DISCRIMINATION, BULLYING
& SEXUAL HARASSMENT

ACEM MEMBERSHIP CONSULTATION PAPER

AUGUST 2017

BACKGROUND

The Australasian College for Emergency Medicine (ACEM) Board initiated the Discrimination, Bullying and Sexual Harassment (DBSH) project in August 2016. As a first step, ACEM conducted a survey into the prevalence of discrimination, bullying and sexual harassment in the emergency medicine specialty during April-May 2017.

The results suggest that emergency medicine has similarly high rates of these behaviours to other medical specialties within Australia and New Zealand, and internationally. Our members are both perpetrators and victims, and it is likely that these behaviours have a significant impact on the culture and working conditions within emergency departments.

ACEM takes this matter very seriously, and has a leadership role to play in ensuring that emergency medicine is practiced in a respectful and inclusive environment, free from bullying, discrimination and sexual harassment. Having investigated the extent of DBSH within the emergency medicine specialty in Australia and New Zealand, the College is committed to developing and implementing an action plan to address these behaviours.

WE WANT YOUR FEEDBACK

The DBSH Project Working Group has been tasked with developing an action plan on behalf of the membership to address these issues. The Working Group has now analysed the survey results, and is seeking the input of members and trainees on strategies and specific actions to prevent and address DBSH in emergency medicine.

This paper presents an overview of the survey results, as well as key themes for discussion. The paper is structured by these themes, with some suggestions for addressing these issues. The College is seeking a broad range of feedback, and you are not limited by the questions in the paper. In responding to this consultation paper, you can answer as many or as few questions as you wish.

HOW TO GIVE FEEDBACK

You can give your feedback via an anonymous form on the ACEM Website.

Alternatively, you can email your feedback to Ange Wadsworth (DBSH Policy Officer) at angela.wadsworth@acem.org.au. In your email, please number your responses to the questions using the numbering in this consultation paper.

We are accepting feedback until **5 September 2017.**

All feedback will be treated confidentially. If you have any questions, please email Ange Wadsworth.

THE MEMBERSHIP SURVEY

The survey of College Fellows, members, trainees and Specialist International Medical Graduate (SIMGs) was independent, confidential and anonymous. *Best Practice Australia* was contracted to design, administer and analyse the survey results.

The survey had a high response rate and a large sample size: the response rate was 44% of College members and trainees (2,121 respondents from a total of 4,817), of whom 54.7% (1,152) identified as male and 44.6% (939) identified as female.

The full survey report from Best Practice Australia is available on the ACEM website. This consultation paper discusses the major findings from the report.

DEFINITIONS USED IN THE SURVEY:

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. New Zealand, Australian Federal and State legislation outline a list of characteristics protected by law against which discrimination is unlawful. (For example: gender, age, religious belief, political belief, pregnancy, breastfeeding, disability, impairment, marital status, family responsibilities, sexual orientation, cultural background).

Bullying is unreasonable behaviour that creates a risk to health and safety. It is behaviour that is repeated over time or occurs as part of a pattern of behaviour. 'Unreasonable Behaviour' is behaviour that a reasonable person, having regard to all the circumstances, would expect to victimise, humiliate, undermine or threaten the person to whom the behaviour is directed.

Harassment is unwanted, unwelcome or uninvited behaviour that makes a person feel humiliated, intimidated or offended. Harassment can be racial hatred and vilification, related to disability or victimisation of a person who has made a complaint.

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.

THE MAJOR ISSUES HIGHLIGHTED IN THE MEMBERSHIP SURVEY

Members were asked if they have *ever* been subjected to DBSH behaviours in the workplace while practising in emergency medicine.

49.8% of respondents stated they had been subject to discrimination, bullying, sexual harassment or harassment in the workplace as a FACEM, Emergency Medicine trainee, ACEM Certificant, ACEM Diplomate or Specialist International Medical Graduate (SIMG) applicant.

PREVALENCE RATE RESULTS

The reported prevalence rate by behaviour was:

Behaviour	% answered yes
Bullying	34.5%
Discrimination	21.7%
Harassment	16.1%
Sexual Harassment	6.2%

Females reported DBSH behaviours at higher rates than males, with the exception of harassment which was experienced at almost equal rates by both genders:

Gender	DBSH (% yes)	Discrimination (% yes)	Bullying (% yes)	Harassment (% yes)	Sexual Harassment (% yes)
Female	55.7%	26.1%	38.2%	15.2%	12.2%
Male	45%	17.8%	31.3%	16.4%	1.5%

BULLYING AND HARASSMENT

The four most commonly experienced bullying behaviours were belittling, anger tantrums, accusations and verbal abuse. The four most commonly experienced harassment behaviours were belittling, inappropriate comments, anger tantrums, and accusations.

> *Ongoing, severe, daily bullying by consultant body in previous job. Being put down, told I was incompetent without evidence or advice as to how to rectify it, being belittled and screamed at in front of patients and staff, being told I was unsuitable for Emergency Medicine and that I should quit the training programme, denied any form of primary exam support when it was given to others, denied opportunities to train or lead in resus or on the floor despite asking for further training.*
> *Being told many times I'm not doing the job like I should and that I am the worst of my cohort.*
>
> *Consultant yelling and shaming in public. Quick to anger and public humiliation about medical skill.*
>
> *I was bullied by a FACEM at work after disagreeing with him. He publicly humiliated me on several occasions, in front of patients and colleagues.*
>
> *Yelled at in front of patients and colleagues and then taken to an empty corridor and yelled at some more. Told that I had to do anything the consultant asked me to do. Told to continue to attempt a procedure that I had unsuccessfully attempted multiple times to perform and when my continued attempts were hurting the patient and where there were other experienced doctors present who would have been able to perform the procedure.*

DISCRIMINATION

The most commonly reported discriminatory behaviours and reasons for discrimination were categories of gender-based discrimination (gender, parenting, pregnancy and breastfeeding discrimination and sexual harassment) or racism (race or colour-based discrimination). Exclusion was also a frequently reported discriminatory behaviour.

GENDER DISCRIMINATION

Female gender discrimination is a common theme in the survey:

> *Not being included in training and practical experience because of my gender. Being put into positions where I will be forced to undertake less interesting jobs because of my gender. Being ignored, being interrupted when attempting to give an opinion in meetings. Having my contributions dismissed as irrelevant when they are not.*
>
> *Less rotation opportunities and less learning opportunities than my male colleagues.*

Male junior doctors clearly treating me with less respect than other male senior colleagues.

Male only after work social activities, males being given special privilege to swap shifts/get out of night shifts on roster as buddies with the right consultant.

Parenting discrimination (discrimination based on pregnancy or parenting status) is a theme from the survey:

I was told not to apply for a resident job if I was planning on getting pregnant.

…asking during job interviews if I plan on falling pregnant this term. Being told at the start of my training as an advanced trainee that as a female of child bearing age we "should all put our eggs on ice" if we want to get through training.

Having children while training in ED garnered many sexist comments in relation to pregnancy and a lack of commitment to training. I was never offered maternity leave.

Inappropriate comments, sexual advances and sexual innuendo were the three most commonly cited **sexual harassment behaviours** in the survey:

Unwanted touching, sexual remarks, repeated leering.

Request for sex whilst on a conference from a consultant who I work with.

Certain FACEM saying sexually loaded comments. Not necessarily directed at me, but just statements with sexual connotations which make me (and other staff) feel uncomfortable. Also being overly friendly and sitting very close when discussing patients at the desk.

Repeated unwelcome sexual advances by a female consultant, unwelcome physical contact (shoulders, arms). The individual was also responsible for my in training assessment, making it very difficult to even raise the issue with other senior staff.

RACIAL DISCRIMINATION

Discrimination on the basis of race or colour was reported by 44% and 32% of 439 respondents who reported discrimination.

The survey didn't specifically ask respondents if they spoke English as a second language. However, if we look at respondents who indicated that their country of birth was a non-English speaking country, the prevalence rates for all behaviours were:

Respondent Category	DBSH (% yes)	Discrimination (% yes)	Bullying (% yes)	Harassment (% yes)	Sexual Harassment (% yes)
Non-English speaking country of birth	58.5%	39.7%	37.6%	22%	2.8%
All respondents	49.8%	21.7%	34.5%	16.1%	6.2%

…Common practice to discriminate and bully south Asian origin registrars…We were unfairly bullied at handovers. Always felt that management was not supportive. Mocked, ridiculed and criticized behind our backs. There has been many occasions where derogatory comments were made towards Indigenous patients.

During my advanced training year, I was subject to much discrimination which was difficult to disclose to anyone as it was done in a way of silently killing my ego and confidence. I also observed discrimination towards other overseas trained colleagues. It was quite difficult and a sensitive matter to discuss...I have no trust in the system, how fair it will be.

I am left with no doubt that I am treated differently as an [international medical graduate] compared to Australian-born trainees…I am expected to perform at least ten times better to match their scores.

Persistent requests to repeat certain words in "NZ" accent. Jokes about New Zealanders being second class citizens within Australia.

PROFILES OF PERPETRATORS AND VICTIMS

Over 70% of incidences of DBSH happened in the ED. Males were overwhelmingly the main perpetrators of DBSH, with the primary reported perpetrator of any of the four behaviours being a FACEM.

Advanced trainees experienced the highest rates of DBSH; however, other respondent categories also have high rates. The longer the years in training, the higher the prevalence statistic:

- 53.3% (n=389) of the 730 self-identified FACEM Training Program Advanced trainees who completed the survey have been subject to any one or more of the four DBSH behaviours.
- 47.8% (n=505) of the 1,057 self-identified Fellows of the College (FACEM) who completed the survey have been subject to any one of the four DBSH behaviours.
- 44.9% (n=83) of the 185 self-identified FACEM Training Program Provisional trainees who completed the survey have been subject to any one of the four DBSH behaviours.

A significant proportion of the membership reported repeated exposure to DBSH (more than 20 times):

Behaviour	*% exposed to DBSH >20 times*
Bullying	17.5%
Discrimination	19%
Harassment	18.1%
Sexual Harassment	8.6%

With the exception of sexual harassment, approximately one quarter of respondents had experienced the behaviour in the last six months.

RESOLVING DBSH ISSUES

High rates of respondents said that DBSH behaviours had not been resolved to their satisfaction:

Behaviour	*% answered not satisfactorily resolved*
Bullying	54.5%
Discrimination	64%
Harassment	59.8%
Sexual Harassment	40.4%

High rates of respondents reported that they did not seek action to address the reported DBSH behaviour:

Behaviour	*% who did not seek action*
Bullying	35.2%
Discrimination	55%
Harassment	38.8%
Sexual Harassment	57.3%

- 50.6% of respondents said they believed reporting DBSH would have negative consequences. Respondents were asked to name barriers to taking action - the standout barrier was effect on future career options. Potential for victimisation also rated highly. Of those who did take action, making a formal complaint to HR rated low as an action.
- A significant minority said they addressed the behaviour directly with the perpetrator. Talking with a peer, family or friends, or supervisor were the most common responses given under taking action.
- Only 22.6% of respondents reported attending training in the last five years on dealing with DBSH.

THEMES

1. Does our membership understand DBSH behaviours?

Discrimination, bullying and sexual harassment have been prohibited by law in the workplace for more than 30 years. Professional standards are clearly established through medical regulation and education. All registered medical practitioners in Australia are held to account against the standards set by the Medical Board of Australia in *Good medical practice: A code of conduct for doctors in Australia*, and in New Zealand by the Medical Council of New Zealand's *Good medical practice.*

All members of the College are bound by the ACEM's Code of Conduct.

Recent studies have indicated that high rates of discrimination, bullying, harassment and sexual harassment persist in the health sector, despite clear evidence that these behaviours jeopardise patient safety and negatively impact on victims.

Possible actions
Among the measures that could be considered are:

- Mandate regular training on identifying and dealing with DBSH for all members and trainees
- Establish targets for female representation on the ACEM Board, Council of Advocacy Practice and Partnerships (CAPP) and Council of Education (COE)
- Establish a Diversity Committee at ACEM
- Review and communicate the ACEM Code of Conduct to the membership
- Consult with the membership to develop an emergency medicine core values statement, emphasizing positive values such as respect and inclusion
- Produce guidance on rostering to promote parenting and caregiver equity.

Questions for comment:

a. Do our members recognise DBSH behaviours, or have these behaviours become normalised?
b. Are our members aware of the relevant professional and educational standards? If they are, why do some ignore them?
c. What more needs to be done to increase awareness of the law, standards and expected codes of conduct?
d. What do you think of the possible actions listed in this section? What specific actions would you suggest to address this theme?

2. Do we have a culture of bystander silence?

Discrimination, bullying, harassment and sexual harassment in the health sector is discussed and witnessed. Addressing these problems not only requires change by the individual perpetrators, it will require others – colleagues, senior executives and everyone working in the health sector – to decide it is unacceptable and take action to stop it.

Possible actions
Among the measures that could be considered are:

- Mandate regular training in identifying and dealing with DBSH for all members
- Establish leadership programs
- Work with health sector employers to establish a framework for post-incident debriefing, so it becomes a safe practice to call out incidents in a no-blame way, to better inform general and specific education and training
- Work with health sector employers to introduce random workplace audits of staff awareness of and compliance with reporting requirements.

Questions for comment:

a. What stops bystanders speaking up when they hear about or witness discrimination, bullying, harassment and/or sexual harassment?
b. What in the culture of medicine – or emergency departments and hospitals – makes these issues someone else's job or responsibility to fix, or prevents someone from taking responsibility for addressing these issues?
c. What actions can be taken by individuals, teams and organisations to prevent and address current discrimination, bullying, harassment and sexual harassment?
d. What do you think of the possible actions listed in this section? What specific actions would you suggest to address this theme?

3. What skills do we need to build a supportive culture where these behaviours are not tolerated?

ACEM is responsible for overseeing emergency medicine training, its requirements and the accreditation of the sites in which training occurs. As such, it can work with employers to improve workplace training on these issues. ACEM also has an obligation to do so.

Training in compliance with discrimination, bullying, harassment and sexual harassment laws and workplace policies has increased, but clearly has not solved the problem. The results from the survey show that we have issues with gender and racial discrimination. Research shows that leadership and mentoring increase good behaviour and are powerful in fostering cultural change. Other research suggests that compliance-oriented training may not be as effective as focusing on the link between professional behaviour and patient safety.

Possible actions
Among the measures that could be considered are:

- Mandate regular cultural competency training for trainees, FACEMs generally and Directors of Emergency Medicine Training in particular, as part of the FACEM Training Program and as a requirement for CPD
- Mandate regular training for all members in identifying and dealing with DBSH
- Provide a leadership training program to members
- Develop an emergency medicine core values statement, emphasising positive values such as respect and inclusion.

Questions for comment:

a. Do you think compulsory cultural competency training is sufficient to address gender and racial discrimination? What else could we do?
b. Research has shown that leadership training is effective in increasing good behaviour. Who do you think would benefit from leadership training?
c. How can the link between patient safety and appropriate behaviour be made clearer?
d. What do you think of the possible actions listed in this section? What specific actions would you suggest to address this theme?

4. How can we build confidence in complaints processes to address these behaviours?

Research clearly indicates incidences of discrimination, bullying, harassment and sexual harassment in the health sector are under reported. ACEM receives few complaints directly about DBSH behaviours by members.

The ACEM prevalence survey backs confirms this, with only 11.4% of respondents saying they made a formal complaint about bullying, despite 34.5% of respondents experiencing it. The most commonly cited reasons for not making a complaint were:

- Effect on future career
- Effect on assessments
- Potential for victimisation
- Uncertainty about whether the incident would be judged as serious enough
- Impact on daily practice
- The stress associated with filing a complaint and enduring an investigation
- In the case of sexual harassment, concern at not being believed or taken seriously by management and loss of reputation for self also come through strongly.

Possible actions
Among the measures that could be considered are:

- A sustained communications campaign by ACEM to raise awareness of complaints mechanisms.

Questions for comment

a. What confidence do you have in existing complaints pathways – both in the workplace and at ACEM?
b. How does lack of awareness about how to make a complaint and to whom, impact on making a complaint?
c. What can the College do – alone or in partnership with employers – to make it safe to complain and take a stand against unacceptable behaviour?
d. What do you think of the possible actions listed in this section? What specific actions would you suggest to address this theme?

5. Are there factors unique to emergency medicine that contribute to DBSH?

The ED is a pressure environment. EDs across Australia and New Zealand are experiencing high patient numbers, which are increasing yearly, and overcrowding is common. EDs appear to be experiencing an increase in patients displaying aggressive behaviours. Stressful environments are not an excuse for poor behaviour; however, they may increase the likelihood that DBSH behaviours occur and are tolerated.

Respondents to ACEM's Workforce Sustainability Survey Report (2016) said that their three main work-related stressors were ED overcrowding, access block and conflicts with inpatient teams. The majority of respondents to that survey had moderate to high degrees of burnout. Burnout is characterised by emotional exhaustion, depersonalisation and diminished feelings of personal accomplishment.

We know from the Workforce Sustainability Survey that the membership expects ACEM to advocate on their behalf to address work-related stressors in the ED.

Possible actions
Among the measures that could be considered are:

- Direct lobbying by ACEM of politicians
- Commissioning more research to address these issues
- Developing a clear ACEM position on work-related stressors
- Stronger advocacy around violence in the ED.

Question for comment

a. What could ACEM do to better advocate on work-related stressors in the ED?

NEXT STEPS

Your feedback will be used to develop a draft action plan. The DBSH Project Working Group will meet in October to progress this piece of work, and the ACEM membership will be provided further opportunity to give feedback on the draft action plan, prior to it being finalised by the ACEM Board.

HOW TO GIVE FEEDBACK

You can give your feedback via an anonymous form on the ACEM Website.

Alternatively, you can email your feedback to Ange Wadsworth (DBSH Policy Officer) at angela.wadsworth@acem.org.au. In your email, please number your responses to the questions using the numbering in this consultation paper.

We are accepting feedback until **5 September 2017.**

All feedback will be treated confidentially. If you have any questions, please email Ange Wadsworth.

Thank you for taking the time to provide input into this important piece of work.