Victorian Equal Opportunity & Human Rights Commission

Submission to the Expert Advisory Group on discrimination, bullying and sexual harassment

Advising the Royal Australasian College of Surgeons

4 August 2015

Expert Advisory Group

on discrimination, bullying and sexual harassment

Advising the Royal Australasian College of Surgeons

Issues Paper Response Template

The Victorian Equal Opportunity and Human Rights Commission (the Commission) welcomes the opportunity to make a submission to the Expert Advisory Group to the Royal Australasian College of Surgeons, into the issues of discrimination, bullying and sexual harassment.

The Commission is an independent statutory body that has functions under the *Equal Opportunity Act 2010*, the *Racial and Religious Tolerance Act 2001* and the *Charter of Human Rights and Responsibilities Act 2006* (the Charter), which include complaints and dispute resolution, education and training about human rights and equal opportunity, as well as research and investigative projects. In addition the Commission has a role to report to the Victorian Attorney-General on the operation of the Charter, to conduct Charter and Equal Opportunity Act legal interventions and, at the request of an organisation or public authority, conduct compliance reviews.

The Commission has considered the Issues Paper provided by the Australian College of Surgeons, and the submission which follows includes recommendations relating to policy and training and addressing the barriers to reporting for both victims and bystanders. Historically, these three measures have been the predominant strategies used to address discrimination, bullying and sexual harassment within workplaces, along with ensuring the knowledge, skills and leadership of management around the issues. Whilst each of these strategies continues to be important, the evidence is becoming increasingly clear that they are insufficient on their own. Relying on complaints as a method to either gauge the extent of the problem or provoke systemic changes has proven to be especially problematic. This is due in part to the fact that very few victims lodge formal complaints and when formal complaints are made, they are generally handled confidentially, therefore are often not 'visible' within organisations. Further, complainants – both victims and bystanders – are often punished themselves through further vicitimisation, ostracism and other negative personal and professional consequences. Consequently there is a growing focus on the need to also utilise a range of primary prevention strategies in order to effect real change. Primary prevention focuses on strategies that address the root causes of sexual harassment and discrimination before the problem occurs. There is specific evidence of the beneficial effects of promoting gender equality within the workplace is effective. To this end, our submission also details a number of primary prevention recommendations and we urge the College of surgeons to pay particular attention to these.

Our responses are drawn from previous research we have undertaken into discrimination and sexual harassment, as well as incorporating broader literature and research from the field. Of particular relevance is our 2012 research report into women lawyers' experiences of sexual harassment and discrimination at work entitled, *'Changing the rules: the experiences of female lawyers in Victoria'* ('*Changing the rules*').[1] This research was prompted by concerns within the profession about the markedly different career trajectories between men and women, the high attrition rate of women from the profession, concerns that women lawyers earn less than their male counterparts, are less likely to progress to senior practicing roles within firms and that widespread discrimination and harassment issues were being reported.[2] The findings of this research may be generalised to the surgical profession, given the similarities in differential career pathways between men and women in both the legal and surgical professions[3] and the high prevalence of sexual harassment and gender discrimination in both industries.[4] In addition, the Commission is currently in the process of conducting an *Independent Review into Sex Discrimination, Sexual Harassment and Predatory Behaviour within Victoria Police* - work that we will also draw on to inform our responses to the questions posed.

Our responses are further contextualised within Victoria's legal framework, whereby sexual harassment, discrimination and victimisation are unlawful under the *Equal Opportunity Act*. The Act aims to eliminate discrimination, sexual harassment, vilification and victimisation to the greatest extent possible (including their systemic causes), and to promote and facilitate the progressive realisation of equality as far as reasonably possible. Discrimination can become systemic when it is entrenched within an organisation or profession's culture and reinforced by a workplace's policies and procedures.

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[1] Victorian Equal Opportunity and Human Rights Commission, *Changing the rules: The experiences of female lawyers in Victoria* (Report) (2012), 8.

[2] Ibid., 3.

[3] Although over women represent over 50 per cent of medical graduates in Australia, only 11 per cent of surgeons are women; Catherine M Joyce, Johannes U Stoelwinder, John J McNeil and Leon Piterman, '*Riding the wave: current and emerging trends in graduates from Australian university medical schools'* (2007) 186(6) *Medical Journal of Australia* 309; Royal Australasian College of Surgeons Annual Activities Report 2014. http://www.surgeons.org/media/21713909/activities-report-jan-dec-2014.pdf

[4] Victorian Equal Opportunity and Human Rights Commission, *Changing the rules: The experiences of female lawyers in Victoria* (Report) (2012), 8.

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Unlawful discrimination can be direct or indirect, and must be in an area of public life (such as employment) and substantially on the basis of a protected attribute (such as sex or sexual orientation). Direct discrimination occurs when a person treats, or proposes to treat, a person with a protected attribute unfavourably because of that attribute. Direct discrimination often happens because people make assumptions about what people with certain attributes can and cannot do. The test in Victoria does not require any comparison between the treatment of two people to determine whether the victim was treated "less favourably" than the other. Rather, consideration must be given to whether the conduct was adverse to the person's interests. Bullying can be discrimination when the treatment is substantially related to a person's protected attribute.

Indirect discrimination occurs when a requirement, condition or practice that purports to treat everyone the same actually disadvantages someone with a protected attribute. Within a professional/workplace context if an employer cannot show that the requirement or practice is reasonable in the circumstances, it is considered to be indirect discrimination.

Sexual harassment is a defined, stand-alone cause of action. The Equal Opportunity Act defines it as unwelcome conduct of a sexual nature 'in circumstances in which a reasonable person, having regard to all the circumstances, would have anticipated that the other person would be offended, humiliated or intimidated'. In this definition, it is the impact on the complainant that is relevant, not the intention of the respondent. A single incident can amount to sexual harassment, and can be physical, oral or written (including by email, the internet and social media). For example:

- intrusive comments or questions about a person's private life or the way they look
- sexually suggestive behaviour, such as leering and staring or offensive gestures
- brushing up against a person, touching, fondling or hugging
- sexually suggestive comments or jokes
- displaying offensive screen savers, photos, calendars or objects
- requests to go out or start a relationship
- requests for sex
- sexually explicit messages in emails, text messages or posts on social networking sites.

Within a professional/workplace context an employer must not sexually harass a person seeking employment with them, or their employees. Employees must also not sexually harass other employees, their employer, or any person seeking employment with their employer. Sexual harassment is also prohibited in 'common workplaces', meaning that a person must not sexually harass another person at a place that is both their workplaces.

The Equal Opportunity Act also prohibits victimisation. It is against the law to subject a person to any detriment or threaten to do so because they, or a person they associate with, have made a good-faith allegation or complaint of discrimination, sexual harassment, or racial and religious vilification; been a witness and given evidence or information or produced any document, in connection with any proceeding under the Equal Opportunity Act; participated in an investigation conducted by the Commission, or refused to engage in behaviour that would breach equal opportunity law.

Finally, in Victoria, employers also have an obligation under the Equal Opportunity Act to be proactive in relation to the prevention of discrimination, sexual harassment and victimisation in the workplace. There are a variety of ways by which an employer may meet this obligation, including through the development and communication of clear policies for acceptable behaviour, ensuring staff receive appropriate training, and fostering safe and inclusive workplaces.

Expert Advisory Group
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Issues Paper Response Template

Respond to the issues

1. Organisational Culture

Discrimination, bullying and sexual harassment persist in the health sector, including in the practice of surgery, despite clear evidence that these behaviours jeopardise patient safety and negatively impact on victims.

a. Problems persist despite the legal, policy and standards framework

Questions for comment

i. Do surgeons know where the line is, and still cross it?
ii. Are surgeons aware of the relevant professional and educational standards? If so, why do some ignore them?
iii. What more needs to be done to increase awareness of the law and standards?
iv. What needs to be done to ensure compliance with them?

i) N/A

ii) N/A

iii) What more needs to be done to increase awareness of the law and standards?

In the Commission's 2012 research report *'Changing the rules'*, we found that a number of respondents were not aware of the law and processes available in making complaints of harassment and discrimination, thus affecting their ability to report complaints of misconduct. It is important to note that the respondents in this research were members of the legal profession who are usually expected to be aware of their legal rights, and yet even amongst this cohort some were unaware of avenues for complaint handling. It can reasonably be expected that there would be a higher proportion of people within the surgical profession who are unaware of their rights and obligations, or of avenues for complaint handling, given that many surgeons would not have studied discrimination law. Therefore, increasing awareness of the law, standards of conduct and avenues for redress continues to be a priority action, especially given that employers in Victoria are required to take positive steps to meet their obligations to prevent discrimination, sexual harassment and victimisation in their workplaces.

To this end we recommend that both the College of Surgeons and hospital administrators take the following steps to raise awareness of the law and standards:

- **The adoption of a strong, unequivocal zero-tolerance sexual harassment/ discrimination/victimisation and bullying policy.** This should explain what behaviour is prohibited in the workplace by law, the disciplinary action that will be taken against those who breach the policy, including potential termination of employment, as well as guidance on how to make a complaint;
- **Appointment of multiple contact officers** who are trained to provide assistance and support to staff who have questions about the policy or standards, or who wish to make a complaint;
- Formal **launch of the policy**, accompanied by a **communication strategy** across the profession to provide information on both the law and policy standards and the availability of the contact officer(s);
- **Training for new staff** (at induction) on the law and the profession's policy standards and a requirement that employees sign an acknowledgement that they have read and understood the policy and their obligations;
- **Ongoing refresher training** for staff at all levels on the law, policy standards and any changes;
- **The policy standards should be posted and visible throughout relevant organisations** (in tea rooms, corridors, training rooms etc) and available on the staff intranet (where work is office-based) so that at a bare minimum individuals are aware of their rights and responsibilities;
- **Reminding staff about the standards** expected of them under the policy at key times of the year, such as before a conference or staff function. It should also be made clear that managers – as well as senior surgeons or human resources staff – have a role to play in ensuring the ongoing reinforcement of what constitutes acceptable behavior;

- **Linking and promoting the policy standards to other broader social issues within the community**, e.g. November 25 International day for the elimination of violence against women. This could be used as a platform to promote broader community issues and how the policy standards are linked in with these issues;
- Where an incident occurs, the person who has breached the policy should be required to take **additional remedial training appropriate to the circumstances**, in addition to appropriate disciplinary action in the circumstance. The policy standards should also outline the process to ensure that complaints are responded to in a timely and effective way, and that support for the welfare of complainants is also provided; and
- Actions should also be taken to support bystander responses, including **training for bystanders** to identify and take action against discrimination and sexual harassment (see section 3.iii).

It should be noted however, that awareness raising on the law and standards alone will not change behaviour at an organisational or individual level. In many instances it is quite clear that the perpetrator is well aware that their behaviour is unlawful or at the very least in breach of practice standards. One clear indicator of this is the perpetrators use or threat of reprisal if the victim was to speak up about the behaviour. This is covered in more detail in section 4.b.

Given that awareness raising is only one component to address gender inequity and sexual harassment, it is recommended that the College endorse and promote to employers a comprehensive framework that addresses both the drivers of discrimination and sexual harassment, and that is supported by an appropriate response system should it occur. Sections 2.a. and 2.b. provide further detail on the underlying drivers of this behaviour. Section 2.a.i. specifically provides information on developing a comprehensive framework for the College and hospitals to address and respond to discrimination and sexual harassment.

iv) What needs to be done to ensure compliance with them?

The above policy, training and support mechanisms outlined in section 1.iii. are also important ways of promoting compliance with the law and standards. In addition, it is imperative that any breaches and complaints are responded to in a timely, responsive and consistent manner. Once a complaint has been made it should be taken seriously and appropriately investigated as soon as is reasonably practicable. If the allegations made are found to have occurred (i.e. are more likely than not to have occurred), it is important that disciplinary procedures against the person/s responsible are commensurate and proportionate to the seriousness of the behaviour. This should include discipline for any additional victimisation (detrimental conduct) to which the victim has been subjected or threatened because they have complained of sexual harassment or discrimination. Monitoring and enforcement after an incident has occurred is important to ensure compliance (i.e. conducting organisational scans and/or surveys).

It is also important to support the welfare of complainants in the process of complaint handling and afterwards. The person responsible for handling complaints should be sensitive and responsive to the needs of victims, with the focus on obtaining an accurate account of events without in any way blaming or shifting responsibility on to the victim for any unacceptable behaviour on behalf of the perpetrator. Formal supports should be available to victims (e.g. employee assistance programs) and the victim should also be given information on external supports (e.g. Centre Against Sexual Assault) as well as external complaint handling bodies (e.g. Victorian Equal Opportunity and Human Rights Commission).

Prompt investigations and disciplinary procedures arise from legal obligations of procedural fairness to those involved in the process, but also from research suggesting that it is not necessarily the severity of punishment but rather the 'certainty' of punishment that may provide more effective prevention.[5] Sanctions are important in holding the perpetrator to account, providing a remedy to the victim, deterring other potential harassers, encouraging other victims to come forward and sending a strong message across the profession. Perpetrators need to know that their behaviour will be punished regardless of their status in the profession and thus consistency is critical. It is also important that there are confidential channels to communicate across the profession the outcomes of failing to comply with the law and practice standards.

[5] Myrtle P. Bell, James Campbell Quick and Cynthia S Cycota, 'Assessment and Prevention of Sexual Harassment of Employees: An Applied Guide to Creating Healthy Organisations' (2002), 10(1) *International Journal of Selection and Assessment* 163.

1. Organisational culture (continued)

b. Are we teaching the right skills?

Questions for comment

i. Are Surgical Trainees well enough informed about appropriate behaviour in the workplace and given the skills to deal with the inappropriate behaviour of others? If not, what other training do they need?
ii. Why isn't training changing the behaviour in the workplace?
iii. How can the link between patient safety and appropriate behaviour be made clearer?
iv. How helpful is this link in preventing discrimination, bullying and sexual harassment?

i. N/A

ii. Why isn't training changing the behaviour in the workplace?

Whilst we are unable to comment on the content, coverage, impact or depth of training currently delivered, we would like to draw attention to the key principles in primary prevention.

The evidence[6] is well established that prevention is not simply about stopping or disrupting an individual from particular behaviours. Individual behaviour change may be the intended result of prevention activity, but all international evidence indicates that such change cannot be achieved prior to, or in isolation from, reducing structural inequalities in an organisation. Prevention requires changes to the social conditions that excuse, justify or even promote violence – and this means addressing the structures that support inequality in the setting, as well as in individual attitudes and beliefs. It is for this reason that training conducted in isolation from other reinforcing strategies will not change behavior on its own. It needs to be part of a broader framework of activity that addresses inequality within the workplace. Section 2.a.ii. highlights the key factors underlying discrimination and sexual harassment which can act as drivers of inequity in the workplace.

A parallel example at a societal level is the changes to laws, regulations and policing that, *combined with* campaigns targeting individual attitudes to dangerous driving, have seen significant decreases in the road toll.

We would recommend reviewing the current delivery of training in the context of this broader Review. Considerations of what may be incorporated into training programs may include:

- Current understanding of the law/ policy standards and processes involved in reporting;
- Drivers of such behaviors;
- Impact of the behavior on victims, bystanders and the broader culture of the workplaces;
- Highlight positive behaviour in the organisation, target negative behaviours and reinforce norms regarding acceptable behaviours;
- The competency of management/contact officers to respond appropriately and sensitively to reports;
- Importance of creating an organizational culture that is intolerant of such behaviors and supports reporting without reprisals;
- Tailoring specific elements of the training to different audiences. e.g. legal duty/ responsibility of managers/ contact people; and
- Training for bystanders to identify and appropriately respond to instances of discrimination and sexual harassment, as detailed in section 3.iii.

iii. N/A
iv. N/A

[6] Victorian Health Promotion Foundation, *Preventing Violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria (*2007).

2. The culture of surgery

Beyond its persistence in the health sector generally, what is it about the culture of surgery that has not prevented discrimination, bullying and sexual harassment?

a. Gender inequity

Questions for comment

i. What else can be done to address gender inequity or promote gender equity?
ii. Is there a link between gender inequity and discrimination, bullying and sexual harassment? If so, what is it?
iii. How can the College and/or employers better address gender inequity?

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

The science of 'primary prevention' – stopping social or health problems before they occur – is not new. Primary prevention has been successfully applied to areas such as smoking, HIV/AIDS and road safety over recent decades, with Australia recognised as an international leader in prevention across these and other fields. This existing and broad expertise means we know that primary prevention activity must:

- address the underlying 'causes' or drivers of a problem (not just its direct antecedents or its impacts);
- structure and stage complementary activities across settings and over time;
- define indicators to measure progress in the short, mid and long-term; and
- be supported by integrated policy and long-term investment.

For these reasons, one key focus of *Changing the rules* was to develop suggestions of practical steps that organisations can take to work toward gender equality (based on current leading practice). It is clear from the research that for change to be effective, long-term and sustainable, it needs to occur on a number of levels, including at industry-wide, organisational and individual levels.[7, 8] It is also clear that the adoption of one strategy alone is not sufficient to effect the change required to improve gender inequality and thus address the issues of discrimination, bullying and sexual harassment.[9]

From our research a best practice response would be to:

- Undertake an assessment to get baseline data and inform an appropriate response;
- Prepare a comprehensive framework, with a range of mutually reinforcing strategies (that include policy, gender equality plan, complaints processes, education programs etc);
- Collaborate across employers, hospital administrators and other relevant groups on implementing the framework;
- Develop a clear monitoring and accountability framework; and
- Periodically review and report on progress against the framework.[10]

[7] Victoria Health Promotion Foundation, *Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria* (2013) 13.
[8] Paula McDonald, Sara Charlesworth and Tina Graham, 'Developing a framework of effective prevention and response strategies in workplace sexual harassment' (2014) 53(1) *Asia Pacific Journal of Human Resources* 41.
[9] Ibid.
[10] Victorian Equal Opportunity and Human Rights Commission, *Changing the rules: The experiences of female lawyers in Victoria* (Report) (2012), 8.

Below is a list of suggested strategies that could be used in a framework. The Commission recommends that the College internally adopt the outlined strategies, as this would demonstrate leadership and set a standard on the issue. In addition, the College should also work with employers to adopt similar strategies within their organisational contexts.

College of Surgeons

- **Sector wide assessment**: There needs to be a sector wide assessment of women's roles / status, positions and the recruitment practices within the surgical profession. Other professions have developed and mandated a code of reporting that includes annual reporting on gender equity policies and performance against these policies (e.g. Australian Securities and Investments Commission has introduced reporting requirements for registered companies). Reporting may include an outline of the percentage of women in the profession, percentage of women in leadership roles, gender pay gap, number of complaints made based on gender, number of complaints of sexual harassment, discrimination or bullying lodged internally and externally and outcome of complaints. This is one way to track how the profession is progressing.

- **Develop and promote education programs focused on discrimination, harassment and bullying**: Such programs could be incorporated into a continuing professional development program for the sector, and should be accompanied by a robust communications and delivery approach that can mitigate against potential training fatigue within the sector. This may involve holding seminars at different times of the day or online, issuing media releases, using social media or publishing articles in relevant industry journals. It is important for managers to promote this training among their team members and ensure all members of their team participate in the training.

- **Promoting standards of behaviour through discussion, leadership and modeling of behaviour:** This may include a communications plan on how to promote gender equality with the profession more broadly, such as publishing articles in relevant surgical journals, holding seminars, issuing media releases, using social media and confidentially sharing good and bad news stories. Managers play a critical role in setting this standard of behaviour. Managers must lead by example in modeling the appropriate standard of behaviour for their team members to follow. They must also take immediate and appropriate action on inappropriate behaviour against women in the workplace that they either witness or are informed about.

College of Surgeons and Employers/Hospital adminstrators

The below recommendations should be conducted both within the College of Surgeons and in collaboration between the College and Employers to implement within organisations:

- **Open commitment to promoting gender equity**: This should be communicated from leaders within the profession and management/administrators within organisations.

- **Organisational level assessment**: The College and employers should conduct an internal review of women's roles / status, positions (as well as any other diverse groups that may be the target of discrimination), and recruitment practices. In addition an attitude survey on employee's experience with or perception of harassment behaviours and level of sexualised behaviours should be conducted.[11]

- **Develop a positive duty action plan to promote gender equality**: This action plan should have clear goals, objectives, outputs, activities, expected outcomes and accountabilities.

- **Develop an internal working group**: to monitor the progress of the gender equality plan and the progress of the broader elements of the framework.

[11] Myrtle P. Bell, James Campbell Quick and Cynthia S Cycota, 'Assessment and Prevention of Sexual Harassment of Employees: An Applied Guide to Creating Healthy Organisations' (2002), 10(1) *International Journal of Selection and Assessment* 163.

- **Proactively accommodate parent and caring responsibilities:** Research has shown that difficulties in balancing child-rearing and professional goals can discourage female medical students from pursuing particular areas of medical specialization.[12] Services and policies which accommodate parent and caring responsibilities are likely to assist in promoting a greater representation of women entering the surgical profession, e.g. childcare arrangements for hospital staff.

- **Promotion of bystander responses**: This may include toolkits, training or methods to promote stories of bystander responses.

- **Promoting support mechanisms available**: This may include any additional employee assistance programs that are offered, as well as links to external support services.

Additional strategies have also been outlined under section 1.a.iii. that relate to policy, communication strategies, staff training, establishing contact officers, and an appropriate complaints handling response.

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

As was noted in the Background Briefing, there is a nexus between cultures that can perpetuate traditional gender stereotypes and sexual discrimination and harassment.[13] The Commission's *Changing the rules* research identified the key factors underlying discrimination and sexual harassment against women working in the legal profession, which we have summarised below to provide some insight into the relationship between gender inequity and discrimination, bullying and sexual harassment.

- **Male gender stereotypes:** Many respondents commented on the male-dominated 'boys' club' culture, despite more or equal numbers of women in the workplace. It was a common experience that aggressive and dominant behaviours were valued and rewarded within the workplace culture. This made it difficult for individuals with a different approach to progress. This aligns with the findings of a South Australian study of women lawyers aged under 30, in which survey respondents also reported indirect and direct sex discrimination that included 'negative attitudes towards women advancing in the profession, the persistence of gender stereotypes and the existence of exclusive all male social gatherings'.[14]

- **Female gender stereotypes:** Respondents also indicated that women in the firm were required to behave in a manner consistent with traditional female stereotypes, including being attractive, submissive to male lawyers, baking cakes for morning tea and organising social events within the firm. The profession's adherence to stereotypes was discussed in an article in the *New South Wales Law Journal*, which spoke of these attitudes being embedded in systemic practices that allow discrimination to continue.[15] This included attitudes about how women should dress, speak and engage with or manage others.

- **Power differentials:** A consequence of the hierarchical structure of some law firms is that ultimate power vests in the partners (firm managers). As with any institution where power is concentrated in a select few, there is the potential for that power to be misused, with some people feeling frightened to complain or powerless to effect change. Frequently women reported experiencing an imbalance of power leading to discrimination and, in some cases, harassment. The pattern was for men in senior roles within law firms to misuse their position of authority to harass women in more junior positions. This sometimes formed part of the 'boys' club' culture. Unequal representations of women at senior levels of management could have also contributed to women being targeted.

[12] Mary G Harris, Paul H Gavel and Jeannette R Young, 'Factors influencing the choice of specialty of Australian medical graduates' (2005) 183(6) *Medical Journal of Australia* 295.
[13] Expert Advisory Group on discrimination, bullying and sexual harassment, Background Briefing, p.11
[14] Nadine Levy, '*Issues facing young women lawyers'* (2011) 33(10) Bulletin (Law Society of South Australia), p. 28.
[15] Kate Eastman, '*Sex discrimination in the legal profession'* (2004) 27(3) University of New South Wales Law Journal, p. 866.

- **Promotion opportunities:** Respondents discussed that success in the legal profession is often defined by staff members being seen to be present within the workplace, including working long hours. This definition of success was a barrier for women who worked part-time due to parenting and caring responsibilities from progressing to the higher levels of the profession. This, together with unconscious bias in some circumstances, may prevent women from accessing promotional opportunities.[16]

- **Broader cultural patterns:** For some respondents sexual harassment was pervasive, frequent and normalised. For these respondents, sexual harassment was not an isolated incident perpetuated by an individual employee, but rather a pattern of behaviour entrenched in the cultural practices of the firm. The majority of female lawyers who had experienced sexual harassment (75.7 per cent) had experienced harassment on more than one occasion, with almost one quarter (23.3 per cent) reporting that the harassment was ongoing.

The Commission's *Changing the rules* research highlighted the connection between gender inequity and discrimination, bullying and sexual harassment within the legal profession. Given that gender and power inequity were key drivers of this relationship, these research findings are likely to exist within other professions where there is a gross under-representation of women, such as the profession of surgery.

[16] 'Unconscious bias may be defined as attitudinal biases about gender, age, race, etc, that we are unaware we have and are unaware we act upon. Inequities in the workplace develop because people behave differently towards different types of other people': quoted in Workplace Info *Women in professional firms: unconscious bias—busting myths and stereotypes* (2011) <http://www.workplaceinfo.com.au/human-resources-management/eeo/women-in-professional-firms-unconscious-bias-busting-myths-and-stereotypes>.

2. The culture of surgery (continued)

b. The boys' club

Questions for comment

i. What is it about the culture of surgery that contributes to discrimination, bullying and sexual harassment?
ii. What will it take for this to change?
iii. How does the apprenticeship model of training contribute to the problem?

i. What is it about the culture of surgery that contributes to discrimination, bullying and sexual harassment?

Section 2.a.ii. outlines the link between gender inequity and discrimination, bullying and sexual harassment that the Commission found in its research on the legal profession, including the "boys' club" culture that exists in many law firms. It is probable that this may be generalised to the profession of surgery, given the structural and systemic gender inequities that exist in both professions. In the past, surgeons within the medical profession have expressed the view that the limited number of formal complaints of discrimination and sexual harassment were an indication that this was not a significant problem within the profession. However, as discussed in section 4.a., there are a range of reasons why professionals who are victims of discrimination and sexual harassment do not lodge formal complaints, including a lack of awareness of options for making complaints and fears that negative personal and professional consequences will flow from lodging a complaint. Thus, it is critical that the prevalence of discrimination and sexual harassment in the profession of surgery, and medical profession more broadly, be acknowledged and addressed independently of the statistics on complaints.

ii. What will it take for this to change?

Section 2.a.i. outlines practical steps that hospitals, employers and the College can take to address gender inequity and promote gender equality. Further, section 1.b.ii. highlights the importance of targeted training that is endorsed by senior management and focuses specifically on behaviours of concern to create cultural change and effective complaint mechanisms.

iii. How does the apprenticeship model of training contribute to the problem?

The apprenticeship model may contribute to the high prevalence of discrimination, bullying and sexual harassment within the profession of surgery due to the unequal power relationships that are inherent within it. The Commission's *Changing the rules* research found that unequal power relationships were a key driver of sexual harassment and discrimination, as detailed in section 2.a.ii.[17] For example, 40 per cent of survey respondents indicated that the discriminator was their immediate supervisor/manager, while 55 per cent responded that it was their employer or a partner (manager of the law firm).[18] This finding is consistent with complaints data from other human rights commissions across jurisdictions Australia-wide.[19] Of specific relevance to the apprenticeship model, the following experiences of young legal trainees highlight the ways in which power can be misused in apprenticeship and trainee models of professional training:

> *"…young trainees and junior lawyers…bear the brunt of the discrimination and victimisation. Inappropriate behaviour is often dished out from the top down, and…partners 'float on top' without being aware of the issues…"*[20]

> "*Classic situation of superior using their status to coerce the more vulnerable junior staff members."*

[17] Victorian Equal Opportunity & Human Rights Commission, *Changing the rules: The experiences of female lawyers in Victoria* (Report) (2012), 38.
[18] Ibid., 15.
[19] Ibid., 32: complaints are more likely to report they were harassed by someone in a more senior position than a co-worker, particularly female complainants.
[20] Ibid., 20.

> *"There were instances of senior males behaving inappropriately towards young females, either by subjecting them to inappropriate staring or making lewd or slightly off-colour comments."*[21]

Further, the hierarchical relationships inherent within the apprenticeship model means that apprentices are less likely to make complaints about any inappropriate conduct perpetuated by more senior staff members, as apprentices are expected to comply with their seniors' directions rather than challenge their behaviour.

[21] Ibid., 19.

Issues Paper Response Template

2. The culture of surgery (continued)

i. Problems are worse in procedural specialties

Questions for comment

i. **Why are these problems worse in procedural specialties, including surgery?**
ii. **Are surgeons trained well enough to manage the stress of the job?**
iii. **Has inappropriate behaviour become normalised in stressful (procedural) environments?**
iv. **Do surgeons need more training in managing stress and maintaining professional standards under pressure?**

i. **N/A**
ii. **N/A**
iii. **N/A**
iv. **N/A**

3. Bystanders are silent

Discrimination, bullying and sexual harassment in the practice of surgery, in medicine and in the health sector is discussed and witnessed. So why don't people speak out?

Questions for comment

i. **What stops bystanders speaking up when they hear about or witness discrimination, bullying and sexual harassment?**

ii. **What in the culture of medicine – or surgery – makes these issues someone else's job or responsibility to fix, or prevents someone from taking responsibility for addressing these issues?**

iii. **What actions can be taken by individuals, teams and organisations to prevent and address current discrimination, bullying and sexual harassment?**

i. What stops bystanders speaking up when they hear about or witness discrimination, bullying and sexual harassment?

Bystanders are defined in the literature as individuals who are not the perpetrator or the victim of sexual harassment but either directly witnesses the harassment or are subsequently informed about it.[22] In the context of hospitals or consultancies, bystanders can include fellow surgeons, nurses and other hospital staff, supervisors or managers, human resource employees and equity/harassment contact officers.[23]

VicHealth – in partnership with the Social Research Centre, the University of Melbourne and La Trobe University – conducted a major research project on bystander action to prevent sexual harassment, discrimination and violence against women.[24] The following factors were identified as barriers to bystanders taking action:

- **Failure to identify the situation as unacceptable:** Some bystanders did not perceive the behaviour as being sufficiently serious to warrant action, with a tendency to minimise the behaviour as being 'just a joke' or 'nothing serious'.[25] Individuals who held attitudes in support of gender inequity and male dominance were less likely to have taken bystander action in the last twelve months compared to individuals whose attitudes aligned with the principles of gender equality.[26]

- **In-group culture:** Some patterns of exclusive group identity were barriers to bystander action. Specifically, collegial relationships that were based on male peer group identity, masculine aggression and discriminatory behaviour against women prompted bystanders to fear that their masculinity would be called into question if they were to speak out against such behaviour.[27] This is consistent with findings from other research that masculine norms and identities reduce the likelihood of male bystanders intervening to assist women, particularly if they are exclusively in male company.[28] This is also aligned with the Commission's research on the legal profession, which found that strong adherence to gender stereotypes and the "boys' club" culture contributed to and reinforced sexual harassment within the workplace.[29]

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[22] Paula McDonald, Sara Charlesworth and Tina Graham, 'Action or inaction: bystander intervention in workplace sexual harassment' (2015) 26(18) *The International Journal of Human Resource Management* 3; Australian Human Rights Commission, *Encourage, support, act! Bystander approaches to sexual harassment in the workplace* (2012) 8.

[23] Australian Human Rights Commission, *Encourage, support, act! Bystander approaches to sexual harassment in the workplace* (2012) 8.

[24] Dr Anastasia Powell, *More than ready: bystander action to prevent violence against women in the Victorian community* (2012) VicHealth.

[25] Ibid., 29–31.

[26] Ibid.,32.

[27] Ibid., 29–31.

[28] Melanie Carlson, 'I'd rather go along and be considered a man: Masculinity and bystander intervention' (2008) 16 *Journal of Men's Studies* 3–17.

[29] Victorian Equal Opportunity and Human Rights Commission, *Changing the rules: The experiences of female lawyers in Victoria* (Report) (2012), 38.

- **Lack of personal responsibility:** Some bystanders did not perceive it to be their personal responsibility to take action.[30] Other research suggests that bystanders are less likely to intervene when they feel external to the relationship between the harasser and the victim, e.g. if the harasser is the victim's direct supervisor or when the harasser and victim are part of a working team of which the bystander is not.[31] However, team membership does not necessarily facilitate bystander action either, given the aforementioned in-group mentality that can arise within teams.

- **Lack of skills to intervene:** Some bystanders did identify the behaviour as unacceptable, however did not have the skills or knowledge to formulate a strategy to intervene.[32]

- **Fear of negative consequences:** Some bystanders chose not to take action out of fear that it would result in negative consequences, either for themselves or for the victim. Some were focused on preserving their own interpersonal relationships with their co-workers, supervisors and managers.[33] This aligns with other research findings that male bystanders in particular do not intervene or are complicit in sexual harassment when victims are publically humiliated and degraded.[34] In these scenarios, bystanders opted not to intervene out of fear of reprisals or punitive measures from other colleagues, supervisors or managers.[35]

- **Belief that nothing would change:** Some bystanders believed that taking action would not result in the perpetrator changing their behaviour or that any disciplinary procedures would be enacted as a result.[36]

iii. What actions can be taken by individuals, teams and organisations to prevent and address current discrimination, bullying and sexual harassment?

Action that can be taken to address gender inequity or promote gender equity more generally are outlined earlier in this submission (see section 2.a.i.). As such, this section focuses specifically on actions that can be taken to promote and support bystander action.

The research undertaken by VicHealth found that bystanders are most likely to take action when:

- They are effectively able to identify behaviour as discriminatory or sexual harassment and inappropriate;
- They are aware of the harm that discriminatory behaviour and sexual harassment can cause;
- They regard themselves as having personal responsibility to take action;
- They feel confident in their skills and ability to take action; and
- They feel that their action will make a positive difference, either supporting the victim or ceasing the behaviour of the perpetrator.[37]

Thus, bystander action can be promoted by facilitating one or more of these factors. Some examples of actions that can be taken at organisational and team levels include:

- **Promoting standards of behaviour** through discussion, leadership and behaviour modeling.[38] This can assist individuals to identify behaviour as discriminatory or sexual harassment when and if it occurs. Promoting standards of behaviour can also include creating a team culture where each team member is encouraged to assume responsibility for taking action.

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[30] Dr Anastasia Powell, *More than ready: bystander action to prevent violence against women in the Victorian community* (2012) VicHealth 29–31.

[31] Lynn Bowes-Sperry and Anne O'Leary-Kelly, 'To act or not to act: The dilemma faced by sexual harassment observers' 30(2) *Academy of Management Review* 288.

[32] Dr Anastasia Powell, *More than ready: bystander action to prevent violence against women in the Victorian community* (2012) VicHealth 29–31.

[33] Ibid.

[34] Paula McDonald, Sara Charlesworth and Tina Graham, 'Action or inaction: bystander intervention in workplace sexual harassment' (2015) 26(18) *The International Journal of Human Resource Management* 15.

[35] Ibid.

[36] Dr Anastasia Powell, *More than ready: bystander action to prevent violence against women in the Victorian community* (2012) VicHealth 29–31.

[37] Ibid.

[38] Sara Charlesworth and Paula McDonald, 'Sexual harassment in Australia: organisational prevention and responses' (Speech delivered at the Anti-Discrimination Seminar Series, Victorian Legal Aid and Victorian Equal Opportunity and Human Rights Commission, Melbourne, February, 2011).

- **Clear, responsive and consistent grievance procedures** are critical to promoting bystander action and directly addressing the unacceptable behaviour, given that a perception that action would not result in change is a common reason for bystanders not taking action.[39]

- **Training on bullying, sexual harassment and anti-discrimination** for all staff (including managers). This training should also cover bystander education and unconscious bias training.[40] In effort to address common barriers of bystander inaction, training should incorporate identifying behaviours that constitute discrimination and sexual harassment, the harm that it causes victims and others involved and outline strategies for intervening.[41] Strategies may include ways to challenge perpetrators or potential perpetrators, to provide support to victims and to speak out against social norms and inequities underlying sexual harassment.[42]

- **Develop and promote policies that specifically protect bystanders who report complaints** to protect bystanders from victimisation.[43] Disciplinary procedures should be publicly demonstrated if victimisation does occur to send a clear message that victimisation of bystanders will not be tolerated.[44] This facilitates confidence among bystanders that they will be adequately protected should they take action, thus addressing fears of negative consequences that can prevent bystanders from acting.[45]

ii. N/A
iii. N/A

[39] Dr Anastasia Powell, *More than ready: bystander action to prevent violence against women in the Victorian community* (2012) VicHealth, 29–31.
[40] Victorian Equal Opportunity and Human Rights Commission, *Changing the rules: The experiences of female lawyers in Victoria* (Report) (2012), 50.
[41] See Dr Anastasia Powell, *More than ready: bystander action to prevent violence against women in the Victorian community* (2012) VicHealth, 29–31.
[42] Australian Human Rights Commission, *Encourage, support, act! Bystander approaches to sexual harassment in the workplace* (2012) 35.
[43] Ibid., 43.
[44] Ibid., 43.
[45] See More than Ready research report.

4. Complaints

Good data – enabling evidence-based analysis – is known to help drive organisational and cultural change. However, complaints about discrimination, bullying and sexual harassment are under-reported, making it harder to quickly identify trouble spots and emerging issues promptly, and therefore analyse trends in a timely way.

a. Under-reporting

Questions for comment

i. What prevents people from complaining about discrimination, bullying and sexual harassment in the practice of surgery or by surgeons?
ii. How does the power imbalance between perpetrator and victim impact on this?
iii. What confidence is there in existing complaints a pathway – in the workplace and at the College?
iv. How does lack of awareness about how to make a complaint and to whom, impact on making a complaint?
v. How are the problems different for each of discrimination, bullying and sexual harassment?

i. What prevents people from complaining about discrimination, bullying and sexual harassment in the practice of surgery or by surgeons?

Individuals do not make complaints about discrimination, bullying and sexual harassment for a myriad of reasons.[46] In the Commission's *Changing the rules* research, respondents were asked specific questions about complaints, including reasons why respondents did not to make a complaint if this was their course of action. The responses varied depending on individual circumstances and broader organisational culture.

Some of the reasons for not complaining included:

- Fear of not being believed;
- Feelings of embarrassment, guilt, shame, trauma and stigma;
- Fear of retribution/victimisation – including loss of employment, employment opportunities and ostracism in the workplace;
- Fear of publicity – damage to their reputation within the firm and more broadly within the profession;
- Fear of drawing adverse attention to themselves – being labeled as a 'trouble maker';
- Lack of awareness – including behaviours that constituted discrimination and sexual harassment as well as complaints processes;
- Complaints processes that appeared to be too daunting and confronting;
- Limited contact officers / avenues to complain – the absence of multiple 'contact' or 'complaints' persons meant that victims were limited with who they could complain to;
- Ineffective responses and remedies – some respondents did not think anything would happen if they complained or in some cases even whey they did complain the perpetrators were not disciplined and did not have do endure any negative consequences of their behaviour;
- Limited awareness of external complaints bodies – external bodies can offer impartiality and transparency that may not be present in internal complaints processes, hence some victims may prefer this option; and
- Awareness that previous complaints had not been responded to effectively, contributing to a broader workplace culture that condoned sexual harassment and discrimination.[47]

[46] Australian Human Rights Commission, *Working without fear: Results of the 2012 sexual harassment national telephone survey*, 49: More women (4 per cent) than men (1 per cent) felt that they might get fired if they made a formal report or complaint or sought support or advice about sexual harassment or could not trust the people to whom they would be required to submit a report or complaint of sexual harassment (women: 4 per cent; men: 2 per cent). See also, *Beyond doubt: The experience of people with disabilities reporting crime*, p 33 regarding systemic barriers for reporting crimes to police.

[47] Victorian Equal Opportunity and Human Rights Commission, *Changing the rules: The experiences of female lawyers in Victoria* (2012), http://www.humanrightscommission.vic.gov.au/index.php/our-resources-an-publications/reports/item/487-changing the rules- %E2%80%923-the-experiences-of-female-lawyers-in-victoria, 33.

ii. How does the power imbalance between perpetrator and victim impact on this?

In the Commission's *Changing the rules* research, the power imbalance between perpetrator and victims not only had an impact on the victims feeling disempowered to make complaints, but in many cases was also identified as the driver of the sexual harassment and discrimination.

As previously outlined, seventy-eight per cent of respondents to the survey in *Changing the rules* reported that the harasser(s) held more senior positions within the workplace as either their immediate supervisor (23 per cent), employer/partner (30 per cent) or a more senior co-worker (24.7 per cent).[48] This data was consistent with complaints data across all other human rights commissions across Australian jurisdictions, with women complainants were more likely to report that the harasser was someone in a more senior position. [49] Our research also found that sexual harassment was more likely to occur in the early stages of employment, with six out of ten incidents occurring within the first twelve months of employment. This also suggests that victims are more likely to be in a position of vulnerability, making if more difficult to challenge the perpetrator's behaviour.

There are two factors to highlight regarding the relationship between reasons for not reporting discrimination and sexual harassment and power imbalances:

a) **Victims fear negative consequences:** Victims often fear that they will not be believed, are concerned about damage to their reputation and/ or fear retribution/reprisals. Perpetrators who are in positions of power may make it clear to the victim that if the harassment is disclosed or complained about this will have an adverse effect on their career, either through damage to their reputation, demotion, not recommending them, or even by being terminated. This type of threat holds more weight when the harasser is in a position of authority to action the threat, rather than a co-worker who does not have this capacity. This is why it is important to ensure your policy and messaging is clear that victimisation is also unlawful and will not be tolerated.

b) **Senior staff members influence workplace culture:** Senior staff members who harass or discriminate against women can shape and embed this behaviour in to organisational norms and culture. The attitudes and behaviours that senior staff members display reinforce what is acceptable and tolerated in an organisation.[50] If superiors are responsible for the conduct, and if this behaviour is condoned, then it is more likely that the victim would be reluctant to complain. Victims may be justified in thinking that complaining will not cease the behaviour or effect positive change or they may be too scared or frightened to pursue it. The below quotes from *Changing the rules* respondents demonstrates this premise:

> *"I was an article clerk and he was pretty senior. I didn't mention it as, at the time, it was the sort of thing that people joked about and you were supposed to take it in your stride."*
>
> *"The behaviour was pretty openly displayed and accepted by all. I felt uncomfortable about it but as a graduate there was not much I could do and the behaviour seemed to be tolerated at the top."*[51]

It is also important to recognise the broader societal power imbalance that exists between men and women and how this imbalance can drive both sex discrimination and sexual harassment in workplaces. Research has indicated that a risk factor in the perpetration of sexual harassment is when there are skewed gender ratios and high power differentials (within roles and positions) between men and women.[52] This factor is discussed in section 2.a.ii., yet is also worth noting in this section as this power imbalance may also impact on a victims ability to make a complaint.

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[48] Victorian Equal Opportunity and Human Rights Commission, ' *Changing the rules: The experiences of female lawyers in Victoria* (Report) (2012), http://www.humanrightscommission.vic.gov.au/index.php/our-resources-an-publications/reports/item/487-changing the rules-%E2%80%923-the-experiences-of-female-lawyers-in-victoria>, 32.

[49] Sarah Charlesworth, Paula McDonald, Anthea Worley, Tina Graham and Alissa Lykhina, '*Formal complaints of workplace sexual harassment lodged with Australian Human Rights and Equal Opportunity Commissions 1 July 2009- 31 December 2009 (*2012) Centre for Work and Life, University of South Australia, 10.

[50] Myrtle P. Bell, James Campbell Quick and Cynthia S Cycota, ' Assessment and Prevention of Sexual Harassment of Employees: An Applied Guide to Creating Healthy Organisations' (2002), International Journal of Selection and Assessment Vol.10, No.1/2, 162.

[51] Victorian Equal Opportunity and Human Rights Commission, ' *Changing the rules: The experiences of female lawyers in Victoria* (Report) (2012), 35.

[52] Ibid., 161.

iii. What confidence is there in existing complaints pathways – in the workplace and the College? N/A

iv. How does lack of awareness about how to make a complaint and to whom, impact on making a complaint?

Please refer to the Commission's response in section 1.a.iii.

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

One of the key differences between discrimination and bullying and sexual harassment is that the latter includes an unwelcome sexualised element. Consistent with other offences of a sexualised nature, victims have reported that they have not made complaints/reports out of fear that they may not be believed or feelings of shame, trauma, guilt, embarrassment and stigma. In addition, there may also be concerns that their own behaviour may be called into question causing the victim to feel blamed for the conduct of the perpetrator.[53]

The personal impacts of sexual harassment are wide reaching, with reported consequences ranging from mental health issues (e.g. anxiety, depression, post traumatic stress disorder), physical health conditions to work/economic related consequences. The Courts have recognised the serious affects of sexual harassment and awarded significant amounts of compensation as a result.[54] In a number of cases with amounts of $100,000 awarded to the applicant for compensation/damages. In the cases of Richardson and Lee[55], the respective applicants also received compensation for economic loss as well.

These factors (in addition to the other factors highlighted in section 4.a.i) make it increasingly difficult for victims to report sexual harassment. It is therefore critical that there be a comprehensive organisational framework and mutually reinforcing strategies to prevent and respond to sexual harassment. It is also critical that key contact or complaints officers are trained to respond appropriately to disclosures of sexual harassment and assault.

[53] Victorian Equal Opportunity and Human Rights Commission, ' *Changing the rules: The experiences of female lawyers in Victoria (*Report) (2012), http://www.humanrightscommission.vic.gov.au/index.php/our-resources-an-publications/reports/item/487-changing the rules-%E2%80%923-the-experiences-of-female-lawyers-in-victoria>,35.

[54] *Richardson v Oracle Corporation Australia Pty Ltd and Tucker [2014] FCAFC 82; GLS v PLP [2013] VCAT 221; Tan v Xenos (No 3) (Anti-Discrimination*) [2008] VCAT 584; *Lee v Smith* [2007] FMCA 59 and *Lee v Smith* (No.2) [2007] FMCA 1092.

[55] Ibid.

4. Complaints

v. Fear of reprisal

Questions for comment

i. How does fear of reprisal stop people making complaints?
ii. What would change that?
iii. What can the College do – alone or in partnership with employers – to make it safe to complain and take a stand against unacceptable behaviour?

i. How does fear of reprisal stop people making complaints?

As highlighted in section 4.a.i., the Commission has identified a range of reasons why many individuals do not make complaints of discrimination and sexual harassment (as found in our research with the legal profession). Fear of reprisals was reported as a significant reason for not making complaints in both discrimination and sexual harassment incidents. Of the respondents in our survey in *Changing the rules,* who had experienced discrimination but had not made a complaint, 56.1 per cent stated that they were concerned that there would be negative repercussions for their career,[56] with 45 per cent of respondents who had been sexually harassed and did not make a complaint opting not to do so for this reason. [57]

Fear of reprisals manifested in the following ways:

- **Fear of retribution/victimisation**: This included fear of employment loss (terminated or feeling forced to resign), loss of employment opportunities (not being promoted, not provided training/ advancement opportunities) or being ostracised in the workplace (bullied or isolated).
- **Fear of publicity**: damage to their reputation within the firm and more broadly within the profession. The legal profession (similar to surgery) is a relatively small, tight knit profession whereby many practitioners know one another. Damage to reputation can impact on employment opportunities and referrals.
- **Fear of drawing adverse attention to themselves**: being labeled as a troublemaker, this can also impact on reputation and employment opportunities.

The fear of reprisals is a powerful barrier in preventing individuals from making complaints and is arguably of particular relevance in certain specialised professions. For lawyers (or surgeons) who have invested a considerable amount of their lives (time and money) studying and attending professional development opportunities to both qualify for and advance in their profession, the fear that making a complaint could jeopardise this has very real and hard hitting consequences for their career. Unfortunately, when a victim assesses whether or not to make a complaint, the negative consequences may outweigh the benefits in coming forward. Particularly if there have been other complaints that have been mishandled and not responded to appropriately, it may appear to the victim that the outcome of a complaint is rarely advantageous to the victim.

In the case of *Tan v Xenos* [2008][58] the applicant successfully sued for sexual harassment, yet also acknowledged that the claim cost her career. The case received considerable public attention and could have potentially deterred other victims from coming forward. This is not the fault of the applicant who was vocal about the fallout to her career, but a fault within the profession that allowed her career to be damaged as a consequence of complaining.

[56] Victorian Equal Opportunity and Human Rights Commission, *Changing the rules: The experiences of female lawyers in Victoria* (Report) (2012), 18.
[57] Ibid 35.
[58] *Tan v Xenos (No 3) (Anti-Discrimination) [2008] VCAT 584.*

ii. What would change that?

The College and employers should adopt a framework supported by a range of strategies to prevent and respond to discrimination and harassment more broadly. Suggestions to this end have been outlined in section 2.a.i. Specifically in dealing with the issue of reprisals, both the grievance handling process and the outcome is critical. As already detailed, complaints need to be investigated quickly, thoroughly, confidentially and respectfully. There needs to be an appropriate outcome proportional the severity of the perpetrator's behaviour. Importantly, the perpetrator needs to be held accountable both for their discriminatory or harassing behaviour and also for any victimisation or threats of victimisation (or reprisals), as this behaviour is also unlawful.

Making it clear within an organisational context that such behaviour is not tolerated and that it will also be appropriately responded to is one step towards changing culture. Research has also reported that the 'certainty' of punishment may provide more effective prevention then actual severity of punishment,[59] as it sends a clear message that all inappropriate behaviour is unequivocally not tolerated and will be punished (regardless of the perpetrator's professional status).

iii. What can the College do – alone or in partnership with employers – to make it safe to complain and take a stand against unacceptable behaviour?

Section 2.a.i. outlines a possible framework for the College and employers to addresses the drivers to discrimination and sexual harassment. This framework includes sector-wide assessment, training programs, promoting standards of behaviour through leadership.

It is important to adopt this approach internally with the College as this would demonstrate leadership and set a standard on this issue. In addition, the College should also work with employers to adopt a similar framework within their own organisational contexts to address discrimination, bullying and sexual harassment on an organisation-wide level.

[59] Myrtle P. Bell, James Campbell Quick and Cynthia S Cycota, *' Assessment and Prevention of Sexual Harassment of Employees: An Applied Guide to Creating Healthy Organisations'* (2002), International Journal of Selection and Assessment Vol.10, No.1/2, 163.

w. Response to complaints

The EAG is interested in your views about organisational responses to complaints of discrimination, bullying and sexual harassment, for example by employers, professional associations such as medical colleges, including the Royal Australasian College of Surgeons, and regulators, such as the Medical Board of Australia and the Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Council of New Zealand.

Questions for comment

i. How effectively do you think organisations use the powers they have to sanction this kind of
ii. inappropriate behaviour?
iii. Do existing complaints management and appeal processes allow for fair and equitable treatment (for example, recognising unconscious bias on the basis of gender or race)? Or how could these be improved?
iv. Is there enough transparency when sanctions are imposed?
v. How effectively are these sanctions followed up?
vi. What do you think would be effective in generating lasting behaviour change as a result of sanctions having been imposed?

i. N/A

ii. N/A

iii. N/A

iv. N/A

v. N/A

vi. What do you think would be effective in generating lasting behaviour change as a result of sanctions having been imposed?

Appropriate sanctions and responses are one important element in beginning to create lasting behavioural and organisational change. Sanctions that are commensurate and proportionate to the behaviour complained about are important, and should include punishment for any additional victimisation to which the perpetrator has subjected the victim. Sanctions are important in holding the perpetrator to account, in providing a remedy to the victim, deterring other potential harassers, encouraging other victims to come forward and sending a strong message across the profession that sexual harassment, bullying and discrimination will not be tolerated. Perpetrators need to know that their behaviour will be punished regardless of their status within the profession, thus the profession should adhere to a consistent approach.

However it must be reiterated that sanctions alone are not sufficient to create lasting cultural and behavioural change. Behavioural and organisational change can only be achieved when there are a range of reinforcing strategies (as part of a broader framework for change) across the organisational structure that is monitored and updated as outlined previously as outlined in section 2.a.i. and 3.iii.