AMA Submission to the Australian Human Rights Commission - National Inquiry into Sexual Harassment in Australian Workplaces

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The AMA's submission is in the following content order:

- Summary
- Recommendations
- AMA Position Statements
- Data (national medical workforce experience)
- Drivers of workplace sexual harassment (medical workplace culture examined)
- Impacts (on patients and medical workforce)
- Existing good practice (public hospitals)
- Responses (addressing the fundamental problems)
  - Four key steps for cultural change
  - Giving names to behaviour
  - Improved leadership competency in medicine – leading change
  - Establish measurable objectives and goals for improving workplace culture
  - Improve confidence in systems dealing with complaints
  - Enhance knowledge and improve training regarding relevant workplace issues
- Current legal framework (promote useful employment regulation / entitlements)

SUMMARY

The AMA submission's general thesis is that sexual harassment in the medical profession's healthcare workplace is a symptom (sub set outcome) of both an absence of genuine leadership and the opportunity for power to be exercised, largely unchallenged, born from an evolved majority male paradigm hierarchy. Achieving respect in the medical workplace is fundamental to eradicating sexual harassment. The multi-factorial promotion of workplace (non-clinical) accountability, regulation, education, gender equality / equity and diversity can achieve change. Enshrining the principle of 'legitimacy of difference' encourages dilution of normed toleration / resistance / rejection of people perceived as "other" and assists achievement of the transformation objective of "acceptance" of all in the workplace.

In the main, the AMA's submission refers to the medical profession in public health service / public hospital setting and addresses the following components of the AHRC National Inquiry Terms of Reference:

- Drivers of workplace sexual harassment
- Impacts on individuals and business
- Existing good practice
- Current legal framework

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RECOMMENDATIONS

Arising from our submission, the AMA provides the following recommendations as being relevant and useful for the AHRC National Inquiry's final report to either address and / or encourage:

A. Organisational commitment to ongoing cultural change (continuous improvement to individual & organisation) through encouraging gender equity (including leadership opportunity), diversity, education & training (i.e. defining the issue & the ways to respond; including professional development, demonstrating support and reward of leadership competencies). (refer p.9)

B. Identify and recommend a suitable model for cultural change to be implemented across salaried and contracted medical practitioners such as the programs: Vanderbilt/Melbourne Health or St Vincent's Health Australia Ethos. (refer pp.13-16)

C. Regularised surveying, analysis and public report as to the scope and incidents of sexual harassment and progress of positive measurers to address cultural change (also decouple this behaviour from other inappropriate workplace behaviours i.e. not 'lumped in' with bullying & discrimination as often occurs) (refer pp.20-21)

D. Design and implement reward mechanisms for interveners who witness wrong workplace behaviour (to reduce bi-standing and encourage leadership) (refer p.19)

E. Implementation of binary management / leader obligations and accountabilities regarding their responsibility to intervene and fix when they did know or could have, or should have, known about a concern (this arises from being the delegated employer with duties to manage safety and from being an organisational symbol (wanted or not). (refer pp.18 and 27-28)

F. Promulgation of definitions and examples of what behaviours should be, and should not be, occurring (naming is educative, empowering, encourages a stand for change and rights. Also, mental health wellbeing is assisted because makes medical (counselling) intervention to be more likely to be voluntarily sought out. (refer pp.10 and 17-18)

G. Minimise (remove) potential for reprisal where seeking to raise concern or positively intervene (includes demonstrating safety (i.e. confidentiality, objectivity and professionalism) of complaint handling systems. (refer pp.23-25)

H. Implement effective training to enhance leadership competencies and understanding of the duties and risks associated with required non-clinical components of doctors' employment contract. (Doctors will tend to identify with their vocation rather than their legal contractual status and therefore can misunderstand totality of risk) (refer p.25)

I. Enhance transparency (visibility) as to what steps to take and where to obtain professional / independent advice when seeking to raise a concern. (refer p.24)

J. Appropriately resource people and culture (human resources) practitioners (with the necessary: EFT, internal influence, competency / knowledge and skill to serve and harness the medical profession as leaders for positive change). (refer p.26)

K. Endorse the AMA's National Bargaining Framework (relevant aspects as being appropriate and viable). (refer pp.26-30)

L. Streamlined access to dispute resolution (preferable to enable immediate referral to the relevant industrial commission as enables speedy, expert, independent intervention and creates incentive for culture to shift to avoid adverse findings and / or potentially public dispute). (refer p.27)

AMA Position Statements

The following are selected parts of major AMA policies (called 'Position Statements' - as endorsed by the AMA Federal Council arising from AMA Committee recommendation after member engagement / consultation). The AMA's Position Statements (regularly reviewed and updated as required) act as the leading voice for change to prevailing medical culture norms and community expectations. For the full text of these AMA Position Statements, please use the included hyper link**.**

AMA Position Statement - Sexual Harassment in the Medical Workplace 2015
https://ama.com.au/position-statement/sexual-harassment-medical-workplace

While all doctors are at risk of sexual harassment, female doctors report a higher incidence. Gender inequity has a proven causal relationship with the incidence sexual harassment of female employees. This is particularly relevant for medicine where significant gender imbalances emerge in the majority of specialties despite female medical students and trainees slightly outnumbering their male counterparts.

The impact of sexual harassment is profound. It effects physical and mental health and undermines performance and collegiality in the workplace. Sexual harassment can influence career choice and career progression, and ultimately has the power to impact on the availability of female role models in medicine.

There is no place for sexual harassment in any workplace, including in medicine. All members of the medical workforce have a right to be treated with respect, dignity and as equals.

The medical profession must play a leadership role in tackling sexual harassment, modifying professional culture and modelling appropriate behaviour. This must include senior members of the profession making it clear that sexual harassment is unacceptable.

AMA Position Statement - Equal Opportunity in the Medical Workforce 2016
https://ama.com.au/position-statement/equal-opportunity-medical-workforce-2016

It is important that the medical profession and workplace embraces the professional, economic and social contribution of doctors from diverse backgrounds and makes the most of the extensive skills, perspectives and networks that a diverse medical workforce will bring to the medical work and training environment. This will lead to a more productive, responsive and empathetic medical workforce, well equipped to deliver and advocate for the best health outcomes for patients and the broader community.

The AMA recognises the current under-representation in leadership positions of women and supports developing targets to address this.

Fair and transparent processes should be applied in assessing the capacity of a person to perform the job-related requirements of a position, having regard to the person's knowledge, skills, qualifications and experience and their potential for future development.

AMA Position Statement - Workplace Bullying and Harassment 2009 [Revised 2015]
https://ama.com.au/position-statement/workplace-bullying-and-harassment

Medical students, doctors in training, female colleagues and international medical graduates have been identified as the most likely targets of bullying and harassment with more senior trainees most likely to be reported as the perpetrator. Other factors which increase the risk of workplace bullying and harassment include the presence of work stressors, leadership styles, systems of work, work relationships and workforce characteristics.

Incidences of bullying and harassment are often not reported because of fear of reprisal, lack of confidence in the reporting process, fear of impact on career, and/or cultural minimisation of the problem.

Workplace bullying contributes to poor employee health including the physical and psychological manifestations of stress and depression.

Appropriate management and leadership training must be provided and should be a requirement for those in leadership or supervisory roles. This includes education on performance management, providing constructive feedback, communicating about difficult issues, and effective complaint management to prevent issues escalating where possible.

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Data - national medical workforce experience

There may well be chronic under-reporting reasons including………. a level of 'acceptance and normalisation of bullying', fear of career repercussions, and distrust of, or lack of confidence in complaints investigation and resolution processes.[1]

*Although unprofessional behaviour is common, **the true prevalence** is likely to be significantly underestimated, with **wide spread under-reporting**"*[2].

There is no reason to believe medicine in Australia is somehow immune from the general Australian (and international) experience of workplace sexual harassment. Fundamentally, the culture of medicine is a causation for chronic under-reporting of what is a serious problem. Any argument suggestive that there 'is no problem' for want of evidence is misguided (see also - **confidence in systems**, p.23 below).

For the past four years, starting in Western Australia, a number of state AMAs (with the co-operation of the Australian Salaried Medical Officers Federation (ASMOF) in some jurisdictions) have conducted workplace surveys amongst our doctors-in-training (DIT i.e. non-specialist doctors). The following outlines the most recent and relevant survey results from various jurisdictions:

NSW[3]

Amongst all NSW DIT survey respondents:

- **42 percent** have **experienced bullying** or **harassment**
- **53 percent** have **witnessed** a colleague being bullied or harassed
- The **majority** perceived the issues had been **inadequately dealt with**
- **66 percent feared negative consequences** of reporting inappropriate workplace behaviours
- **66 percent** were **concerned** there might be **negative consequences** in their workplace **if they reported** inappropriate workplace behaviours

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[1] Beyondblue Submission - *Medical complaints process in Australia, Senate Standing Committee on Community Affairs* [October 2016] p10

[2] *Endemic unprofessional behaviour in health care: the mandate for a change in approach* - Johanna Westbrook, Neroli Sunderland, Victoria Atkinson, Catherine Jones and Jeffrey Braithwaite Med J Aust 2018; 209 (9): 380-381.

[3] *Alliance New South Wales Hospital Health Check Survey 2018 (AMA New South Wales and Australian Salaried Medical Officers' Federation New South Wales)*

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Victoria[4]

Amongst all Victorian DIT survey respondents:

- **45 percent** reported that they have **experienced bullying** or **harassment**
- **63 percent witnessed** unacceptable workplace behaviors
- **74 percent** said they had **not reported witnessed** unacceptable behaviour
- **71 percent reported fear of career damage** was a reason to **not report** their experience
- **20 percent** of respondents described being **asked inappropriate questions during an interview** such as marriage plans or sexual orientation[5]

Queensland[6]

Amongst all QLD DIT survey respondents:

- **37.9 percent** had **personally experienced** bullying, harassment or discrimination
- **72.9 percent** had **witnessed** a colleague experience bullying, harassment or discrimination
- Of those saying they have **experienced or witnessed** bullying, harassment or discrimination, **60.9 percent felt there was nothing they could do about it**

Western Australia[7]

Amongst all WA DIT survey respondents:

- **a third of WA doctor** respondents said they had **experienced sexual harassment** in their workplace
- **20 percent** reported an **inappropriate question at interview**

Australian Capital Territory[8]

Amongst all Canberra Hospital DIT survey respondents:

- **42 percent** have **experienced** bullying or harassment
- **39 percent** have **witnessed** a colleague being bullied or harassed
- **68 percent** feared **negative consequences** of reporting inappropriate workplace behaviours

Other information

There is also considerable anecdotal evidence of the existence of sexual harassment within medical culture. In the Australian Broadcast Commission story, *"At their mercy"* some examples emerged suggestive that sexual harassment was widespread in the surgical profession[9].

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[4] AMA Victoria - Hospital Health Check Survey [18 January – 3 February 2018]

[5] *2018 Hospital Health Check Survey* (AMA Victoria)

[6] *2018 Resident Hospital Health Check Survey* (AMA Queensland)

[7] *Medicus* AMA(WA) [April 2016]

[8] *2018 AMA (ACT) Hospital Health Check Survey*

[9] ABC 4 Corners – aired 25 May 2015

Arising from the recent National AHRC workplace sexual harassment survey[10] close to half of sexual harassment events in past five years occurred in four key industries; one of which was the health industry (though not specifically doctors). The following general AHRC survey findings are useful for the AMA to include here because they are analogous to the doctor experience (refer pp. 17, 22 & 24 below):

- **Bystander inaction** was reported to be, in part, because *"didn't know what to do"* and *"(was) not their responsibility"* with more men than women stating this reason.

- **Seeking advice** – 60 percent report they approached friends and family rather than professional associations / advisers or other external (independent) entity for advice and representation.

- **Reason why not making report:** others thinking *"overreaction*" (49 percent) *"easier to keep quiet"* (51 percent) *"I would if I thought things would change"* (43 percent) (noting 55 percent said no change after complaint).

- Degree of **perceived seriousness** of the intimidation or offence correlates to the probability of complaint.

As a neat synopsis of contemporary survey response data related to the medical context, the following three paragraphs are republished from a Beyondblue 2016 Senate Submission[11] .

> "In 2015, the Royal Australasian College of Surgeons (RACS) commissioned an Expert Advisory Group (EAG) to investigate and advise the College on the prevalence of discrimination, bullying, harassment and sexual harassment in surgery in Australia and New Zealand. Overall, 3,516 individuals participated in the prevalence survey representing a 47.8 percent response rate. Almost half of the respondents (49.2 percent) indicated that they had experienced discrimination, bullying, harassment and sexual harassment including some who had experienced multiple behaviours. This proportion was consistent across every specialty. Bullying was the most prevalent experience (39 percent), followed by harassment (19 percent), discrimination (18 percent) and sexual harassment (7 percent).

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[10] *Everyone's Business: Fourth national survey on sexual harassment in Australian workplaces – Australian Human Rights Commission 2018*

[11] Beyondblue Submission - *Medical complaints process in Australia, Senate Standing Committee on Community Affairs* [October 2016] pp9-10

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The percentage of female respondents experiencing any of these behaviours was significantly higher than males. Trainees appear to be particularly vulnerable to bullying and harassment. Of the 532 respondents in the RACS EAG prevalence study who identified themselves as surgical trainees, 468 (88 percent) reported that they had experienced one or more of the behaviours. 24 percent of respondents said they had experienced discrimination, 23 percent harassment and 12 percent they had experienced sexual harassment.

A 2014 systematic review and meta-analysis of harassment and discrimination in medical training, which reviewed 59 studies from a range of countries, found that around 63 percent of trainee doctors had experienced some form of harassment, with verbal harassment being the most common type of abuse. The 2014 review also found, of the studies reviewed, just under 60 per cent of medical students had experienced some form of harassment, with sexual harassment appearing to be common. In a study of 293 medical students, over one third (38 percent) reported they had experienced some sort of sexual harassment during their undergraduate training. The prevalence was higher among female students and among students in the clinical years, compared to those in the pre-clinical years."

Drivers of Workplace Sexual Harassment - medical workplace culture examined

Unprofessional behaviour is sufficiently widespread in the Australian health care system that it could be considered endemic*….Bullying, discrimination and harassment are just the tip of the iceberg. Unprofessional and disruptive behaviour encompasses a wide spectrum that includes conduct that more subtly interferes with team functioning, such as poor communication, passive aggression, lack of responsiveness, public criticism of colleagues and 'humour' at the expense of others. Although unprofessional behaviour is common,* ***the true prevalence*** *is likely to be significantly underestimated, with* ***wide spread under-reporting***"[12].

In the hospital setting, the incentives to challenge wrong behaviour or make a complaint about sexual harassment can be outweighed by incentives to remain silent, hence an aggressive culture can be perpetuated which selects people who can survive it – these people may then become role models for future generations of poor behavers.

[12] *Endemic unprofessional behaviour in health care: the mandate for a change in approach* - Johanna Westbrook, Neroli Sunderland, Victoria Atkinson, Catherine Jones and Jeffrey Braithwaite Med J Aust 2018; 209 (9): 380-381.

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The AMA's workplace relations advisors in various jurisdictions have enormous experience in representing doctor members who either face allegations or have made complaint. Real case examples follow:

- A unit, knowing of a doctor's pregnancy, avoids offering a contract despite candidate merit. The justification, an absent doctor on parental leave means no patient service.

- During a senior female consultant's case presentation, the doctor commented on likely technique evolution. A junior male consultant interjected saying, *"That won't matter to you as you will be pumping out another kid by then"*. Everyone laughed, including the senior female consultant. The senior consultant felt humiliated, disrespected, disempowered and felt forced to 'play along'.

There are clear power structures in medicine and therefore incidences of sexual harassment can be high, while the reporting of concerns can be low. This can be sustained where there is a substantial power imbalance between colleagues (supervisor and trainee (DIT) being an example). The imbalance arises, and the failure to report occurs, because of the following features of a medical career and medical culture:

- highly competitive training programs and clinical workplaces;
- fixed term employment contracts causing uncertainty / lack of security and need to keep decision makers 'on-side' (for references and contract renewal offers);
- a reliance on (potentially subjective) assessment / recruitment practices;
- fear of losing their job or damaging their career prospects, especially when the harasser is a senior colleague;
- concern about looking / feeling 'weak' (or not being 'cut out' to be a doctor);
- embarrassment;
- not wanting (or feeling unable) to confront the pervasive culture;
- a desire to (try) and cope (doctor's vocational comitment has tendency to encourage doctors to attempt to be 'super-human"*);
- a feeling (belief) complaints will not be taken seriously;
- the need to keep working no matter what (financial / ego reasons);
- not knowing whether their perception about the behaviour they are receiving will be confirmed by their workplace; and/or
- unclear, difficult and/or unsafe reporting processes.

* Young doctors and female doctors appeared to have higher levels of general and specific mental health problems and report greater work stress[13].

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[13] *National Mental Health Survey of Doctors and Medical Students* [Beyond Blue, October 2013 p4]

Hospital settings can demonstrate the hallmarks of what has been termed "institutional betrayal". The term's meaning and implications are very close to those associated with personal betrayal. Such institutions do not just operate on power and fear but also on trust and dependency. The latter elements create an inherent conflict for a doctor suffering abuse between them staying and receiving more of the same or reporting then potentially losing critical relationships.

The following general characteristics are informative to understand institutional (public hospital) betrayal and what needs to change in medicine[14]

- **Membership requirements:** clearly defined groups that give high value to conformity and swiftly correct deviance from (what are wrong) norms.

- **Prestige:** holding an elevated position obscures the perpetrator of abuse and causes an unquestioning of authority.

- **Priorities**: valuing performance of core business and reputation over, or divorced from, the well-being of its members (maintaining appearances at all costs).

- **Denial:** where there is group cohesion, an "us against them" approach is common where allegations of impropriety arise (includes the ideas of: the "bad apple"; the recipient of the conduct being a "significant contributing factor"; and/or damage control rather than addressing causality).

- **(3) Barriers to change:**

    1. The organisation not having language that enables the linking of (so called) 'one-off-events' to show what is actually a 'bad' ongoing theme (i.e. allowing interpretation rather than critical thinking because culture makes larger factors difficult to reconcile with professional values (example: the making of an inappropriate comment about a women's body being called a "compliment") (refer p17 below).

    2. It is a *"very human quality to maintain unawareness of injustice around us"* (particularly prevalent where sexual harassment exists).

    3. Where the organisation is itself traumatised (through a culture of punitive decisions, unfairness and accusations) protective mechanisms will spring up (e.g. discourage, refuse to act, refuse to acknowledge).

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[14] *Institutional Betrayal* - American Psychologist, Parnitzke C. and Freyd J. [pp575 – 579, September 2014]

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There has been a failure of diversity and equality in medicine. These are the outcomes of unconscious processes and are deeply embedded in individuals and organisational systems. Only those who are unfamiliar with benefits of gender equalisation will regard it as a bad thing. Some will believe the existence of a problem (organisationally, culturally and/or personally) is overstated because it is outside their experience. In another way, if one does not have insight, it cannot be easily given and relevant knowledge cannot easily be encoded; resistance will be a likely default.

"On the one hand, some men resent female employees and perceive them as a threat in traditionally male dominated work environments. In these cases, the women (are) subject to discrimination and sexual harassment to cause embarrassment and humiliation. The second reaction (is) to exploit the presence of women and make sexual favours and submission to sexual behaviours conditions of employment…to keep (the female employee) from being…adversely affected (in respect of their work and career aspiration i.e. like a 'protection racket')"[15].

The benefit of encouraging diversity is obvious. If we relate that to female doctors in the workplace, adherence to the diversity principle causes efficient use of over half of an organisation's available talents and increases / improves[16]:

- creativity;
- ability to attract talent;
- holistic analysis of issues;
- innovation;
- spurs motivation & effort;
- organisational performance; and therefore
- highest quality patient care.

[15] *Sexual Harassment on the job: what it is and how to stop it* (4th edition) Petrocelli W. & Repa B. K. (1998)

[16] *The business case for gender equity* - Workplace Gender Equality Agency [September 2016]

Impacts –
patients and medical workforce

*‘**Unprofessional and disruptive behaviour** encompasses a wide spectrum that includes conduct that more **subtly interferes with team functioning**, such as poor communication, passive aggression, lack of responsiveness, public criticism of colleagues and ‘humour’ at the expense of others. Although unprofessional behaviour is common, the true prevalence is likely to be significantly underestimated, with wide spread under-reporting.’*[17]

The negative impacts of inappropriate behaviours are felt by:

- **Patients**, resulting in - poor workplace culture linked to safety and errors including increased surgical complications, hospital acquired infections, medication errors and adverse outcomes;

- **Staff**, resulting in - turnover and associated recruitment costs, reduced productivity through poor morale, demands on management time, poor workplace health & safety, training needs, resetting career goals and the suppression of innovation; and

- **Institutions**, resulting in - the stifling of potential, adversely affecting operational efficiency and revenues, significant legal costs, reputational damage, economic cost and propagation of poor culture[18].

Inappropriate behaviours can also be directed towards doctors from those outside the profession such as hospital administration or nursing staff.

It is well recognised that continued exposure to unacceptable workplace conduct can cause both psychological harm and physical illness[19]. Conversely, workplaces where staff are happier are associated with better patient outcomes, improved quality and reduced adverse events[20].

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[17] *Endemic unprofessional behaviour in health care: the mandate for a change in approach* - Johanna Westbrook, Neroli Sunderland, Victoria Atkinson, Catherine Jones and Jeffrey Braithwaite Med J Aust 2018; 209 (9): 380-381.

[18] *The Ethos Program: Re-defining Normal* - Dr Victoria Atkinson Group Chief Medical Officer Group General Manager Clinical Governance Cardiothoracic Surgeon

[19] Hutchinson, M., Vickers, M., Jackson, D., and Wilkes, L. (2006). Workplace bullying in nursing: towards a more critical organisational perspective. Nursing inquiry, 13(2), 118-126.

[20] Schwartz, Richard W., and Thomas F. Tumblin. "The power of servant leadership to transform health care organizations for the 21st-century economy." Archives of Surgery 137, no. 12 (2002)

Women in medicine continue having limitations placed on them in respect of: career advancement opportunities; experiencing workplace recruitment & general discrimination; workplace harassment; and inadequate accredited training opportunities.

- *"That's going to be very hard as a women"* (in respect of choosing a medical craft and about male paternalism seeking to pre-determine a women's self-interest)
- *"If a women is: 'fun' she is flirtatious - if a man is: 'fun' he is cool"*
- *"If 'hit on' by a senior male, women don't know how to say 'no' without risking their career being limited"* (regarding power imbalance / system gender bias in the workplace)[21]

The culture of workplace harassment is not unique to the Australian health sector. International studies, in particular in the United States and United Kingdom, suggest disturbingly high levels of mistreatment at all levels in the medical profession from application to medical school to examination success, job application, and the allocation of distinction awards to consultants[22].

Existing Good Practice – public hospitals

The AMA believes that the evidence shows that:

- early intervention can prevent minor inappropriate behaviours from escalating into sexual harassment;
- cultural change is created through conversations[23]; and

[21] From female doctor attendees at - *"Leading Doctors to End Gender Discrimination"* (30 July 2015, AMA Victoria Event)

[22] The Japan Institute for Labour Policy and Training (2013) Workplace Bullying and Harassment: JILPT Seminar on Workplace Bullying and Harassment; Quine, L. (2002) Workplace bullying in junior doctors: questionnaire survey, BMJ 2002; 324; Woodrow, S.I., Gilmer-Hill, H. and Rutka, J.T. (2006) The Neurosurgical Workforce in North America: A Critical Review of Gender Issues, Neurosurgery, vol. 59, no. 4.

[23] *The Ethos Program: Re-defining Normal* - Dr Victoria Atkinson Group Chief Medical Officer Group General Manager Clinical Governance Cardiothoracic Surgeon

- prevailing culture is merely a set of basic assumptions and shared solutions as to *'how'* to survive and remain part of the group, evolved over time[24]. This does not suggest some intent of design nor suggest norms are legitimate because they exist.

Two of the most often cited programs to bring about cultural change and reform in the workplace are the Ethos Program at St Vincent's Health Australia and the Vanderbilt Accountability Pyramid.

St Vincent's Health Australia (SVHA) Ethos program[25]

The Ethos program looks beyond bullying and harassment to redefine the broader question of what "normal" behaviour in healthcare has become. Over time, healthcare has acquiesced to seemingly 'less sinister' behaviours, which now threaten to cripple any cultural evolution.

These include behaviours that interfere with team work, contribute to ineffective communication and create risk. Less obvious examples include a lack of responsiveness, poor or ambiguous communication, publicly criticising members of the team, refusing to follow established best practice, learning by humiliation, intimidation, ignoring, isolating and laughing at others' expense.

SVHA Ethos program pillars:
WE FEEL SAFE
WE FEEL WELCOME
WE FEEL VALUED

SVHA Ethos program principles:

- All staff are entitled to a safe workplace.
- Personal courage is not required to live our values.
- We will encourage, acknowledge and reward behaviours that reflect our values.
- Our response to behaviour that undermines patient or staff wellbeing will be consistent, transparent and equitable.
- Our staff are enabled and empowered to speak up. If they cannot, we will provide them with a safe voice.
- Our staff are given an opportunity for reflection and self-regulation where appropriate.
- Particular attention will be paid to vulnerable groups e.g. trainees, junior staff.
- Diversity and gender balance are central to organisational strength.

[24] Sarros, James, (ed) Contemporary perspectives on leadership : focus and meaning for ambiguous times. Tilde University Press, pp36-44
[25] The following from Catholic Healthcare publication *The Sector Speaks – "The Ethos Program: Re-defining normal"* - Dr Victoria Atkinson, Group Chief Medical Officer St Vincent's Health Australia

The Ethos program highlights that while addressing the disruptive elements is critical, it is insufficient on its own. Whilst it is essential to create a system that equitably holds destructive staff to account, the cultural change required is more far reaching and daunting than this handful of true bullies. We must seek to understand how the remaining vastly dominant majority of staff are interacting; it is these many conversations that weave the fabric of an organisation and will serve to nourish or extinguish our worst behaviours.

The Vanderbilt Accountability Pyramid[26]

Vanderbilt Pyramid is built on the premise that:

- most staff are good people, doing the right thing for the right reasons;
- rewards should exist for people who are behaving well (includes when they act as leadership symbols);
- based on peer accountability, peer messaging and peer comparison;
- create micro / macro environments to intervene early & often;
- data and safety driven interventions; and
- systems enable the right culture.

The Pyramid is built on a structure of escalated communication as patterns of unprofessional behaviour develop but is based in the concept that the vast majority of professionals conduct themselves in exemplary ways. All health professionals and administrators are subject to lapses and may engage in what appear to represent single "acts" of unprofessional conduct.

Individuals who exhibit recurrent patterns of unprofessional conduct genuinely represent an anomaly, and therefore need to have their behaviour addressed. When a pattern of unprofessional conduct appears to exist, individuals need varying levels of intervention.

Dotted lines separate various levels of intervention. They are not solid, to reflect the importance of professional judgment and differences among organisations in deciding when to use each level. Research reveals that for those who exhibit patterns of unprofessional conduct, most respond to an awareness intervention (opportunity for personal insight). Unfortunately, some individuals will not or cannot respond at the awareness level and need a more directive approach higher in the pyramid. The conversations establish a structure of escalated communication, and everyone needs a supported plan for responding to reactions to conversations.

[26] The Vanderbilt Centre for Patient and Professional Advocacy

In 2016, Melbourne Health introduced a system similar to the Pyramid model. Volunteer and respected specialist doctors, as required (i.e. can be in reaction to confidential intranet staff reporting), are authorised to privately speak with a peer who are showing an emerging trend of exhibiting negative behaviour. The idea is that a person would prefer to 'know' (because often the behaviour is unconscious). It is a 'third way' to 'nip in the bud' and informally manage instead of either 'doing nothing' or after allegations of harm 'prosecuting'.

Where there is a risk that Melbourne Health's duty of care would be compromised if it maintained confidentiality and did not become more interventionist there are carefully designed systems that will come into operation. The AMA has information that persons who have been spoken too via this system are grateful for the insights offered and tend to quickly reverse.

Responses –
addressing the fundamental problems

The AMA's submission takes the view that there are several key issues that need to be addressed through institutional commitment, investment and new systems design. On that basis, we provide a variety of responses the AMA thinks are required and capable of addressing the fundamentals and therefore the symptoms. These responses need implementation in combination and with sustained organisational effort.

Referring to the AMA's general submission thesis, sexual harassment is a symptom of at least two fundamental medical / public hospital culture deficits; namely:

- lack of genuine workplace leadership (all leaders wield power but not all power wielders are leaders – having a title that comes with an authority to exercise does not a leader make); and

- lack of respect for everyone, by everyone, in the workplace.

Below we identify four key stages the AMA thinks necessary to deliver real (new normal) positive cultural change.

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➢ Shifting Culture in Four Stages

1. REGULATION and LEADERSHIP: applying good enforceable rules consistently & fairly combined with leaders acting as good symbols to copy / who set the right standard.

Leaders, armed with good rules, set the standard and can then ensure-

2. VISIBILITY: regular reporting of "where change is at" (survey and other data) & marketing of: definitions, complaint processes, organisational steps to combat.

With the organisation learning what the (new) standards are through being shown what to do, how to do it and seeing evidence that whole organisation is pushing in the same direction, what arises is-

3. LEGITIMACY: differences arising from the diversity of style, background and/or gender become accepted; not tolerated nor resisted. Women in leadership positions are encouraged through fair recruitment not governed by cultural / unconscious bias. Fairness and equity is the basis for agreed rights obligations & entitlements.

The legitimacy of difference leads to the transformation goal for affected organisations (as suggested by the AMA); that is-

4. RESPECT: the standard is set and properly reinforced, difference is embraced and valued (over time proven to be beneficial to quality, productivity and efficiency through reporting & measuring) necessarily unacceptable workplace behaviours are marginalised as the culture, instead of breeding contempt, breeds respect.

➢ Giving Names to Behaviour

In instances of inappropriate behaviour in the workplace, doctors cannot necessarily define the problem other than feeling unhappy or distressed.

By way of explanation, the most common reason why women do not complain after having been sexually harassed in an Australian workplace is because they believe it to have *"not (been) serious enough"*. The next most common reason is that the behaviour is common place or accepted and that the behaviour was *"meant to be a joke"*. It seems that there needs to be extreme offence taken to cause any form of reaction by the recipient of the behaviour[27].

[27] *Everyone's Business: Fourth national survey on sexual harassment in Australian workplaces – Australian Human Rights Commission 2018*

From a legal and workplace policy perspective, these reasons appear flawed in both logic and awareness and it is for these reasons the AMA believes that definitions are important. Definitions raise awareness, create legitimacy; aid understanding of an experience and; importantly, provide a starting point to navigate solutions and make choices about what to do (refer also p.24 below about professional representation).

In the AMA's view, development, promulgation, education and use of definitions and language is an important part of cultural change but is not sufficient on its own.

As an example, the AMA(WA) and the WA Department of Health (WADH) while together have committed to a zero-tolerance policy towards sexual harassment are also are fully committed to supporting the cultural and attitudinal changes that need to occur in the medical profession. The AMA(WA), in collaboration WADH, has created a resource outlining what sexual harassment is and what you can do to recognise, act, and if necessary, report. This helps everyone to define what they see or experience, know it is wrong and know what to do.

- **Improved leadership competency in medicine – leading change**

> *"As leaders…we all have responsibility to make our (workplace) safer. Yes, policies and procedures are an important tool in setting and enforcing standards. However, mere documents are not going to shape respectful or a safe culture that does not tolerate sexist comments…or create a culture that encourages gender equality…Leaders do this! To all leaders I say this: heed the warning signs – your people deserve that much".*[28]

The AMA seeks to emphasise that leadership is a main key to fix the pervasively negative aspects of medical culture. Strong and effective leadership in the health system is vital as it is important for patient safety and the wellbeing (mental health) of people in the workplace. The later is in the context that a doctor, no matter their career stage (whether Director of Medical Services, Unit Head, Supervisor, Registrar, Resident or Intern et al) have at least an informal, if not formal, leadership responsibility automatically conferred on each of them. A doctor's willingness to be a leader through individually seeking promotion is not material to the fact that social dynamics, the structural / organisation position of doctors and their clinical lead / professional duties make a leadership role firm and unavoidable.

[28] (Ken Lay, former Victorian Chief Police Commissioner) *The Age*, p.45, Wednesday, 11 March 2015

Positive work environments (free from sexual harassment) provide a workplace that is supportive and encouraging for staff and can increase effectiveness and productivity and improve overall staff morale. In healthcare settings this can lead to reduced risk, lower adverse events and better overall patient outcomes[29] (not to mention people's right and need for general wellbeing).

Understanding leadership is more about self-mastery than power wielding; legal relations (not professional role or personal style) is the determinant for appropriate conduct. Where an organisation's management or leadership is insensitive, of poor standard, inconsistent, unfair or not transparent and/or where its people are not aware of proper expectations, what their rights are and how to enforce them safely, the opportunity to reduce disputation, enhance clinical team efficiency, maintain quality and develop employer of choice characteristics is undermined.

Leaders need to encode that they serve as symbols. It is therefore a required professional competency for leaders to be equipped to engage in personel mastery meaning that they:

- regulate emotions;
- manage themselves and others through self-awareness (and awareness of unconscious beliefs manifested through cultural norms); and
- develop trust (by being reliable / consistent).

In step order, this is what the AMA believes we must expect from our (doctor) workplace leaders -

- ✓ Listen
- ✓ Modify original thoughts / impressions / objectives based on received information (i.e. engaging in *genuine* consultation)
- ✓ Set clear and fair boundaries / expectations
- ✓ Clearly communicate what the boundaries / expectations are
- ✓ Reward compliance / act against non-compliance
- ✓ Reward those who choose not to be by-standers (show what is in the 'team' interest)
- ✓ Consistent application of reward / negative consequence[30]

[29] Künzle, B., Kolbe, M., & Grote, G. (2010). Ensuring patient safety through effective leadership behaviour: a literature review. Safety Science, 48(1), 1-17.

[30] *Medical Leadership – Achieving Workplace Professionalism & Understanding Non-clinical Risk - "Is it good enough to just be a good doctor"* [an AMA hospital and/or member training presentation]

AMA

The casual use of language can have a profound effect on women achieving leadership roles because of an unconscious stereotypical implication. That is, certain adjectives in recruitment / performance documentation can define male stereotypical predisposition as *the* desirable organisational traits. For example, consider the stereotypical gender implication of seeking / valuing the words: *"empathy and friendliness*" over *"rationality and competitiveness".*

There are also assumed different characteristics of men and women leaders (male leaders = *"good blokes"* / female leaders = *"nasty"*). For women in leadership they can be perceived as running directly counter to stereotypical gender notions about empathy, nurture and being parent orientated[31]. Oddly, these are excellent leadership attributes but society can instead (mistakenly) tend to reward persons with leadership roles who are ruthless-self-serving-self-promoters (i.e. perhaps charismatic but not much-else).

In sport parlance, the star player is not necessarily the best leader; often the best captain is the player who is of average skill but is the most selfless and the most caring (always puts their body on the line for the team, is first to encourage after under-performance and is first to empathise after injury or loss). We should be promoting persons with these positive characteristics; irrespective of gender or background.

Visibility and outcomes show off a doctor's attributes and abilities but where like attracts like, and men are in charge of who gets what opportunity, women's chances to 'shine' are reduced. Those that enjoy significant competitive advantage (i.e. given prevailing norms; men) are more likely be seen as strong performers. The meritocracy model of reward (so called) can be inadequate (when applied in the current male workplace paradigm) as, for example, to define a core job requirement as being, *"always available and geographically mobile"*, near guarantees bias towards the choosing of a childless male (even though thoughtful consultation / job re-design could show such requirements to be a habit or belief rather than being genuinely disruptive to clinical service delivery or other objective need).

- **Establish measurable objectives and goals for improving workplace culture**

Reporting

The AMA strongly believes that robust reporting will create visibility then build confidence in the legitimacy of raising issues and confidence an organisation will make change through its honest acknowledgement of the issues.

[31] Said (para-phrased here) by Julia Gillard, Chair, Global Institute for Women's Leadership (GIWL Kings College, London). GIWL mission is: *Working to create a world in which being a woman is not a barrier to becoming a leader in any field, nor a factor contributing to negative perceptions of an individual's leadership.*

A first action is to understand what problems exist. The purpose of collecting data about incidents and complaints is to collect information that is objective and can be used to identify recurring issues or trends, make improvements to systems and enable services to improve their reputation. Analysis of incidents and complaints should be done regularly and reported on with the following fields in mind:[32]

- volumes and trends over time;
- the types of issues being raised and their impact;
- complaint outcomes;
- the actions taken in response;
- the systemic issues identified; and
- the demographics of the people making complaints.

There is inherent positive competition arising from reporting (intra and inter organisational). Those willing to report their wins and acknowledge their short comings enhance trust, have a reference for continuous improvement and have evidence to design positive strategies. Those that prefer not to report will still have an incentive to match their competitors by doing so and are likely to perceived with a degree of suspicion if they remain 'out of step'. In the healthcare sector, these perceptions relate not just to employer of choice characteristics but also to community trust and confidence in the quality and safety of care provided.

Collecting data, analysis, developing plans and goals and measuring outcomes against the achievement of goals is fundamental to cultural change. Of recent times, the work done by the Royal Australasian College of Surgeons (RACS), through its Expert Advisory Group (EAG), demonstrated precisely this approach[33].

Targets

The benefits of setting targets to enhance women in medicine's opportunities for recognition and advancement include[34]:

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[32] Whole of government commitments to effective complaints handling, NSW Ombudsman [2015]

[33] RACS established its EAG on discrimination, bullying and sexual harassment in March 2015. The EAG advises on strategies to prevent discrimination, bullying and sexual harassment in the practice of surgery in Australian and New Zealand hospitals and in the College. The EAG considered gender inequality in surgery and the extent that this was linked to issues of discrimination, bullying and sexual harassment (refer pp.7-8 of the AMA's Submission).

[34] *Achieving gender diversity in Australia: the ugly, the bad and the good* [April 2015] Workplace Gender Equality Agency

- **Commitment:** creates disciplined focus and clarifies accountabilities to improve gender balance;

- **Competition:** implies reportable measures that create a competitive market between organisations' encouraging improvement and showing value as an employer of choice;

- **Capability:** delivers improved talent pool, succession planning options and from that genuine merit-based selection and enhanced organisation brand value.

People can be motivated by intrinsic (personal) or extrinsic (externally provided) rewards. Extrinsic motivators are a rule imposed externally to force a certain way forward. When used, some people responsible for delivering the outcome will become less motivated in response to perceived coercion (whether via reward or penalty). Targets need to be part of a broad suite of change agendas because any gain for one group (women) is often perceived as a loss for another group (men), leading men potentially to perceive unfairness[35]. There may also be a perceived negative representation of women because 'women need help'[36].

RACS have moved well beyond the data collection and analysis stages and have established some targets for gender equity. While the overall goals include increasing the representation of women in surgical education and training and on college bodies, the specific targets are[37]:

- Increasing the representation of women in Surgical Education and Training (SET) to 40 percent by 2021

- Increasing the representation of women on RACS Boards and Committees to 20 percent by 2018 and 40 percent by 2020.

These decisions by RACS, which the AMA support, indicate that the College recognises there are structural and hierarchical impediments holding women back in access to surgical training and representation on boards and committees.

The state and territory AMAs (sometimes in-conjunction with ASMOF) are likewise focusing on the collection of data through survey[38] to form baseline information that over time informs the design of objectives, targets and strategies employed by the public hospital system.

[35] *Gender and the Economy* (University of Toronto) – He J. and Kaplan S.
[36] *Ibid*
[37] RACS Diversity and Inclusion Program [November 2016]
[38] Known as *"AMA Hospital Health Check"* Surveys

AMA

Improve confidence in systems dealing with complaints

> *"There was no clear pathway for managing my concerns and I had to present to the head of department, which was highly intimidating. These concerns were downplayed, despite reports from multiple individuals, and inadequately handled"*[39]
>
> 38 percent of junior doctors' survey respondents reported poor or very poor understanding of policy, protocols and frameworks[40]

It is unrealistic to expect a doctor (or other staff member), to navigate employment law and human resources complexity particularly when there is usually a lack of trust in the process. This is because there can be a basic lack of understanding that might be 'obvious' to those familiar with human resources practice but will likely be 'foreign' to a doctor. It should not be assumed the recipient of unacceptable workplace conduct understands:

- what fair treatment is (includes timeliness of actions);
- can trust, unpack and navigate redress schemes;
- knows when procedural fairness is not being applied; and
- can properly define then express what the problem is (i.e. when you're 'in it' you might think it's normal, or think it is something other than what it objectively is).

The best practice policies asserting 'zero tolerance' require implementation by people. How well implementation is perceived and the degree to which people are held accountable for wrong conduct without damage to the complainant are indicia of success. To assure best practice there needs to be capability improvement amongst doctors because if there is:

- ignorance about reasonable expectations for behavior and process management;

and there is a,

- muddled understanding about non-clinical legal (employment based) responsibilities;

and where the,

- exercise of power rather than leadership competency dominates;

then the prevailing (cultural) whim will trump best practice.

In the above circumstances, the favoured few will prosper no matter the merit, damage will be done undeservedly to some and others of talent will leave or not reach full potential.

[39] AMA Victoria survey 2015
[40] ACT Health's *Review of Clinical Training Culture – TCH and HS* [September 2015] p21

The AMA endorses Royal Australian College of Surgeons (RACS) goals to revise and strengthen complaints management process, increase external scrutiny and demonstrate a best practice complaints management that is transparent, robust and fair[41]. Key actions identified by RACS with which the AMA agrees include:

- revise Code of Conduct and sanctions policy to incorporate clear expectations about the management of complaints, including clear consequences for adverse findings, and to support professionalism;
- incorporate principles helping prevent victimisation and increase /ensure protection for those who make complaints;
- establish and provide external, expert and independent review and oversight of complaint processes including reviewing processes and recommending actions when processes are not followed or are inadequate;
- strengthened confidentiality processes;
- requirements to report information about complaints;
- enable external expert mediation for complaints; and
- annual and public reporting on aggregated outcomes of complaints.

As identified earlier in the AMA's submission (refer p.7 above) employees (doctors included) do not naturally seek professional advice and representation and instead have preference for seeking out support from informal sources (friends / family). Professional advice / representation has a variety of important benefits for all parties associated with a complaint and should be encouraged as a first primary step by an organisation / leader / manager.

The benefits of representation include (applying equally to the complainant or respondent and drawn from the experience of the AMA's workplace advisers representing doctor members at all stages of their career and for all manner of issues):

- inherent efficiency and fairness arise if there is accurate definition of the issues after forensic consideration of fact and law. Understanding the problem is not 'common sense'. A false premise, taken to its logical conclusion, inevitably forms the wrong answer;

- making a compliant or constructing a defense against allegations are serious steps that requires expert drafting to:

[41] Goal 8 – 3. Complaints Management - *Building Respect, Improving Patient Safety - RACS Action Plan on Discrimination, Bullying and Sexual Harassment in the Practice of Surgery*

- in the case of being a complainant, avoid potential of being perceived as vexatious and presenting in a way capable of being upheld rather than being undermined because of unintended exaggeration, inaccuracy, ambiguity or dominated by emotion and perception rather than objectivity; AND

- in the case of the respondent, effectively defend against what is denied, locate appropriate mitigation if relevant and objectively available, ensure the written and verbal expression is understood as is intended (both the complaint and the response) and that opportunity is given to reflect and gain insight so that genuine choice is exercised about one's own accountability;

- navigate and explain often complex and unfamiliar investigative process, policy and workplace rights. This also acts as confidence builder and a cross check about the safety of the process and the maintenance of procedural fairness; and

- provide effective pastoral care and ensure the complainant (or respondent) understand the choices, implications and risks at any point.

➢ **Enhance knowledge and improve training regarding relevant workplace issues**

Training should not just focus on deliberative, conscious thinking, such as "diversity training". Organisations (particularly human resources (HR) and medical workforce management units) and the medical profession generally need to understand how unconscious bias works to be less likely to make unfair and inaccurate decision and more likely to push back on bias when the experience it / see it in operation[42].

Training should focus, in part, on capacity building via learned strategies to mitigate the impact of unconscious bias. Training about how to lead, manage and what "employment") actually is would be useful also (regarding non-clinical duties, responsibilities and obligations arising).

Opportunity afforded through recruitment is fundamental to advancement but professionalisation of the process is so often overlooked because it is an (unwanted) distraction from the usual day's clinical activity. Training in the conducting of structured interviews and use of designed, explicit, criteria will enable objective compatible evaluation (between candidates and to the job). This being mindful that rating and ranking systems do not conclusively mitigate the influence of unconscious bias because of reliance on intuitive judgement[43].

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[42] For discussion on the indicia of medical profession unconscious bias refer pp.10-11 and 19-20 of the AMA's submission.

[43] *What works: Gender equality by design; Bohnet I.* - Harvard University Press [2016]

There is a proposition that within healthcare, where patient priority usually trumps other organisational resource allocation needs, HR (or People & Culture) are under some strain. Along with this idea is the suggestion that HR's capability to internally influence and act proactively is not optimum and that their nuanced understanding of the medical workforce is limited because doctors are a small fraction of an organisations' total EFT staffing.

Doctors have some leadership and organisational importance, have different responsibilities / obligations. A degree of crafted management is required to avoid perverse outcomes or to enable the harnessing of the medical workforce's positive potential to lead change. This raises the questions as to whether there are appropriate levels of investment to ensure HR professionals are equipped with the competency, knowledge and skill to ensure there is both the capability and time to manage issues related to doctors.

Current Legal Framework

promote useful employment regulation / entitlements

AMA National Bargaining Framework (relevant model clauses)

The AMA has designed a National Bargaining Framework (model clauses) as a resource / reference tool for all AMA jurisdictions when engaged in enterprise bargaining on behalf of doctor members (who may also be members the Australian Salaried Medical Officers' Federation (ASMOF); the framework is for its use also).

The AMA believes that it is important for there to be enforceable and express workplace rights, duties and obligations that encourage equity, fairness and management accountability to act against unacceptable behaviours. A main idea is to enshrine the reality and legitimacy that women give birth and represent over 50 percent of graduating medical practitioners. On successful implementation (along with other measures noted in AMA's submission), culture will shift to be equality / equity based assuring equal career path rights.

Enforceable workplace entitlements are a promotion of these themes, have active inducement potential to change behaviour and demonstrate an organisation's willingness to require change (because in the main, new entitlements require employer agreement). Enforceable entitlements change expectations and enhance respect & understanding which in turn reduce improper behaviours as a respectful culture evolves. Recognising men are entitled to prioritise their family responsibilities without career path implications helps the later agenda.

The AMA has selected from our National Bargaining Framework relevant subjects that should be minimum workplace entitlements in part response to incidents of sexual harassment. Summarised below are the AMA's general model clause design approach then, by subject, the AMA's rationale, the problem the AMA is seeking to solve and the AMA's objectives. The information the AMA provides here can be equally used to design workplace instrument clauses, workplace educational systems and workplace policy.

AMA

GENERAL DESIGN RATIONAL

i) maximise regulation judged against fairness, justice, current deficits / needs gaps and emerging community trends / expectations;
ii) reinforce the legitimacy (normalcy) of women having children by regulating family related rights in the workplace. This acts as a cultural change device in that through formally recognise and valuing of gender diversity (equity & equality) likely there will be reduction in incidence of improper conduct born from a lack of respect;
iii) educate both hospital and doctors (partly by saying what is intended in straight forward language - i.e. through: the use of headings as a guide to intent, the use of the word "must", being prescriptive about action steps, requiring consultation & policy promulgation and in-built clause compliance mechanisms);
iv) shift culture, in some cases there should be agreed party statements as to 'why' the clause exists;
v) enshrine expression that provides clear / express rights, process steps, responsibilities, accountabilities and consequences and / or explanations (i.e. easy steps to follow / easy understanding of decision justification or what is in dispute);
vi) encourage managerial / leadership competency and skills within medicine; leaving no doubt as to what steps to take to ensure compliance (this to counter the common styles / approaches to entitlement delivery; i.e. 'see one, do one, teach one' / act through experience / 'only do what I think is fair' need to instead become: 'just read the Agreement then do that');
vii) enhance prospect of compliance and/or enforcement through a *'belts & braces'* / comprehensive clause drafting approach (closing off as many predictable gates and ambiguity arguments as are reasonably foreseeable); and / or
viii) streamline access to conciliation then arbitration conducted in a formal settings (Tribunal) because clause procedural requirements already 'flesh out' the issues in dispute or there are practical reasons to encourage quick settlement.

SUBJECT:
PROFESSIONAL MANAGEMENT OF CONDUCT OR PERFORMANCE

Problem seeking to solve

A. Lack of consequence for leaders when they wrongly act as bi-standers
B. Lack of procedural fairness or administrative / managerial professionalism (when making finding of fact, determining whether a valid reason and/or appropriate penalty)
C. Transfer of responsibility between hospital and Learned College ensuring no accountability (i.e. employee / employer v trainee / supervisor)
D. Doctor participating in a process without representation (lack of clarity to the situation can make things far worse)

AMA

Objective of the AMA model clause (entitlement in a snap shot)

E. Where the leader could have, should have, or did, know about unacceptable conduct and did not act according to their duty to provide a safe system of work; they become subject to performance management.
F. If in the "course of employment", Learned College conduct (who are not legally an employer) is deemed a hospital liability (because a hospital employee will be acting as the Learned College supervisor usually within the hospital)
G. Right of AMA / ASMOF representation (not as support person)
H. Specifics in writing
I. Opportunity to Respond
J. Right of Appeal (EBA dispute framework)
K. Minimise doctor fear response
L. Ensure no 'knee jerk' responses, timeliness of action and confidentiality maintained

SUBJECT:
SEXUAL HARASSMENT, BULLYING AND DISCRIMINATION

Informed by

- AMA Position Statement - Workplace Bullying & Harassment 2009 [Revised 2015]
- AMA Position Statement - Equal Opportunity in the Medical Workforce 2016
- AMA Position Statement - Sexual Harassment in the Medical Workplace 2015
- Workplace Discrimination and Harassment Policy template (Australian Human Rights Commission)

Problem seeking to solve

A. Stop damaging health and career effects to recipient of the perpetrator's behaviour
B. Stop accountability shifting between hospital & Learned College
C. Doctors not trusting there is a safe, confidential and streamlined process to raise concerns and have properly resolved without prejudice

Objective of the AMA model clause (entitlement in a snap shot)

D. Removes concept of victim – they are the "recipient" of destructive conduct by another; the "perpetrator"
E. Cultural change (individual & organisation) through education & training (defining the issue & the ways to respond; including demonstration of leadership)
F. Minimise potential for recipient reprisal
G. Enhance transparency (visibility) to how to raise concerns
H. Create binary management obligations and accountabilities re: their responsibility to intervene & fix
I. Defines what it is (naming is educative, empowering and assists health and wellbeing and clinical presentation where medical intervention is voluntarily sought out by the doctor)
J. Streamlined access to dispute resolution

AMA

SUBJECT:
FAMILY AND DOMESTIC VIOLENCE LEAVE

Informed by:

- AMA Position Statement - Family and Domestic Violence 2016
- AMA Position Statement - Equal Opportunity in the Medical Workforce 2015
- Department of Prime Minister and Cabinet – Domestic & Family Violence Policy
- AMWU Model Clause

Problem seeking to solve

A. This is a workplace problem. 1 in 6 Australian women report victimisation; therefore, colleagues are being impacted, colleagues are perpetrators and the implications could be disruptive to organisational goals if unmanaged

B. Lack of free time available to recipient to deal with the complexity and health effects the issue creates

C. Highlights what is 'not on' outside of work has no place at work (family & domestic violence is analogous to workplace bullying, sexual harassment and discrimination)

Objective of the AMA model clause (entitlement in a snap shot)

D. Removes concept of victim – they are the "recipient" of destructive conduct by another; the "perpetrator"

E. Workplace conditions lead community response through visibility & legitimacy

F. Remove stigma and maintain confidentiality

G. Enable paid release for legal, medical appointments, organising accommodation, respite time

H. Introduce formal and clear support mechanisms

I. Encourages attitudinal changes and encourages respectful relationships

J. Make doctors safe within their workplace and to encourage employees at risk of or are experiencing domestic and family violence to seek support

K. Define what it is (naming is educative, empowering and assists health and wellbeing clinical diagnosis where medical intervention is voluntarily sought out by the doctor)

SUBJECT:
FAMILY FRIENDLY ARRANGEMENTS

Informed by:

- AMA Position Statement - Flexibility in Medical Work and Training Practices 2005 [Revised 2015]
- AMA Position Statement - Equal Opportunity in the Medical Workforce 2015
- AMA Position Statement - Workplace Facilities and Accommodation for hospital doctors 2006
- Div. 4 (NES) *Fair Work Act (Cth.) 2009*

CHILD CARE FACILITIES

Problem seeking to solve

A. Lack of child care facilities

B. Lack breast feeding / breast milk storage facilities

Objective of clause (entitlement in a snap shot)

C. Require hospital to take steps to introduce child care supports

CHILD CARE REIMBURSEMENT

Problem seeking to solve

A. There is imbalance between work and family obligations / supports (unhealthy for sustainable clinical practice, society and individuals)

Objective of clause (entitlement in a snap shot)

B. Compensation to doctor for unreasonable disruption to planned child care arrangements

C. Incentive for roster posting compliance

END OF AMA SUBMISSION