Gender Equality and Junior Doctors

Stephanie Nesbit

Junior doctors are the frontline of the public healthcare system in Australia. Upon completion of medical school, graduates complete one year as provisionally registered interns, which may be followed by one, two, or more years as prevocational trainees before they are accepted into a specialist training college. At this stage in their career, junior doctors are known to work long and unsafe hours and are at increased risk of burnout and depression [1]. They must vie for increasingly competitive positions in specialist training programs, often do not prioritise their own healthcare and may feel pressured not to call in sick to work [2]. These troubles are universal. However, female doctors face particular burdens, including workplace bullying and sexual harassment, and a scarcity of options for maternity leave and job-sharing at this time in their career.

Whilst the conditions for junior doctors continue to improve, ongoing research, advocacy and commitment from both government and hospitals is required. Such efforts will not only improve the health and wellbeing of junior doctors and more broadly the provision of healthcare to the country, but may flow on to create systemic change and promote equality in medicine.

Key facts and figures

There were 3312 accepted intern positions across Australia in 2017 [3]. Although the gender breakdown of these jobs is not available, the percentage of new female medical students has remained stable at 50-52% since 2011, and this does not appear to change significantly as students progress through the course [4]. However, only 34% of hospital-based specialists are female [5], reflecting not only historical

inequality but increased drop-out of female doctors as they progress to more senior positions [6].

A recent survey on the health and wellbeing of 914 junior doctors reported by the Australian Medical Association found that more than two thirds of respondents had experienced high levels of stress at work [7]. Females were more likely to be at risk of burnout (73% vs 65%) and compassion fatigue (59% vs 48%), and had lower levels of job satisfaction compared to males (75% vs 65%).

It was also reported that junior doctors found it difficult to maintain a work-life balance in the role. More than half of the respondents reported that their workload had been excessive and 41% believed that their workload compromised patient safety. Only 3% of respondents were working part-time, of whom 65% were female. Access to parental leave was not directly assessed, but 67% of respondents had taken fewer than five weeks of annual leave, and over three quarters had taken less than a week of personal leave. There is clearly a barrier to accessing different types of leave or job-sharing opportunities as a medical graduate. Lack of available cover as well as the pressure not to call in sick have been identified as reasons not to take leave [2,7].

Parental leave as a junior doctor can be hard to access. Employers are governed by federal legislation that stipulates women are entitled to a period of 52 weeks unpaid maternity leave (including 18 weeks of paid parental leave at minimum wage). “Dad and Partner Pay” specifies that fathers are also eligible for 2 weeks pay at minimum wage. When the period of maternity leave has finished, either partner may request a further 52 weeks unpaid leave (totalling 24 months unpaid leave for the couple). They may also request a return to part-time or flexible hours which the employer must show reasonable grounds in order to refuse [8,9]. Further, state-based

Enterprise Bargaining Agreements stipulate periods of paid leave. As an example, the AMA recently secured a new Victorian EBA, which includes 10 weeks paid leave at full-pay for primary caregivers and one week paid leave for non-primary caregivers [10]. However, junior doctors are typically employed on only 12-month contracts. As most young doctors are in their 20s, women often feel that they must either defer having children, or risk having no job to come back to [11]. The lack of parental leave options for doctors has been identified as a significant structural barrier to women moving into leadership roles and those with higher pay [6,12].

What's happened in this area lately?

Concerns about a culture of bullying and harassment in the medical profession have come in to the spotlight recently. This issue emerged following several high-profile cases coming to the media attention, particularly a piece by Dr Gabrielle McMullin who described the sexual harassment of female surgical trainees as "rife within the profession [13]." The AMA also suggested that this is likely to be "replicated in other medical specialties" and 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 [14]."

The AMA Western Australia released a survey on the prevalence of sexual harassment in the medical workforce. They found that 31% of 950 respondents of a survey had experienced sexual harassment in the workplace, including whilst applying for a job or training position. 81% of these who had experienced sexual

harassment were women [15]. AMA WA has recently launched a campaign called SH-OUT, aiming to help doctors recognize, fight, and report sexual harassment [16].

Following these allegations, the 2016 inquiry into the medical complaints process in Australia recommended that "all hospitals review their codes of conduct to ensure that they contain a provision that specifically states that bullying and harassment in the workplace is strictly not tolerated towards hospital staff, students, and volunteers [17]." Such a change of culture requires systemic change, and the AMA, RACP and RACS have all released statements acknowledging and condemning the prevalence of workplace bullying in medicine [18–20].

What still needs to change?

Harassment, sexual harassment, and bullying: We do not have accurate or extensive information on the prevalence and effects of harassment and bullying amongst junior doctors. While the 2015 Expert Advisory Group Report to the Royal Australasian College of Surgeons uncovered an entrenched culture of discrimination, bullying and harassment across all surgical specialties, this broad-strokes report did not specifically capture the effect of this culture on junior doctors, only surgical trainees [21]. Therefore we cannot comment on whether unaccredited trainees and the most junior medical staff are more, or less likely to be impacted by this behaviour. There have also been a few high-profile media cases addressing the issue, and the AMA WA survey which suggests that sexual harassment is "endemic" in medicine [22]. Surveys such as the Health and Wellbeing survey must include questions on harassment, sexual harassment and bullying, and must target junior doctors specifically. Given the results of the WA survey, similar projects should be rolled out

Australia-wide. This will not only elucidate the extent of the problem but also allow us to evaluate programs promoting change.

Additionally, there needs to be a framework to address the problem of workplace bullying in medicine. The Senate inquiry into the medical complaints process in Australia advocated for a “cross-sector approach” in which “government, medical boards, AHPRA, hospitals and specialty colleges” are involved [17]. Junior doctors rely primarily on their hospitals of employment to enact action plans which provide training to staff and appropriate reporting and counselling services. There is not currently coordination between these entities to create a standardized approach to tackle the issue, which is required if the response is to cover junior doctors in all corners of the country.

Parental leave: Improving the access of junior doctors to parental and personal leave requires a multi-level approach. The Medical Board of Australia needs to facilitate part-time work and parental leave for junior doctors as part of its accreditation requirements. Award agreements need to incorporate provisions for doctors to take parental leave in circumstances where their contract may expire in the period of leave, and employers must integrate flexible arrangements as part of their rostering system. It must be noted that broader cultural change around parental, which promotes both men and women accessing parental leave and sharing childcare responsibilities, is sorely needed.

Working conditions: Working conditions for junior doctors continue to improve, and there are now caps on working hours, overtime, and night shift stipulated by both hospitals and award agreements. However junior doctors continue to have poorer-than-average mental health. There needs to be restrictions on the number of hours that doctors can work, to minimize burnout and compassion fatigue. Hospitals need

to recognize the burden on their junior staff and implement support programs and avenues for younger staff to raise their concerns, report inappropriate behaviour, and ask for help. Senior leaders need to lead the fight against the hierarchical system which neglects junior doctors, and both individuals and institutions must make a commitment to abolishing harassment and bullying in medicine.

Representation of junior doctors: One of the factors contributing to the difficult transition between medical school and internship is a lack of belonging and structure for junior medical staff. Medical students can turn to their university for advice and support, and registrars look to their training college. However junior doctors exist in a no (wo)man's land between the two. There are several avenues available for support, but none are perfect. The first includes the official hospital channels - for feedback or guidance, but some may not trust their employer as an impartial judge in matters such as harassment, bullying, mental health, and fair work conditions. Secondly, hospitals have RMO societies which act as informal in-hospital support networks for junior doctors and registrars. Such societies are useful for informal advice, but are governed by their hospital, and have little leverage to advocate for junior doctors.

A third stakeholder is the AMA's Doctors in Training (DiT) arm, which aims to support pre-vocational doctors and ensure that their voices are heard in AMA discussions, submissions and reports. However not all junior doctors are part of the AMA, and the DiT does not act as a surrogate college or university for young medical professionals. They work within the AMA's existing framework to provide advocate for "issues of importance to junior doctors," including "work on doctor health and wellbeing, the continued advocacy for safe working hours in medicine, a renewed push for flexible work arrangements across the country, support for Indigenous trainees and a fierce call for the protection of education and training conditions in the

pre-vocational space [23,24].” For junior doctors, none of these parties can fulfil all the roles of a registrar’s college, or a university. There needs to be transparent and comprehensive support networks for junior doctors at the hospital level, through either connecting these parties, expanding the role of the AMA DiT and similar services, or creating a body which acts solely in the interest of unaccredited medical graduates.

What should Level do?

There are multiple opportunities for Level to advocate for change. Firstly, Level can help develop and promote projects which survey junior doctors about their concerns, as well as their experiences of harassment, sexual harassment and bullying. Level should also continue to advocate for improvements to leave opportunities for junior doctors. Level’s Emily Dunn has published an article Parental Leave in Medicine which highlights the issues faced by doctors in accessing Parental Leave, and her recommendations for change are equally relevant for junior doctors [12].

To truly tackle the issues facing junior doctors, Level’s future work should include students and doctors at all levels of their training. The organisation began as a community of medical students, but as its reach grows, so must its base. By engaging students, doctors and leaders from a variety of backgrounds, we can better understand and improve gender equality in medicine at all levels.

How can medical students advocate on this issue?

Medical students and junior doctors should advocate for better working conditions and continue to raise awareness of the issues that face them. The impact of this

should not be underestimated. The AMSA submission to the inquiry on the Medical Complaints process in Australia was particularly impactful. Elise Buisson, then-president of AMSA, described to the committee one example of sexual harassment reported by a female medical trainee, which made a significant impression on the committee and influenced their standing on the prevalence of sexual harassment in the medical community [17,25].

Junior doctors and medical students must also prioritise their own health and wellbeing and that of their colleagues. By engaging in open discussions about the difficulties they are facing and offering support, they can create an accepting and inclusive atmosphere. They should make themselves aware of the policies and plans of the hospitals where they work, and know what provisions are in place if they or colleagues feel burnt-out or depressed, or if they experience bullying or harassment. This includes becoming familiar with, and supporting the work of, their supervisors, RMO societies, Medical Workforce Units, and the AMA DiT. They should educate themselves on how best to feedback to their employers, take opportunities to give constructive criticism, and continue to emphasise how important such feedback and support systems are.

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