ARTICLE

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Sexual Harassment of Junior Doctors: Helping Whistle Blowers Who Reveal a Significant Mental Health Issue

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Standfast

It is twenty years since the whistle blower initiated Bristol Inquiry promised to revolutionise clinical medicine with patient-centred, pro-reporting clinical governance. Now whistle blowers are revealing another major issue in clinical medicine with significant mental health implications: the reluctance to report or take seriously sexual harassment of junior colleagues.

Introduction

Lack of resilience, depression and suicide are major mental health problems for junior doctors (Murray & Crotty, 2017).

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The #Metoo whistle blower campaign on Twitter and Facebook has drawn attention to the mental health problems associated with sexual abuse and harassment of women including those in the medical profession (Haynes, 2017). Such sexual abuse indeed seems rife amongst the medical profession. A 2018 Australian survey of intern (n=374) and resident (n=44) junior doctors in New South Wales (NSW) and Australian Capital Territory (ACT) (estimated response rate 17-20%) revealed 16-19% had experienced sexual harassment, including 29% of females (Llewellyn, Karageorge, Nash, Li, & Neuen, 2018). Reasons for taking no action included workplace normalisation of these behaviours, fear of reprisal, and lack of knowledge or confidence in the reporting process. Those who did take action reported ineffective or harmful outcomes including being dismissed or blamed (Llewellyn et al., 2018). In response to these results the President of the Australian Medical Students Association (AMSA) stated that 'Medicine doesn't have a reporting culture. We hear from students that they're taught from first year that whistle blowing is career suicide." (Scully, 2018).

That this is the apparent lesson of health care whistle blowing is not difficult to understand. One of the most significant whistle blowing cases in clinical medicine was The Bristol Royal Infirmary paediatric cardiac surgery inquiry initiated by whistle blower Dr Stephen Bolsin; it spawned a series of governance reforms aimed at reducing the 'club culture' in which senior administrators and colleagues placed the reputational interests of surgeons above the welfare of patients (Smith, 1998). The British Medical Association and the General Medical Council subsequently openly encouraged whistle blowing in principle since the Bristol Inquiry (O'Dowd, 2015). Yet, more than 20 years on from the Bristol Inquiry, patients and junior doctors continue to suffer as a result of the 'club culture' in medicine. Ongoing discrimination against whistle blowers by those in charge of clinical governance systems is exemplified by the cases of Dr Kim Holt (Deveson et al., 2010), Dr Raj Mattu (Ionescu, 2015), Dr David Drew (Drew, 2014), nurse Helene Donnelly (Well, 2014), administrator Kay Sheldon (Ashton, 2015; Beaussier, Demeritt, Griffiths, & Rothstein, 2015), and junior doctor Chris Day (Dyer, 2016). Plans for regular revalidation of clinical competence (i.e. by either written examination or peer supervision) have been one response to such deficiencies (Bolsin, Cawson, & Colson, 2015; Bolsin & Colson, 2013). The role of whistle blowers remains critical to initiating and ensuring the appropriate conclusion of valuable quality and safety inquiries into clinical medicine (Faunce & Bolsin, 2004). Despite this, the poor treatment of whistle blowers who bring to public attention such continuing deficiencies remains a stain on the reputation of most health services

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(Holt, 2015).

It has long been known that whistle blowers suffer mental health problems as a result of attempting to apply ethical principles in the face of institutional obstacles. This is even more so when that whistleblowing relates to conduct that itself is highly likely to create mental health problems, such as sexual harassment. Yet, laws in some jurisdictions inhibit help-seeking by mandating that doctors made aware of a colleague's mental health problem must report that colleague to professional authorities (Worthington & MacKenzie, 2017). Likewise, laws purportedly protecting from reprisal whistle blowers making public interest disclosures do not cover claims of sexual harassment. Sexual harassment is not explicitly outlawed under the *Fair Work Act* 2009 (Cth); it is instead barred by the *Sex Discrimination Act* 1984 (Cth) and so is typically handled by the Australian Human Right Commission (AHRC) through a conciliation process that frequently stretches on for months (Williams, 2018). In this paper we investigate the ongoing interaction between clinical governance systems and whistle blowers focusing on one pertinent contemporary case study: sexual harassment of junior female colleagues.

Sexual Harassment: New Frontier for Health Care Whistle Blowing

Sexual harassment of junior colleagues has become a growing area of considerable dysfunction in health care systems throughout the world (Fnais et al., 2014). It is what is known in philosophical circles as a 'wicked problem' (Crebbin, Campbell, Hillis, & Watters, 2015). It necessarily involves senior doctors trading on their reputation for doing good to patients to knowingly indulge self interest in the form of sexual fantasy behaviour against the wishes and to the detriment of their junior colleagues (Timm, 2014).

At the 2015 Australian Medical Association (AMA) medical conference, sexual harassment and poor mental health were identified as some of the biggest problems affecting medical students (Watters & Hillis 2015). A meta-analysis identified that 60% of medical trainees in the U.S. had experienced at least one form of harassment or discrimination during their training (Fnais et al., 2014). Hospitals and other professional associations can foster a culture of abuse that resists multilevel interventions (Watters & Hillis, 2015). Surveys conducted in Australia, the United Kingdom, United States, Sweden and Canada confirm that between 25 - 75% of women had

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experienced sexual harassment in training or practice (Nora et al., 2002). Reported incidents of sexual harassment in medical school range from sexual advances, sexual favouritism, and denied opportunities (White, 2000). Although the issue is not confined to women, there is a far greater prevalence of sexual harassment towards women than men (Nora et al., 2002). Students from sexual minorities are also more vulnerable (Przedworski et al., 2015). In a large survey of surgical trainees in Australia and New Zealand, sexual harassment was reported by 30% of women, with the perpetrator being male in over 90% of cases (Williams, 2018). Senior surgeons were identified in the same study by both hospitals and individuals as the most likely perpetrators of bullying and sexual harassment. Residents in procedural disciplines are more vulnerable (Nora et al., 2002).

Whistle blowers are forced to play a leading role in fighting such behaviour simply because the perpetrators are so deeply ensconced in the upper echelons of the clinical governance systems purportedly tasked with responding to it (Coopes, 2016). Such harassment undoubtedly worsens outcomes for patients (Rosenstein, 2011). It does this not only by adversely impacting individual and team morale but through reducing quality and safety of overall clinical performance (Flynn, 2015).

The problem arises and is harder to solve in large part because the medical profession remains inherently patriarchal creating significant ethical dilemmas for ambitious female junior colleagues who have experienced or witnessed this type of misuse of institutional power (Crowe, Clarke, & Brugha, 2017). Most medical training is built upon the apprenticeship model, which relies upon patronage to access limited opportunities. Such career entry paths create fertile environments for the kind of power structures that support sexual harassment and bullying and silence potential whistle blowers. Junior doctors are dependent on their senior colleagues for progression, or even survival in the profession (Babaria, Abedin, Berg, & Nunez-Smith, 2012). The institutional power of the perpetrators is reinforced when bystanders refuse to acknowledge bullying and sexual harassment they have witnessed and gradually become desensitized to professional misconduct (Babaria et al., 2012). Sexual harassment that occurs in such dependent relationships, “betrayal trauma”, is less likely to be recognised by victims or bystanders (Smith & Freyd, 2013). Female medical students and junior doctors even can be led to believe the process is an inevitable part of toughening them up for the rigors of clinical practise (Freyd & Birrell, 2013). Sexual harassment undoubtedly therefore is under-recognised.

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Problems with Reporting Sexual Harassment

Widespread reluctance to report incidents of bullying and sexual harassment remains prominent (Coopes, 2016). This is largely due to inadequate processing of complaints and fear of adverse career consequences (Venkatesh et al., 2016). Peer group stigmatisation is also an inhibiting factor (Hinze, 2004). A study conducted by the AMA found that although Colleges have clear and accessible policies on bullying in place, few doctors felt that complaints were handled in a timely manner by their College (Stone, Douglas, Mitchell, & Raphael, 2015). It has been suggested that the legalistic framework for managing complaints perpetuates individual's reluctance to report incidents (Faunce, Boslin, & Chan, 2004). Of particular concern is the "immediate notification to the perpetrator and identification and subsequent vilification of the whistle blower" (Walton, 2015).

Reported sexual harassment is a complex problem for professional regulators, directly overlapping with the criminal law, workplace relations law, and professional misconduct law; and being at the heart of the transition to a more female-dominated medical workforce. The experience of Dr Caroline Tan highlights the legitimacy of concerns about the adequacy of remedies available. In 2005, whilst a registrar in her third year of training in neurosurgery at Monash Medical Centre, Dr Tan was sexually assaulted (as was subsequently proven before a legal tribunal) by a senior neurosurgeon in his private consulting rooms. Dr Tan made a complaint to the Human Resources Department of the Hospital, however it was found to be not established and no disciplinary or further action was taken. Aggrieved by this decision, Dr Tan stepped outside the professional regulatory system, in effect becoming a whistle blower. She pursued her claim in a legal tribunal and was successful (*Tan v. Xenos*, 2008). However, despite her claim being vindicated, Dr Tan's career has suffered detriment, with her being overlooked for positions in private and public hospitals throughout Australia (Mathews & Bismark, 2015; Medew, 2015a). Dr Tan's experience highlights how women in medicine must weigh up the risks to their professional and personal identity when speaking out about sexual harassment (Stone et al., 2015).

Bullying within the medical profession is of similar concern as it is embedded at a cultural and institutional level forming a "transgenerational legacy" (Scott, Caldwell, Barnes, & Barrett, 2015). Any institutional culture that tolerates bullying creates an environment capable of spawning unreported sexual harassment. A review by the College of Intensive Care Medicine of Australia and New Zealand found 32% of trainees and Fellows had experienced or witnessed bullying (Babaria et al.,

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2012). In a large survey by the Royal Australasian College of Surgeons 54% of trainees had experienced bullying (Williams, 2018). Teaching by humiliation is a subtle rather than overt form of bullying which is often experienced by students but rarely reported. A literature review found that less than one third of bullying incidents were reported due to a lack of awareness of procedure, doubt the report would be followed up or acted upon, and a fear of retaliation (Dyrbye, Thomas, & Shanafelt, 2005). Of greater concern, but little surprise, is the number of individuals advised against reporting the abuse (Rees & Monrouxe, 2011). Professionalism is a core ideal within medical school and inextricably linked to ensuring quality care and patient safety. However, the "hidden curriculum" of bullying and mistreatment of trainees by senior doctors seriously undermines the values of the profession and impacts upon the quality of services provided to patients (Faunce & Bolsin, 2004). The association between recurrent mistreatment and medical student burnout emphasises the importance of accessible and effective reporting processes (Cook, Arora, Rasinski, Curlin, & Yoon, 2014).

The experience of Dr Imogen Ibbett at the Monash Medical Centre echoes that of Dr Tan. In 2013, whilst a neurosurgery registrar, Dr Ibbett made a complaint to Monash Health regarding bullying by a female senior neurosurgeon. Dr Ibbett alerted the hospital to the abusive mistreatment of staff by the senior surgeon. However, the hospital deemed Dr Ibbett's claim unsubstantiated and no further action was taken. In 2015, the hospital initiated multiple further investigations into the senior surgeons conduct following further complaints (Medew, 2015b). Despite her initial complaint, Dr Ibbett was later excluded from providing evidence of her experiences by the hospital's human resources department because she was no longer an employee, despite Dr Ibbett making a claim whilst previously employed at the hospital (Medew, 2015c). Once again, this type of tepid institutional response effectively cedes regulatory authority to the whistle blowing process. The experiences of Dr Tan and Dr Ibbett highlight the ongoing challenges faced by women in surgery due to a lack of equality and mentorship (Seemann et al., 2016). The handling of each whistle blower's complaint and their subsequent vilification and exclusion perpetuate medicine's 'club culture' and the reluctance of other victims to come forward.

Following media attention surrounding these two incidents in 2015, the Royal Australasian College of Surgeons (RACS) established and Expert Advisory Group to review policies, set up a reporting framework for sexual harassment and bullying, and explore ongoing issues of gender

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imbalance within the profession (Mathews & Bismark, 2015). Considering the 2014 survey by the AMA, review of College policies and complaint handling processes is a welcome advancement. The RACS Expert Advisory Group substantiated the anecdotal evidence of high levels of sexual harassment, discrimination, and bullying in surgical training and practice, finding that 49% of 3516 RACS members had experienced at least one of these behaviours (Williams, 2018). The President of the College issued a public apology to trainees and surgeons, calling the results of the survey "quite frankly, shocking" (Coopes, 2016). The key findings of the report noted the negative impact of inappropriate behaviours on the health workforce and patient safety (Expert Advisory Group, Royal Australasian College of Surgeons, 2015a). Themes of power imbalances within a hierarchical system, ineffectual response processing and fear of reporting consequences were identified as factors maintaining the endemic 'culture of abuse' (Expert Advisory Group, Royal Australasian College of Surgeons, 2015b). In line with this, it was identified that College polices and guideline regarding harassment and bullying are not sufficient to change the workforce culture (Walton, 2015). Consequently, the recommendations of the report outlined the need for an independent complaints process, along with appropriate avenues for support operated by an independent external agency, and greater measures of accountability (Coopes, 2016). The integrated approach recommended by the report needs to be implemented at all levels to combat the structural systems maintaining the culture of bullying and harassment and preventing change.

Sexual harassment differs from some other forms of whistle-blowing in that whistle blowers are reporting a private incident that they had personally experienced, which may have been normalised or ignored by others. There is evidence that medical students and residents have difficulty recognising abuse, possibly due to past experience within the hidden curriculum where such behaviour is normalised. Sexual harassment is less likely to be reported by the recipients than bullying and discrimination, and institutional responses can be very slow, even after cases have proceeded through the courts. Responding to sexual harassment therefore requires multiple reporting mechanisms, including anonymous reporting. Aggregating anonymous reports into institutional report cards provides a mechanism for trainees to compare potential workplaces, and may impose a market penalty on institutions which receive poor scores on their reports.

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The Path Forward

More than 20 years from the Bristol enquiry, whistle blowers continue to play a critical role in making the system accountable and are now contributing to the struggle to eliminate sexual harassment of junior colleagues.

It must now be accepted that whistle blowers can be hospital administrators as well as nurses or doctors and will continue to play an important role even in the presence of established clinical governance pathways (Faunce & Bolsin, 2004). Legislation designed to protect whistle blowers who make public interest disclosures from unjust reprisals (such as the *Public Interest Disclosure Act* 2013 (Cth)) can too readily be circumvented by performance reviews.

Some institutions have tried to counter factors responsible for harassment (Fried, Vermillion, Parker, & Uijtdehaage, 2012). At the Australian National University Medical School, students are taught that from a virtue ethics perspective, whistle blowers should be presumptively considered amongst the most ethical practitioners of medicine. They are attempting to develop positive character traits by applying ethical principles (principles whose application would lead to general flourishing) in the face of obstacles. At this medical school, students are taught how to whistle blow. Instruction focuses on initial attempts to pay respect to and utilise existing clinical governance pathways, but going outside them to senior colleagues or the media if those clinical pathways prove incapable of responding appropriately (Faunce, 2004). The approach is supported by 'zero-tolerance' policies against sexual harassment supported by senior academics and clinicians in the medical school with robust pathways for reporting and dealing with sexual harassment (Australian National University, 2017).

Financial rewards for whistle blowers have a proven successful track record in the areas of large-scale corporate fraud on the healthcare system (Faunce, Urbas, & Skillen, 2011). Such a system, however, is not suitable for rectifying problems such as sexual harassment in medical training institutions. It is to be hoped that clinical governance pathways will become more supportive of whistle blowers in such situations. Medical colleges, professional regulatory organisations, and medical institutions should valorise proven effective whistle blowers and reward them with career advancement and professional wards of recognition. One such mechanism is for hospitals and academic institutions to create policies advising junior colleagues of members of staff appropriately

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trained in this area and willing to be approached informally to discuss concerns about harassment. Sexual harassment of junior medical colleagues is too important a mental health issue to be left in the hands of a withering patriarchy.

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