Re: Operate with respect: how Australia is confronting sexual harassment of trainees


In response to:
Coopes, A., Operate with respect: how Australia is confronting sexual harassment of trainees
BMJ 2016; 354 doi: http://dx.doi.org/10.1136/bmj.i4210 (Published 01 September 2016)

“I don't agree with it, but I've said I would never speak out because of my career”

We applaud the Royal Australasian College of Surgeons for their action plan addressing bullying and harassment (1) but consider that the problem goes much deeper than surgeons behaving badly.

In 2015, we conducted a focus group and interview study in New South Wales, Australia about conflicts of interest in medicine. Participants were medical students (focus groups), and medical educators and other clinicians (interviews). A theme that featured heavily in focus group discussions was the conflict that students and junior doctors felt between reporting others’ inappropriate behaviour and protecting their own jobs or job opportunities.

These behaviours included bullying and harassment, as Coopes describes (2), but also actions that compromised patient safety such as not following procedures for scrubbing in or otherwise cutting corners. Participants struggled more with the idea of not reporting safety-compromising behaviours than with turning a blind eye to situations where they were (what they considered to be) the sole victims, such as bullying or harassment. In both scenarios, however, participants admitted they would be unlikely to report their senior colleagues. This reluctance seemed to stem from a deeply felt role conflict: students are taught that their responsibility is to patients, but know that reporting a doctor more senior than themselves is very likely to be harmful to their studies or careers. We agree there is a “culture of fear and reprisal” that prevents victims from making complaints, but we also suggest that the hierarchy that forms the backbone of Australia’s medical training and associated institutions means that the “silent bystanding” that Coopes mentions is enculturated from the outset of medical education.
While both our participants and the College of Surgeons emphasise the importance of “culture change”, this needs to go deeper than introducing polices to address bullying. In addition to focusing on the day to day behaviour of practicing senior clinicians, culture change efforts need to focus on the reality that current students and junior doctors are made acutely aware of existing hierarchies and their vulnerable career positions from their first years of medicine. Culture change also needs to address the imbalance of men and women in senior medical roles. Numbers of female medical graduates have been similar to or greater than male students since 1994 in Australia (3); yet more than 20 years later we do not see anything like that representation of women in senior medical roles. The challenge is that this “deep” kind of culture change will not happen without the strong political commitment of those who are least likely to benefit from it – those senior male doctors for whom the current hierarchical and male-dominated system works best, as well as solidarity from male medical students, who will likely occupy senior positions in the future medical hierarchy.

References


Competing interests: No competing interests