SPECIAL ARTICLE

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Prevalence of bullying, discrimination and sexual harassment in surgery in Australasia

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Abstract

Background: The topic of discrimination, bullying and sexual harassment in surgery was raised in the Australian media earlier in 2015. This led the Royal Australasian College of Surgeons (RACS) to commission an Expert Advisory Group to investigate and advise the College on their prevalence in surgery in Australia and New Zealand. This paper reports the findings with respect to prevalence of these inappropriate behaviours.
Methods: The data in this paper were drawn from the published results of two quantitative surveys. One was an online survey sent to all RACS members. The other was an invited survey of hospitals, medical institutions and other related professional organizations including surgical societies.
Results: The prevalence survey achieved a 47.8% response rate, representing 3516 individuals. Almost half of the respondents 1516 (49.2%) indicated that they had experienced one or more of the behaviours. This proportion was consistent across every specialty. Male surgical consultants were identified as the most likely perpetrators. More than 70% of the hospitals reported that they had instances in their organization of discrimination, bullying or sexual harassment by a surgeon within the last 5 years. Surgical directors or surgical consultants were by far the most frequently reported perpetrators (in 50% of hospitals).
Conclusions: Discrimination, bullying and sexual harassment are common in surgical practice and training in Australia and New Zealand. RACS needs to urgently address these behaviours in surgery. This will involve a change in culture, more education for fellows and trainees, and better processes around complaints including support for those who have suffered.

Introduction

Early in 2015 the public media (press and TV) published a number of stories highlighting illegal and inappropriate behaviour of surgeons in the workplace (e.g. see Medew[1]). In response, in March 2015, the Royal Australasian College of Surgeons (RACS) established an Expert Advisory Group (EAG). The Group was tasked with advising the College on strategies to address discrimination, bullying, sexual harassment and harassment (DBSH) in surgery.

Following a review of what was already known about DBSH in the medical environment, and in other professions such as the army and law, both in Australasia and overseas a background briefing paper[2] and an issues paper were produced.[3]

Given the lack of current information about DBSH in surgical practice and surgical training in Australia and New Zealand, the EAG commissioned further research into the prevalence and effects of discrimination, bullying and sexual harassment in Australia and New Zealand.

The purpose of this paper is to present the findings of this research with the aims to:

(1) identify how common DBSH are in surgery;
(2) identify what inappropriate behaviours surgeons, trainees and international medical graduates (IMGs) have been subjected to and whether those experiencing the behaviour(s) are likely to report it;
(3) identify whether there are specialty or regional difference; and
(4) gain an understanding of the experience of workplace organizations in relation to DBSH particularly focusing on the behaviour of surgeons.

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Method

This paper is based on the findings of the two quantitative surveys:

(1) Between 26 May 2015 and 26 June 2015 Best Practice Australia (BPA) administered an online survey of a total of 7405 individual members of the College (fellows, trainees and IMGs). BPA were commissioned by RACS to administer and analyse the ‘Discrimination, Bullying and Sexual Harassment Survey’ on behalf of the EAG to gain prevalence data. The results of that survey are published on the College website.[4] A copy of the survey is also available.[5]

(2) The survey of employers and other educators, specifically with educational groups (including speciality societies) and jurisdictions that is hospitals and health services, was conducted by ORC International. A total of 352 hospitals and educational organizations throughout Australia and New Zealand were invited to participate in the survey, which was conducted from 29 June 2015 to 20 July 2015. A copy of the survey and the results are available on the College website.[6] One hundred and seventeen responses (33%) were received (Table 1), which was considered to be a very strong response rate from such organizations. The purpose of this survey was to gain an understanding of their approaches to handling discrimination, bullying and sexual harassment within their members and workplaces.

Neither the College nor the EAG had access to any of the individual survey responses. All of the data in this report have been drawn from the collated, di-identified reports submitted to the EAG.

The following definitions were used:

- *Discrimination* means treating a person with an identified attribute or personal characteristics less favourably than a person who does not have the attribute or personal characteristic. Legislation in Australia at both federal and state level and in New Zealand outline a list of characteristics protected by law against which discrimination is unlawful (e.g. gender, age, religious belief, political belief, pregnancy, breastfeeding, disability, impairment, marital status, family responsibilities, sexual orientation, race and cultural background).
- *Bullying* is an unreasonable behaviour that creates a risk to health and safety. It is a behaviour that is repeated over time or occurs as part of a pattern of behaviour. ‘Unreasonable behaviour’ is a behaviour that a reasonable person, having regard to all the circumstances, would expect to victimize, humiliate, undermine or threaten the person to whom the behaviour is directed.

Table 1 Data from the survey conducted by ORC Inc. showing the organizations invited to respond to their survey and the response rates

Group	Number invited	Number completed	Response rate
Target			
Training hospitals	267	106	40%
Other (including specialty societies)	85	11	13%
Country			
Australia	296	89	30%
New Zealand	56	28	50%
Total	352	117	33%

- *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 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.
- *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 disability or the victimization of a person who has made a complaint.
- *SET trainee* is a doctor who is training to become a surgeon, undergoing an educational training programme under the governance of the RACS Education Board, the relevant Specialty Society and a conjoint Specialty Training Board.
- *International medical graduate* is a surgeon trained overseas who has been assessed as partially or substantially comparable with an Australian or New Zealand trainee and who is on a pathway to fellowship.
- *Younger fellow* is a person with FRACS who has had less than 10 years of experience.
- *Experienced fellow* is a person with FRACS and more than 10 years of experience.

Results

Results from the DBA prevalence survey

Demographic data

A total of 3516 (47.8%) individuals responded to the DBA prevalence survey. Table 2 shows the overall percentage response rate and the percentage response rate from each of the specialties that ranged from 32% ophthalmology to 58% neurosurgery.

- The highest proportion of respondents, 1612 (49.8%), identified themselves as experienced fellows.
- The majority identified themselves as either surgeons, 2130 (34.8%), and/or surgical consultants, 1491 (24.4%).
- Of 1333 current trainees, 532 (39.9%) responded, with trainees making 16.5% of all respondents. Each of the training years (1–5 years) had between 16 and 22% of trainees responding.
- In terms of gender, 81.1% (2606) were male and 18.7% (602) female (a small proportion did not identify their gender).

Experience of inappropriate/illegal behaviour

Almost half of the respondents answering the question on personal experience of discrimination, bullying, sexual harassment or harassment in the workplace answered ‘yes’. That proportion was consistently above 50% in all of the specialties (Table 2, column 3) except otolaryngology head and neck surgery, orthopaedic surgery and ophthalmology. There was, however, significant variance between specialties and across four kinds of behaviour.

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Table 2 Data from the survey conducted by BPA showing information by specialty from the questions: 'I have been subject to Discrimination, Bullying, Sexual Harassment or Harassment in the workplace' (column 3) and 'I have been subject to this behaviour in the workplace'

	Number of respondents/% of specialty	Number answering the question/% answering 'Yes'	Discrimination (% yes)	Bullying (% yes)	Sexual harassment (% yes)	Harassment (% yes)
All specialties	3516/48%	3079/49%	18%	39%	7%	19%
Cardiothoracic surgery	123/47%	111/63%	15%	49%	4%	37%
General surgery	1197/48%	1054/52%	21%	42%	8%	20%
Neurosurgery	190/58%	168/54%	14%	42%	11%	19%
Otolaryngology head and neck surgery	361/55%	327/47%	17%	37%	8%	15%
Orthopaedic surgery	757/41%	660/42%	15%	32%	**3%**	15%
Paediatric surgery	89/56%	79/52%	23%	38%	6%	24%
Plastic and reconstructive surgery	299/50%	254/54%	21%	44%	12%	21%
Urology	281/47%	239/50%	16%	38%	8%	18%
Vascular surgery	148/56%	127/51%	26%	39%	6%	19%
Ophthalmology	71/32%	60/30%	15%	**22%**	13%	**10%**

Note: The significantly lower percentage of ophthalmology respondents who stated that they had experienced any of the behaviours may have had an impact on the results shown in row 1, which is the overall averages. The lowest percentages in columns 4–7 are highlighted in bold.
BPA, Best Practice Australia.

As shown in Table 2, bullying is the most prevalent form of inappropriate/illegal behaviour, with discrimination and harassment varying between specialties. Although sexual harassment appears to be the least prevalent form of reported behaviour, 10% or greater was reported in three specialties.

In terms of the geographic location of where the behaviour took place, the proportion of all four behaviours was very closely aligned to the proportion of College members located in each region. For example, 29% of members are located in NSW whereas the reported location was 28% discrimination, 29% bullying, 30% sexual harassment and 29% harassment.

Of the 532 who identified themselves as trainees, 468 reported that they had experienced one or more of the behaviours. More than half (54%) responded that they had been subjected to bullying, 24% to discrimination, 23% to harassment and 12% to sexual harassment. Some had experienced more than one form of behaviour. However, experience of DBSH in the workplace is not limited only to trainees. IMGs, younger fellows and established fellows also reported experiencing one or more of the behaviours.

Figure 1 shows the percentage of reported experiences of each form of behaviour by level of experience. Trainees reported the highest rates of being subjected to bullying (54%), sexual harassment (12%) and harassment (23%), whereas IMGs were the group most frequently subjected to discrimination (27%).

Females were much more likely to experience DBSH than males. In relation to each of the four behaviours, the percentage of female respondents was significantly higher than males (Fig. 2).

Respondents who indicated that they had experienced any of the four behaviours were asked to provide additional information. The following relates only to that group of respondents. That is 468 of the 532 SET trainees, 129 of the 137 IMGs, 908 of the 953 younger fellows and 1558 of the 1612 established fellows.

In response to questions about the scope of each of the behaviours:

- Frequency: over 50% of respondents experienced the behaviours on more than three occasions, bullying being the highest reported experience with 71%.

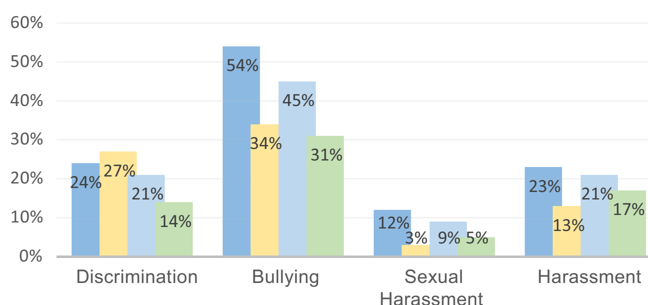

Fig. 1. Data from the survey conducted by Best Practice Australia relating the level of experience of respondents with their reported levels of experience of discrimination, bullying, sexual harassment and harassment. (■) SET trainee, (■) IMG, (■) Fellow <10 years, (■) Fellow >10 years.

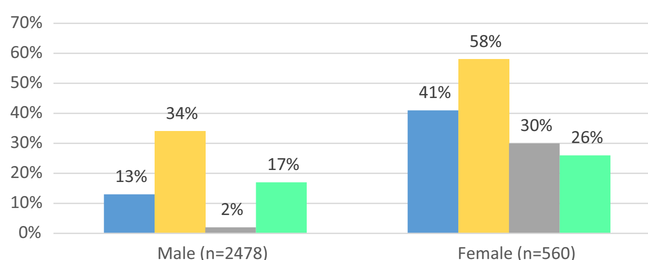

Fig. 2. Data from the survey conducted by Best Practice Australia relating the gender of the respondents with their reported levels of experience of discrimination, bullying, sexual harassment and harassment. (■) Discrimination, (■) Bullying, (■) Sexual harassment, (■) Harassment.

- Recency: between 38.3 and 48.7% of these experiences occurred more than 5 years ago, the highest reported experience being sexual harassment.
- Role: a surgical consultant was identified as the person most likely to display the behaviour (discrimination 84.8%, bullying 84.5%, sexual harassment 75.7% and harassment 81.3%).

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- Gender: for each behaviour, over 79% of respondents identified the perpetrator as male. Sexual harassment showed the highest male predominance with 90.3%.

These respondents were also asked by way of open-ended questions to describe the behaviour they had experienced.

- In relation to discrimination, 448 respondents identified a type of behaviour. These were coded and the most frequent responses were cultural/racial discrimination (33%) and sex or gender discrimination (16%).
- Belittling behaviour (22%) was the most prevalent theme of the 964 responses in relation to bullying.
- In relation to harassment three behaviours – harassment (15%), inappropriate criticism/accusations (14%) and belittling behaviour (14%) – were almost equally identified by the 412 respondents.

In relation to sexual harassment 10 behaviours were listed on the survey instrument and respondents had the option of ticking as many as applied to them. A total of 186 respondents indicated that they had been the recipient of sexual harassment. The highest frequency of mentioned behaviours was sexually explicit or offensive jokes (59%), unwelcome sexual flirtations (56%), inappropriate physical contact (53%), questions or insinuations about sexual or private life (52%).

Of the 344 who responded to a specific question focusing on gender-based discrimination, the most prominent behaviour identified was hurtful and humiliating comments (68.3%). Other frequently identified behaviours included being excluded from social events (38.7%), being denied training opportunities (38.4%), being assigned meaningless tasks (33.7%) and being denied operating lists (31.7%). There was little difference in these experiences between trainees, IMGs and fellows with less than 10 years of experience (70.7–75.6%), or between females (71.9%) and males (64.4%).

Taking action

Respondents were asked whether they took any action to address the behaviour. The most frequent outcomes for those who did take action included:

- the behaviour continued (22–33% across the four behaviours with the highest being harassment).
- I left my job (10.5–18.5% across the four behaviours with the highest being discrimination).
- I was victimized for making a complaint (5.3–15% across the four behaviours with the highest being harassment).
- the behaviour stopped (10.1–30.1% across the four behaviours with the highest being sexual harassment).

Those who responded that they did not take action ranged from 44.7% for bullying to 56.1% for sexual harassment. The highest ranking barrier to taking action identified by respondents was the potential for negative effects on future career options. As demonstrated in Figure 3, all levels of experience identified this as a barrier with trainees reporting the highest level of concern.

Results from the survey of hospitals and educational institutions

More than 70% of the responding hospitals reported that they had instances in their organization of discrimination, bullying or sexual harassment by a surgeon within the last 5 years. Bullying by surgeons was the most frequently identified behaviour with reported occurrences ranging from at least once per year (63%) and at least monthly (14%) to weekly (3%).

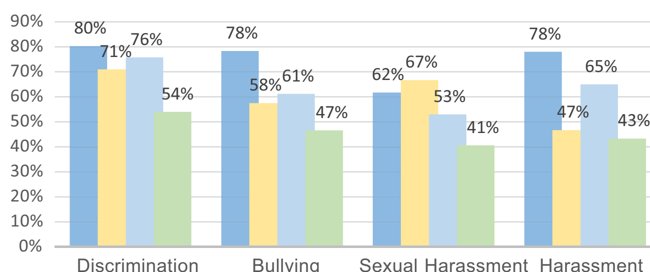

Fig. 3. Data from the survey conducted by Best Practice Australia relating the level of experience of respondents with the frequency of concerns about the future of their career as a barrier for taking action. (■) SET trainee, (■) IMG, (■) Fellow <10 years, (■) Fellow >10 years.

Surgical directors or surgical consultants were by far the most frequently reported perpetrators (in 50% of hospitals) with other medical consultants (24%) and nursing staff (26%) also commonly identified perpetrators.

Of the participating hospitals, 67% consider bullying by surgeons as a concern for the organization and the most frequent kinds of bullying were identified as verbal abuse (40%), ignoring service requirements/denying breaks (23%) and aggressive behaviour (21%).

Discrimination by surgeons was identified as a concern for the organization by 31% of the responding organizations with race/religion/cultural bias being identified as the most frequent form of discrimination (35%), followed by denial of opportunities/bias selection (20%) and gender/sex/pregnancy (18%).

Sexual harassment was identified as a concern by 14% of the organizations with suggestive/inappropriate comments being the most frequent behaviour (38%).

Many organizations became aware of the instances of discrimination, bullying or harassment by surgeons through informal, rather than formal, sources. Word of mouth was most the most frequent source (52%). Informal reporting was also identified as important (42%), whereas formal complaints were identified by 47% of the participating organizations.

Discussion and conclusions

The results of these two surveys indicate that the four behaviours – discrimination, bullying, sexual harassment and harassment – occur in all surgical specialties, in all geographic regions and have been experienced by RACS members at all levels (trainee, IMG and fellows). They also show that both individuals as well as a large proportion of hospitals have identified that surgeons, and in particular senior surgeons, are likely to be the perpetrators.

This is one of the most comprehensive surveys relating to the prevalence of DBSH undertaken in Australasia. Although the find-

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ings are consistent with much published data,[7–13] the scale of the problem will doubtlessly shock many surgeons, other health care professionals and the public. The studies focus on the behaviour by surgeons, but it is likely that similar issues affect other medical specialties and health care more broadly.

It is important to note that the reports of the behaviours have been taken at face value. There was no attempt to prove or disprove any of the reports. Nonetheless, the reports are so consistent that they cannot be dismissed or ignored. The incidence of sexual harassment and gender-based discrimination is particularly concerning, and may reflect the continuing male dominance within surgery. There is also a high incidence reported of race or cultural-based discrimination affecting IMGs.

The surveys also highlight the current lack of reporting. This appears to reflect fear that reporting will damage a career. Comments from employers highlighted that most of their information about the behaviour of their staff comes through informal rather than formal reporting channels.

Having received this information, there is now an imperative for RACS to act. RACS has committed to developing an action plan to address these issues. However, these challenges cannot be addressed by the College alone. Major cultural change can only be achieved in partnership with the training boards and specialty societies, with other Colleges, employers and the regulators. Likely solutions will require leadership and then broad commitment from the profession.

Initial steps:

- The College has issued an apology to the public, our fellows, trainees and IMGs for not ensuring these standards were met in the past.[14]
- Key standards for behaviour and equity emphasizing the rights of patients, health care workers and surgeons, including IMGs have been defined and promulgated.

Longer term responses will include:

- To achieve changes in behaviour and culture will require education about DBSH, about non-intimidatory teaching methods and how to deliver feedback appropriately.
- Complaint handling, support and counselling must all be improved dramatically, and again will require partnerships. However, the College needs to ensure people affected by DBSH feel safe to complain and that the process to address complaints is founded on sound processes that are robust, fair and subject to external scrutiny.
- Ongoing collaboration to ensure appropriate responses, investigations, natural justice and sanctions.
- Identifying ways to ensure safety for bystanders and to encourage them to speak out.

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Conflict of interest

Graeme Campbell is a member of the EAG.

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