EAG - Issues Paper Response
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Monday, 20 July 2015

To whom it may concern,

RE: Issues paper calling for submissions on discrimination, bullying and sexual harassment in the practice of surgery

Please find attached a submission on behalf of Level Medicine Inc. on the RACS issues paper on discrimination, bullying and sexual harassment in the practice of surgery.

Level Medicine ("Level") is a not-for-profit organisation, started by University of Sydney medical students seeking to change the conversation around gender in medicine. We aim to encourage women in medicine and surgery, and to provide a place for resources and discussion about gender roles and life balance throughout a medical career, for men and women alike.

As we have only just incorporated, we do not yet have a website. However, please do not hesitate to contact me via email at level.medicine@gmail.com or on 0423 502 104 if you have any queries.

Kind regards,

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Level Medicine Inc.
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INTRODUCTION

Level Medicine ("Level") is a not-for-profit organisation, started by University of Sydney medical students seeking to change the conversation around gender in medicine. We aim to encourage women in medicine and surgery, and to provide a place for resources and discussion about gender roles and life balance throughout a medical career, for men and women alike.

While the majority of us are in the first year of postgraduate medicine, we have a broad range of experiences (with graduates from biomedical science, law, nursing, humanities, nutrition, and neuroscience, and both mature age and standard entry students), and were all struck by the way our student experience – even in this first six months of our medical career – has already been impacted upon by sexism in medicine. Each of us has been faced with the sexism that is prevalent across medicine, though our experiences have varied, from lecturers making sexist comments, to individual interactions with surgeons, or with interactions among our peers. Indeed, the idea for Level to start as an organisation started even before the furore around Dr Gabrielle McMullin's statements in April earlier this year, and was in fact triggered by a desire to change the inherent, structural biases that create obstacles for women interested in medicine and in surgery.

KEY POINTS

We have included below responses to certain key discussion points outlined in the RACS Background Briefing and Issues Papers. However, we would first like to make two key points that relate to the overarching themes of our responses below, which are reflective of our experiences so far as students in medicine. These are:

1. An ingrained culture of sexism in medicine is evident from the beginning of medical education (i.e. at the university level), meaning that any truly effective strategy to reduce ingrained sexism needs to begin by engaging students at this level and discouraging them from absorbing inherent and unconscious gender-based biases; and

2. Sexism and sexual harassment are fundamentally different in character and in cause from non-sexual bullying/harassment of trainees, and need to be treated as such.

RESPONSES TO THE "RECURRENT THEMES"

1. *Organisational culture*

Since Dr. Gabrielle McMullin noted in early April that female surgical trainees were better off in terms of their career to submit to sexual harassment rather than make an

official complaint, numerous women in medicine (not just surgery) have come forward to voice similar stories. The prevalence of these stories, and the attitudes of surgeons that they imply, show that a toxic culture exists among some surgeons that it is acceptable to sexually harass trainees and that such behaviour will go unpunished.

While it is very difficult to say if surgeons know where the line is, and yet still cross it (discussion point 1(a)(i)), it does seem likely that most perpetrators would be aware that blatant, physical sexual harassment is unlikely to fall within the confines of the law. Education about this, and about consent, the law, and sexual relationships more generally, as well as specifically about the relevant professional and educational standards, *could* be a useful tool to prevent such egregious behaviour.

However, any such educational initiative would need to take into account two factors.

Firstly, such a program would be impinging upon the time of already very busy, and very stressed doctors. While this is necessary, it means that education around this area would need to be particularly engaging and well thought out, to not simply fall into the trap of distancing doctors from the goals of the program by becoming an extra administrative burden (which is relevant to points (1)(a)(ii) and (iii), and (1)(b)(i) and (ii).

Secondly, sexual harassment laws usually reference a very low standard in comparison to what should be acceptable workplace culture; in educating surgeons, trainees, and other members of the surgical workforce, we need to aim for a positive workplace environment where not only is no-one being sexually harassed, no-one feels like they are limited or stereotyped in any way by their gender

Refocussing training to prevent sexual harassment by emphasising patient safety

Using patient safety as a focus point to discuss sexual harassment may be useful, but only in conjunction with other efforts to change the toxic culture and attitudes around gender in surgery. While it may be more useful in terms of preventing bullying of trainees, given that bullying of trainees often relates to their performance in relation to patients, sexual harassment is often simply about the relationship between the perpetrator and the victim, and is often gender- rather than performance-based. This is a phenomenon that would need to be taken into account in any program that refocusses these issues to be about patient safety, as we would be concerned that any program that seeks to refocus these issues solely to ones of patient safety would run the risk of creating more backlash, where trainees feel further unable to speak up about sexual harassment that has occurred to them for fear of being told they are also reducing patient safety/experiences. WORDING.

2. The culture of surgery: (a) Gender inequity

i. What else can be done to address gender inequity or promote gender equity?

We believe that there are a number of key strategies that the RACS should investigate and implement in the surgical profession. Strategies that should be pursued include:

- **Mentorship program:**
  - Implementing a more formalised female mentorship program, such as that run by AFMW NSW for female trainees: https://mwsnsw.wordpress.com/mentoring/ ; this could provide women with more support in their training and encourage them by providing positive examples of women who have become surgically qualified
- **Code of Practice:**
  - We would support a Code of Practice or MOU between the College and key institutions, especially key training hospitals, that is linked to key performance indicators and targets promoting gender equity
  - However, such a Code of Practice should also give guidelines for management of trainees, particularly advanced trainees, who require flexibility

- **Job share, part-timing, maternity and paternity leave and time off:**
  - The RACS should create and promote standards for the availability of job share, part-time work, maternity leave and time off, and negotiate with training hospitals to ensure that hospital staff and other institutions will support trainees who require this flexibility
  - The RACS should also actively encourage its male trainees to take paternity leave, to encourage gender equality in the family and also to allow male trainees the time to engage with being a parent of a young child
  - There has been some success linking part-time employment of doctors with financial incentives for hospitals in the UK; this could be something to investigate further by the RACS in surgery

- **Engagement with university students**
  - The RACS and surgical professionals should engage with university students, male and female, with a non-gender-biased perspective, and actively combat the culture that reminds and reinforces stereotypes of surgery as being unfriendly or challenging particularly for women, and to dispel the myths of surgical training programs as being incompatible with starting a family

- **Gender-based quotas**
  - Level recognises that in any profession, gender-based quotas are not, and should not, be a method for unfairly promoting unqualified

applicants. Despite this, it has been recognised that gender bias in selection panels may be a significant obstacle in increasing the number of women trainees being accepted into surgical training, and one which could be combatted by creating gender quotas.

- However, such a quota would need to be clearly supported by a series of policies that ensure that women coming into surgery under them are not subject to a culture that treats them simply as having gotten in *because* of those quotas, which would likely simply exacerbate the existing high rates of drop-outs of female surgical trainees, often cited as being due to lack of support.
- Furthermore, this would also require that enough adequately experienced women are getting to the PGY2 application stage (i.e. would require ensuring that women feel empowered to take on surgical experiences in medical school as well as PGY and intern years, in order to be competitive applicants)
- However, quotas may prove too difficult to implement on a practical (or immediate) basis; in such a case it would also be worth the College encouraging (perhaps through a clearly stated Code of Practice) a policy of aiming for quotas in, e.g. surgical teaching and surgical conferences. For example, events hosted by the RACS should aim for equal representation of men and women (or at the very least, no all-male panels).

ii. Is there a link between gender inequity and discrimination, bullying and sexual harassment? If so, what is it?

Female trainees in surgery are more vulnerable to discrimination, bullying and sexual harassment in a number of ways:

- **Persistent domestic gender roles:** women are still expected to take on the majority of the burden of running a household, raising children, and caring for elderly parents, meaning that it is often up to them to take more time off than their male counterparts; this puts them in the situation of having to ask for more time off, from superiors (and institutions) who are often not supportive or sympathetic to their aims. This is an issue that we already see at the university level, with many male students automatically encouraged to take on the challenge of surgical training with only a warning about how intellectually challenging it is likely to be, while the surgical-minded women in our group have all uniformly noted that many times, on expressing their interest in surgery, the first response they receive is a question on how they plan to have and raise children

- **Maternity leave:** if they would like to have children, women need to take some time off to do so (even for the minimum amount of time); this is not something that men have to face, though one way to deal with this would be to

encourage (and perhaps even mandate) a minimum amount of paternity leave for male trainees

- **Lack of support and mentorship:** a lack of available advisors, who have been through similar pathways and can offer realistic support and also take effective action, is also likely to impinge on the ability of women to make complaints about inappropriate behaviour

3. **Bystanders are silent**

As Dr McMullin pointed out earlier this year, victims of sexual harassment in surgery are silent because they do not trust the institutional response to their complaint. Bystanders are likely to feel similarly, and also are very unlikely to receive a supportive institutional response. Without the trust that they will be treated justly, bystanders are then simply just as likely to remain silent.

This can be addressed by ensuring that RACS has a strong public stance indicating that sexual harassment and gender discrimination will no longer be tolerated, or ignored, such as could be done by implementing the voluntary Code of Practice or MOU with key institutions, referred to above. Key points that would need to be covered in such a policy include:

- Systematic guidelines to deal with complaints of sexual assault in a transparent and reliable way
- Statements of support and reassurance for trainees and staff that if they are a victim of sexual harassment, speaking out will not threaten their career
- Possible avenues for making examples of perpetrators of sexual harassment, to help change the culture of surgery to one that visibly and clearly will hold to account perpetrators of sexual harassment

4. **How are the problems different for each of discrimination, bullying and sexual harassment?**

Bullying of trainees is fundamentally different to sexual harassment. While bullying is based on hierarchy, it is, we would argue, on a spectrum of trainees that has appropriate disciplinary action and teaching styles at one end, and unfair and inappropriate bullying, discrimination, and non-sexual harassment at the other. As such, any initiative designed to combat bullying of trainees needs to educate surgeons at every level, but particularly those with significant teaching and supervisory roles, about positive teaching methods and how to treat those subordinate to them. In some cases bullying is hard to distinguish from necessary hierarchy- where junior doctors need to know and stick to their limitations. The response to the problem of bullying in medicine is a long-term cultural response to shape the way our hierarchy exists, and

change attitudes to teaching and training, and could be addressed by the “no-blame” complaints system

Sexual harassment and gender-based discrimination, on the other hand, are not on a spectrum, but rather need to be treated with a “zero tolerance” policy. This is because gender biases are created not just on the basis of single, more rare events of sexual harassment, but on the everyday subjugation of trainees on a gender basis, from comments about how a female trainee may look, or about them applying for time off for maternity leave, to comments to female medical students interested in surgery about the difficulty of having a family with a surgical career. It is the everyday obstacle that such attitudes create that can discourage women from entering surgery, that can discourage them from engaging one-on-one with male supervisors for fear of how it may appear, and that can then discourage them to make complaints. This everyday sexism can only be prevented with a strong, and enforced, policy on sexual harassment, and with engaging and innovative educational programs that promote surgeons and their colleagues to create a gender-free environment.