working arrangements, and the ongoing inequities experienced by doctors which we have outlined indicate that the legislation must be strengthened. ASMOF supports the ACTU’s recommendations to amend FWA to embed a commitment to gender equity, and to explicitly prohibit sexual harassment and sex based discrimination. The Fair Work Commission should have the remit to

actively investigate and address gender-based inequities, which are unfairly disadvantaging doctors across Australia.

### **Workplace entitlements**

ASMOF, in collaboration with the Australian Medical Association (AMA) has designed a National Bargaining Framework (model clauses) which outlines best practice workplace rights and conditions which are designed to promote greater gender equity in medicine. These model clauses include family friendly arrangements and we encourage their adoption in Awards and Agreements covering the medical workforce. Further information about these clauses can be found in AMA's submission to the Inquiry.

## 4. Proactive measures

ASMOF firmly believes that a comprehensive and multi-pronged approach which encompasses a range of measures is necessary to tackle sexual harassment. A stronger legal framework will be one way to shift culture and promote safer and more equitable working environments for doctors.

Any approach must involve collaboration between health services and with other key stakeholders, including specialist colleges. This approach must be underpinned by an understanding of the nature of sexual harassment in the medical workforce, address risks from peers, patients and other service users, and prioritise the safety and wellbeing of women and Doctors in Training,

The following components were most frequently suggested by doctors to proactively prevent harassment, manage incidents of sexual harassment, and more broadly promote gender equity.

### **Leadership**

Writing in the British Medical Journal, Dr John Launer notes the parallels between initiatives tackling bullying in medicine and the change needed to address sexual harassment. He suggests that sexual harassment is 'a problem for men to address' and remarks:

'The crucial factor in tackling negative behaviour seems to be that someone in authority in an organisation accepts that it exists on a significant scale, believes in the seriousness of the problem, and is determined to challenge it.'<sup>x</sup>

A cultural shift in medicine will require strong leadership, and doctors are keen to see the most senior doctors rise to the challenge.

'The attitude of the leadership at all levels should set the standard for all employees. They need to 'walk the walk and not just talk the talk''

'You can't legislate against this. It relies on who is appointed to positions of power and, therefore, governs the culture. so choose appointments wisely.'

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

Respondents to ASMOF's survey also pointed to the need to specifically nurture female leadership in order to promote reform and shift culture.

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

'More women in senior management roles would help change the culture.'

'some departments...are still in the dark ages and this is largely driven by a misproportion of male leaders. I have never thought quotas were a good idea, rather that people should be rewarded for the work they do rather than their gender. However...the big centres with very few women in senior roles are by far the worse. Perhaps a minimum female management quota would help change the balance/culture in the short term. Once the management is a little more equal the rest will likely follow'

'The underrepresentation of women (compared to their proportion of graduates and physicians) in leadership roles in hospitals and College committees is an important issue...

Improving [this] will need the hospitals to specifically consider how to encourage women to take on those leadership roles despite their reluctance to commit time at work which is already stretched to the limit and competing with greater outside commitments than the men...

Berating men to stop jealously holding on to power in hospitals is not likely to achieve much - supporting women who consider taking on leadership roles is the key.'

### **Education & Awareness**

Employers should take a lead role in educating staff on sexual harassment in the workplace in all its forms.

In Western Australia, the findings of Australian Medical Association WA's sexual harassment survey prompted a joint campaign between the AMA WA and the WA Health Department. This campaign was designed to increase awareness, inform doctors of their rights and obligations and encourage those who have been sexual harassed to take action. Posters were placed in WA hospitals and a website *Sexual Harassment OUT* ([www.sh-out.com.au](http://www.sh-out.com.au)) was created.

Respondents to ASMOF's survey highlighted the need for visible reminders addressing sexual harassment, including through posters around hospitals.

Other doctors shared ideas for what would education should be focused on, with respondents typically calling for education to be given to all employees (including senior staff), for this education to be ongoing, for it to give examples of inappropriate behaviours, and for education to include information on addressing harassment from patients.

'Providing strategies to doctors of all genders on how to address sexual harassment from colleagues and patients.'

'Examples should be give as perpetrators often do not have the insight that their particular behaviour is unacceptable'

'Educate everyone that it's not just a female issue. Keep putting out the message that it's not okay and that no-one should get away with it, esp those higher up in the hierarchy'

'Remind people that it's not just in workplace. I answered no to earlier question about having experienced / witnessed it in workplace, but have observed plenty of it at outside-of-workplace work functions (department welcome drinks, end-of-term hospital functions, etc).'

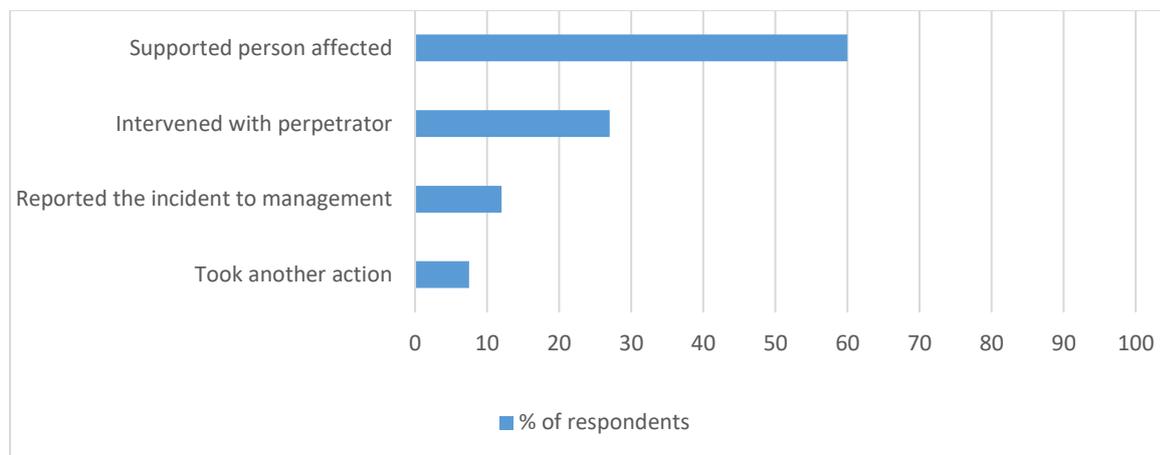
'As a junior doctor was never informed for the line re: sexual harassment from a patient and what to do.'

'have regular conversation about behaviour at workplace'

Education and awareness campaigns should also address appropriate actions for bystanders. 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. A small proportion reported the incident to management. Slightly less than a third of respondents (31%) did not take any action.

### **Actions taken by doctors who witnessed sexual harassment**



Further education will ensure that witnesses are increasingly confident in responding to instances of sexual harassment, including calling out inappropriate behaviour.

‘We all have a responsibility to call it out, and to behave professionally in all of our interactions.’

‘Speaking up, not to punish but to effect change in the right direction’

‘There are certain male dominated fields in medicine where sexual harassment is likely and we should all be encouraged to speak up if we witness this behaviour.’

‘Call it out early, report if persistent, support colleague’s

### **Internal reporting & management of misconduct**

ASMOF NSW members very frequently identified reporting and complaints as area of improvement for workplaces.

Doctors have called for internal reporting pathways which are clear and known to staff, confidential and independent. Many doctors believed there should be an option for anonymous reporting.

'Properly designed procedures for addressing reports of harassment. My report was emailed to dozens of people (including the perpetrator). Confidentiality is important'.

'Have a channel by which we may anonymously make complaints'.

'Workshop explaining specifically how to lodge a complaint and how outcomes will be transparent.'

'Ensure that the identity of the person harassed remains confidential and that reporting doesn't compromise their career progression.'

'Make a transparent complaints process (they seem not to have one).'

'A person to report the incident to who is not directly supervising you'

Additionally, doctors believed that supporting complainants through this process was important.

'Special wellbeing officers- doctors trained to deal with complaints and to support peers.'

'Take early counselling action - for those who report as victims so they can feel more comfortable that their workplaces hears them'

Many doctors called for greater transparency around actions taken as a result of sexual harassment complaints, including consequences for perpetrators, whether they were doctors, colleagues or service users.

'Actual consequences for those who sexually harass staff, regardless of the 'rank' of those involved.'

'Publish anonymised accounts of the behaviour categories of those involved and consequences for perpetrators and victims'

'I think support by a dr in medical admin, removal from the department and the influence of the offender, and progress assessments and support to ensure that no damage has occurred to the complainants career.'

'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. Independent third party is required.'

'I think employers need to make an example of senior clinicians that behave poorly rather than protecting them because of their value in service delivery.'

'Patients are threatened with not being able to continue care if they harass staff, but this is not actually what happens...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.'

### Policy

Doctors identified that strong policies were needed to address sexual harassment. Some doctors articulated that these show be 'no tolerance' or 'zero tolerance' policies which were clear that sexual harassment was prohibited.

'Clear guidelines need to be established about what is and is not acceptable within the workplace, so it is not about he said or she said.'

'Advertise the policy and provide resources to support the policy'

'Stress a no tolerance policy at induction of all new employees'

'Have a strict no tolerance policy'

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<sup>i</sup> AMA WA (2017), 'AMA (WA) launches sexual harassment campaign', available at <https://www.amawa.com.au/amawa-launches-sexual-harassment-campaign/>

<sup>ii</sup> 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](https://www.surgeons.org/media/22045682/PrevalenceSurvey_Summary-of-Facts_FINAL.pdf).

<sup>iii</sup> *ibid*

<sup>iv</sup> *ibid*

<sup>v</sup> *ibid*

<sup>vi</sup> 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.

<sup>vii</sup> 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

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<sup>viii</sup> Skinner N & Pocock B. (2014) 'The persistent challenge: living, working and caring in Australia in 2014' (The Australian Work and Life Index, University of South Australia, Centre for Work + Life, 2014) 5

<sup>ix</sup> Boland M (2018) 'Review of the model Work Health and Safety laws: Final report', available at [https://www.safeworkaustralia.gov.au/system/files/documents/1902/review\\_of\\_the\\_model\\_whs\\_laws\\_final\\_report\\_0.pdf](https://www.safeworkaustralia.gov.au/system/files/documents/1902/review_of_the_model_whs_laws_final_report_0.pdf)

<sup>x</sup> Launer J (2018) 'Sexual harassment of women in medicine: a problem for men to address', *Postgrad Med J*;94:129–130.