



**Australian Human Rights Commission
National Inquiry into Sexual Harassment
in Australian Workplaces**

Australian Medical Association (WA) Submission



The Australian Medical Association (Western Australia)

The Australian Medical Association (WA) is the largest independent professional organisation for medical practitioners and medical students in Western Australia.

The AMA (WA) has industrial representative powers before the Western Australian Industrial Relations Commission (WAIRC) under Section 72B of the Industrial Relations Act 1979 (WA) and has Section 41 Agreements registered by the WAIRC which govern the terms and conditions of employment of both senior doctors and doctors in training operating in WA's public health system. The AMA (WA) also facilitates the Western Australian Branch of the Australian Salaried Medical Officers Federation, which is a Registered Organisation under the Fair Work (Registered Organisations) Act 2009 and promotes the interests of salaried doctors, provides industrial representation to its members before industrial tribunals in the Federal employment jurisdiction and negotiates Employment Bargaining Agreements with employers.

In the aforementioned roles, the AMA (WA) represents doctors across the public and private sector and works to promote and protect the professional interests of the medical profession and the health care needs of patients and communities in Western Australia.

AMA (WA) Position on Sexual Harassment in the Workplace & Addressing the Inquiry's Terms of Reference

The AMA (WA) adopts a zero tolerance approach to sexual harassment, consistent with the Federal AMA Position Statement 'Sexual Harassment in the Medical Workplace',¹ believing that the medical profession must play a leadership role in tackling sexual harassment, modifying professional culture and modelling appropriate behaviour. The AMA (WA) is fully committed to supporting the cultural and attitudinal changes that need to occur within the medical profession and society in order to eradicate sexual harassment in the workplace.

The AMA (WA) has surveyed WA's medical profession and taken action to address sexual harassment in the medical workforce, based on the survey results. The survey results and the action the AMA (WA)'s has taken in response to the survey results, are detailed below. The results and the AMA (WA)'s response, outline potential drivers of workplace sexual harassment in the medical profession, in addition recommendations to address sexual harassment in Australian workplaces, based on the AMA (WA)'s experience.

The AMA (WA) cannot comment on the drivers and impact of workplace sexual harassment outside the medical profession, however there are a number of important considerations related to sexual harassment within the medical profession, which may apply more broadly:

- Medical practitioners in Australia are subject to legal and professional codes of conduct and policy that establish clear responsibilities to treat colleagues with fairness, respect and dignity.
- Ethical behaviour and medical professionalism are fundamental to good medical practice and the doctor-patient relationship, which is built on mutual respect.
- There is a risk that the existence of sexual harassment within the medical profession may compromise the high expectations which the public has for the medical profession and the negatively impact the doctor-patient relationship
- There are wider implications of sexual harassment in a clinical environment that may negatively impact patient care.

The AMA (WA) believes that understanding the extent and nature of workplace sexual harassment as it relates specifically to the medical profession in WA and a collaborative approach to tackling sexual harassment and changing workplace culture, have been critical in maximising the positive impact of the work of the Association. Further, the Association's campaign against workplace sexual harassment and issues that may drive workplace sexual harassment, such as sexism, continues to be a primary focus of the Association.²

¹ Australian Medical Association, "Sexual Harassment in the Medical Workplace", Source <<https://ama.com.au/position-statement/sexual-harassment-medical-workplace>.

² The AMA (WA) has addressed women in medicine in the most recent edition of its journal, *Medicus* (Appendix 5)

The AMA (WA) Equal Opportunities and Fair Workplace Conditions - Sexual Harassment Survey

In 2015, a Sydney vascular surgeon made comments regarding the extent of sexism amongst surgeons, stating that from a professional perspective the safest thing a trainee could do when approached for sex is to comply; the worst thing they could do is to complain.³ While these comments raised public outcry, it also significantly raised the profile of the issue within the medical profession.

In light of the heightened awareness and in recognition of the damage caused by sexual harassment, the AMA (WA) determined to gain a greater understanding of the issue and how it impacts WA medical practitioners, in order to effectively address the issue in collaboration with the wider medical profession and health system stakeholders.

As an initial step to develop a greater understanding of the issue, its prevalence and the impact on WA medical practitioners and their patients, the AMA (WA) created the *AMA (WA) Equal Opportunities and Fair Workplace Conditions - Sexual Harassment Survey* (“AMA (WA) Survey”). (Appendix 1)

Recognising that workplace sexual harassment would not be effectively tackled if the AMA (WA) engaged only with members of the Association, the survey was circulated to 7,795 medical practitioners (including non-practicing doctors) and 1,025 medical students, which included both members of the Association and non-members. A total of 966 people responded to the survey; not every respondent answered every question.

The anonymous survey asked a range of questions relating to individuals’ experience of sexual harassment in the workplace, excluding incidents involving patients. The questions asked were intended to give the AMA (WA) an indication of:

- how common sexual harassment is within the medical workforce;
- individuals’ perceptions of available reporting processes that exist around sexual harassment;
- whether or not medical practitioners feel that their employers are providing a safe workplace through the provision of supportive measures and training.

The following legal definition of sexual harassment was provided to all respondents:

“Any unwelcome: sexual advance; request for sexual favours; or conduct of a sexual nature where a reasonable person would have anticipated the possibility that the person harassed would be offended, humiliated or intimidated. Examples of such behaviour include, but are not limited to:

³ ABC News, “Sexual harassment rife in medical profession, senior surgeon Dr Gabrielle McMullin says”, Source:<<https://www.abc.net.au/news/2015-03-07/sexual-harassment-rife-in-medical-profession-surgeon-says/6287994>>, last accessed: 04 December 2018

- *unwelcome physical touching; staring or leering; suggestive comments or jokes; unwanted requests to go out on dates, or requests for sex; invasive questioning about your private life or body or; displaying posters, magazines or screen savers of a sexual nature.*
- *Sexual harassment does not include situations where the behaviour was welcomed and/or engaged in, on a consensual basis.”*

An analysis of the results demonstrated that sexual harassment exists within the medical profession and revealed the extent to which sexual harassment disproportionately affects female medical practitioners. Given the commitment of survey respondents and the severity of the issue at hand, the AMA (WA) published a summary and analysis of the results of the AMA (WA) Survey in the journal of the AMA (WA), *Medicus*. (Appendix 2)

When compared to national statistics the AMA (WA) Survey showed incredibly low rates of reporting, particularly among female medical practitioners who had experienced sexual harassment.

The AMA (WA) believes that low reporting rates are the result of multiple factors, which include:

- The hierarchical nature of medical training and consequent concerns regarding career progression and reputation if doctors report.
- Entrenched systems and sexism within medicine.
- A lack of information and training on sexual harassment made available in the workplace.
- A lack of knowledge regarding what could constitute sexual harassment and what reporting mechanisms are available.
- A lack of confidence in reporting mechanisms.
- A fear of victimisation following reporting sexual harassment.

The results of the AMA (WA) Survey indicated that a significant number of medical professionals were not aware of workplace policies and procedures that relate to sexual harassment, serving to perpetuate the feeling of futility and helplessness for those who encounter sexual harassment and potentially prevent required cultural change.

The AMA (WA)'s Response to our Sexual Harassment Survey

The AMA (WA) recognised that in order to produce and support the cultural and system change required to address workplace sexual harassment, the Association had to engage in a collaborative approach with key stakeholders. Consequently, the AMA (WA)'s policy making body, the AMA (WA) Council, endorsed the creation of a joint taskforce with the Department of Health (WA), in order to address sexual harassment issues within the WA medical workforce.

The AMA (WA) and Department of Health (WA) (DoH) Joint Taskforce against Sexual Harassment is comprised of an equal number of representatives from both the AMA (WA) and the DoH and has an elected Chairperson. Decisions are made by consensus and the Joint Taskforce has the ability to co-opt additional members for specific purposes, if members agree there is a need. The Joint Taskforce initially met every six weeks and was primarily been focussed on identifying strategies to address issues giving rise to sexual harassment and agree to an action plan including both long term and short term goals.

The AMA (WA) Survey showed that education, training and understanding are key contributors towards creating a culture of respect and openness, in addition to providing a safe working environment where people feel they can report incidents of sexual harassment without reprisal. As such, the Joint Taskforce agreed that an educational campaign was an effective way of creating awareness of what is unacceptable behaviour and created the "Sexual Harassment OUT" Campaign.

The "SHOUT" or "Sexual Harassment OUT" comprised of a two phased strategy which involves visual aids being placed throughout public health facilities in WA and the provision of resources that will allow individuals to seek further information and support if they are subject to or have witnessed sexual harassment.

Phase 1 – Sexual Harassment OUT (SHOUT) Poster Campaign

Phase 1 of the SHOUT Campaign was designed to tackle an unacceptable tolerance of inappropriate behaviour and the prevailing attitude that inappropriate behaviour is not worth reporting. Comments made in the AMA (WA) Survey clearly indicated that, when encountering sexual harassment, many medical practitioners wanted to focus on the clinical care and wellbeing of their patients and feared that reporting sexual harassment would make them appear to be a 'trouble maker', which would impact their career progression.

The Joint Taskforce recognised that breaking this culture of acceptance and stoicism was essential in empowering the medical workforce.

The SHOUT Poster Campaign was designed to educate the medical workforce about what can constitute sexual harassment and specifically, the posters were designed to include behaviour that, although no less insidious, may appear to be less obtrusive and inappropriate. Coupled with the depictions of sexual harassment is the clear message that such behaviour is unlawful, unprofessional and will not be tolerated.

Crucially, the posters depicted sexual harassment occurring in a clinical setting, involving medical practitioners. This was a specific remit of the poster design and was aimed at encouraging medical practitioners to recognise that their profession was not immune from the practice of sexual harassment, those who have been subjected to it should not feel isolated in their experience and create a culture where 'calling-it-out' is seen as an appropriate response.

The Joint Taskforce agreed that a poster campaign was the best approach as a first step and would inform medical practitioners of the unacceptable practice of sexual harassment, with the bold headlines:

- **SEXUAL HARASSMENT IS UNACCEPTABLE!**
- **CALL IT OUT! THERE IS NO EXCUSE!**

The posters can still be seen at public hospitals throughout WA and are attached. (Appendix 3)

Phase Two – Campaign and Website Launch

The campaign was formally launched in December 2017 by the Health Minister, the Hon. Roger Cook, the Director-General of the WA Health Department, Dr David Russell-Weisz, AMA (WA) President Dr Omar Khorshid, and a number of senior clinicians. The campaign launch garnered extensive media attention. (Appendix 4)

“The joint campaign is an excellent way to begin highlighting the seriousness of the issue and I would like to formally thank the Health Department for joining with us to end this unacceptable practice,” AMA (WA) President Dr Omar Khorshid said in a statement.

The launch of the campaign included the announcement of a joint website with the DOH, providing medical practitioners with a confidential avenue to seek information and advice.

This website, created, written and maintained by the AMA (WA) is a creative, innovative way in which to speak to all doctors. Importantly, the website includes prominent details of what individuals can do if they are the subject of unwanted attention. It also includes links to Department of Health policies, contact information for support across all health service providers throughout Western Australia and further information for help or redress if needed, including by contacting the AMA (WA).

AMA (WA) SH-OUT Website - <http://www.sh-out.com.au/>



Australian Medical Association (WA)

National Inquiry into Sexual Harassment in Australian Workplaces

Appendix 1 - AMA (WA) Equal Opportunities and Fair Workplace Conditions - Sexual Harassment Survey

Recent media reports have highlighted the potential barriers and negative experiences faced by people in the medical workforce. The existence of such issues presents a significant risk to workforce equality and may contravene State or Federal discrimination laws.

In light of this, the AMA(WA) has created a series of surveys that will focus on workplace issues, in order to ensure that we continue to provide an adequate level of support and advocacy for all medical practitioners in Western Australia. This survey will focus on the issue of sexual harassment, future surveys will look at discrimination and bullying in the workplace.

All questions are optional and are drafted in a way to ensure that all respondents remain anonymous, even to the AMA. The questions asked relate specifically to workplace interactions (between coworkers, supervisors, management and medical administration) and should not include any issues that have occurred through visitor or patient interactions.

Even though you may not have personally experienced any of the issues highlighted in this survey, your opinion on these issues is still invaluable to the AMA(WA) and we strongly encourage you to complete this survey.

1. Please provide your current position and workplace.

Position (eg. Student,
Intern, Registrar or
Consultant)

Workplace (eg Hospital
name or Health Service)

2. Please identify your gender.

- Male
- Female
- I'd rather not say

3. How old are you?

- 18 - 25
- 26 - 35
- 36 - 45
- 46 - 55
- 55+
- I'd prefer not to disclose my age

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Sexual Harassment

This survey will focus on 'sexual harassment'. This is defined as any unwelcome: sexual advance; request for sexual favours; or conduct of a sexual nature where a reasonable person would have anticipated the possibility that the person harassed would be offended, humiliated or intimidated.

Examples of such behaviour include, but are not limited to:

- *unwelcome physical touching*
- *staring or leering*
- *suggestive comments or jokes*
- *unwanted requests to go out on dates, or requests for sex*
- *invasive questioning about your private life or body*
- *displaying posters, magazines or screen savers of a sexual nature.*

Sexual harassment does not include situations where the behaviour was welcomed and/or engaged in, on a consensual basis.

Discrimination and bullying will be the subject of future surveys. These are defined as:

'Discrimination' is any practice that makes distinctions between individuals or groups of individuals on certain unlawful grounds, so as to treat some less favourably than others. The following grounds are 'unlawful grounds':

- gender, sexual orientation, gender identity, intersex status
- relationship status, pregnancy or potential pregnancy, family responsibilities
- race, cultural background, nationality, disability (physical or mental)
- religion or non-religion, political opinion
- age

'Bullying' is the repeated less favourable treatment of a person by another or others in a workplace, which may be considered unreasonable and inappropriate workplace practices. Examples include, but are not limited to:

- rude, foul, abusive or insulting language
- frightening, humiliating, belittling or degrading actions or language
- inappropriate comments about a person's appearance, lifestyle or family
- ignoring or isolating a person
- undermining performance, work overload or repeatedly threatening to dismiss and employee.

4. Have you ever experienced sexual harassment in the workplace? This includes whilst applying for a job or a college training program.

- Yes
- No
- I'm not sure

5. If you have experienced sexual harassment, when did it happen?(you can select more than one answer)

- In the past two years.
- Between two to five years ago
- Between five to ten years ago
- Over ten years ago

6. At your current place of work, have you ever received any training or information on sexual harassment? For example induction training, reporting procedures etc

Yes

No

If you work at multiple locations, please indicate the locations where you have not received appropriate training.

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Sexual Harassment

Sexual harassment is any unwelcome: sexual advance; request for sexual favours; or conduct of a sexual nature where a reasonable person would have anticipated the possibility that the person harassed would be offended, humiliated or intimidated.

7. Have you reported any sexual harassment that you have encountered?

- Yes
- No

Please provide further information if necessary

8. Who did you report the sexual harassment to?

- Workplace human resources department
- A manager or senior member of staff
- A colleague
- The AMA(WA)
- An external organisation

Please provide further information if necessary

9. Do you feel that there are appropriate structures in your workplace, to allow you to report incidences of sexual harassment?

- Yes
- No

Please provide further information if necessary

10. Do you feel that your concerns, or the issues you raised, were taken seriously?

- Yes
- No

Please provide further information if necessary

11. Do you feel that your concerns, or the issues you raised, were acted upon appropriately?

- Yes
- No

Please provide further information if necessary

12. Were you adequately supported throughout the reporting/investigative the process?

- Yes
- No
- Please provide further information if necessary

13. Were you adequately supported after the conclusion of the reporting/investigative process?

- Yes
- No
- Please provide further information if necessary

14. How long did the reporting/investigative process take?

15. Were you satisfied with the outcome of the process and the further action taken (if any), as a result of you reporting the issue?

- Yes
- No
- Please provide further information if necessary

16. People who report sexual harassment can sometimes face victimisation (subjected or threatened with any detriment). Do you feel that you have been, or would've been, victimised as a result of reporting sexual harassment?

Yes

No

Please provide further information if necessary

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Sexual Harassment

Sexual harassment is any unwelcome: sexual advance; request for sexual favours; or conduct of a sexual nature where a reasonable person would have anticipated the possibility that the person harassed would be offended, humiliated or intimidated.

17. Do you feel that there are appropriate structures in place to allow you to report incidences of sexual harassment?

- Yes
- No
- I'm not sure

Please provide further information if necessary

18. Are you concerned about the consequences of reporting sexual harassment?

- Yes
- No

Please provide further information if necessary

19. People who report sexual harassment can sometimes face victimisation (subjected or threatened with any detriment). Do you feel that you would be victimised as a result of reporting sexual harassment?

- Yes
- No

Please provide further information if necessary

20. Do you feel that your employer has created a workplace environment, where incidences of sexual harassment can be confidentially reported and managed effectively?

- Yes
- No

Please provide further information if necessary

21. Are you aware of any workplace policies and procedures that relate to sexual harassment?

- Yes
- No

Please provide further information if necessary

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AMA (WA) Equal Opportunities and Fair Workplace Conditions

Thank you for completing our survey on sexual harassment.

22. Do you have any further comments to make in relation to anything that has been addressed in this survey?

Thank you for taking the time to respond to our survey. The AMA (WA) is dedicated to advocating on behalf of our members to ensure that their workplace remains safe, productive and supportive.

If you feel like you need further advice on any of the issues raised in this survey, please do not hesitate to contact the AMA (WA) on (08) 9273 3000.

The Doctors Health Advisory Service operate a 24/7, confidential helpline for personal and health problems, they can be contacted on (08) 9321 3098.

SARC is a free confidential service that provides high-quality care for females and males who have been affected by sexual assault or sexual abuse. It is NOT part of the police, however SARC will support a person's decision to involve the police. They can be contacted on (08) 9340 1828 or freecall 1800 199 888.

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Australian Medical Association (WA)

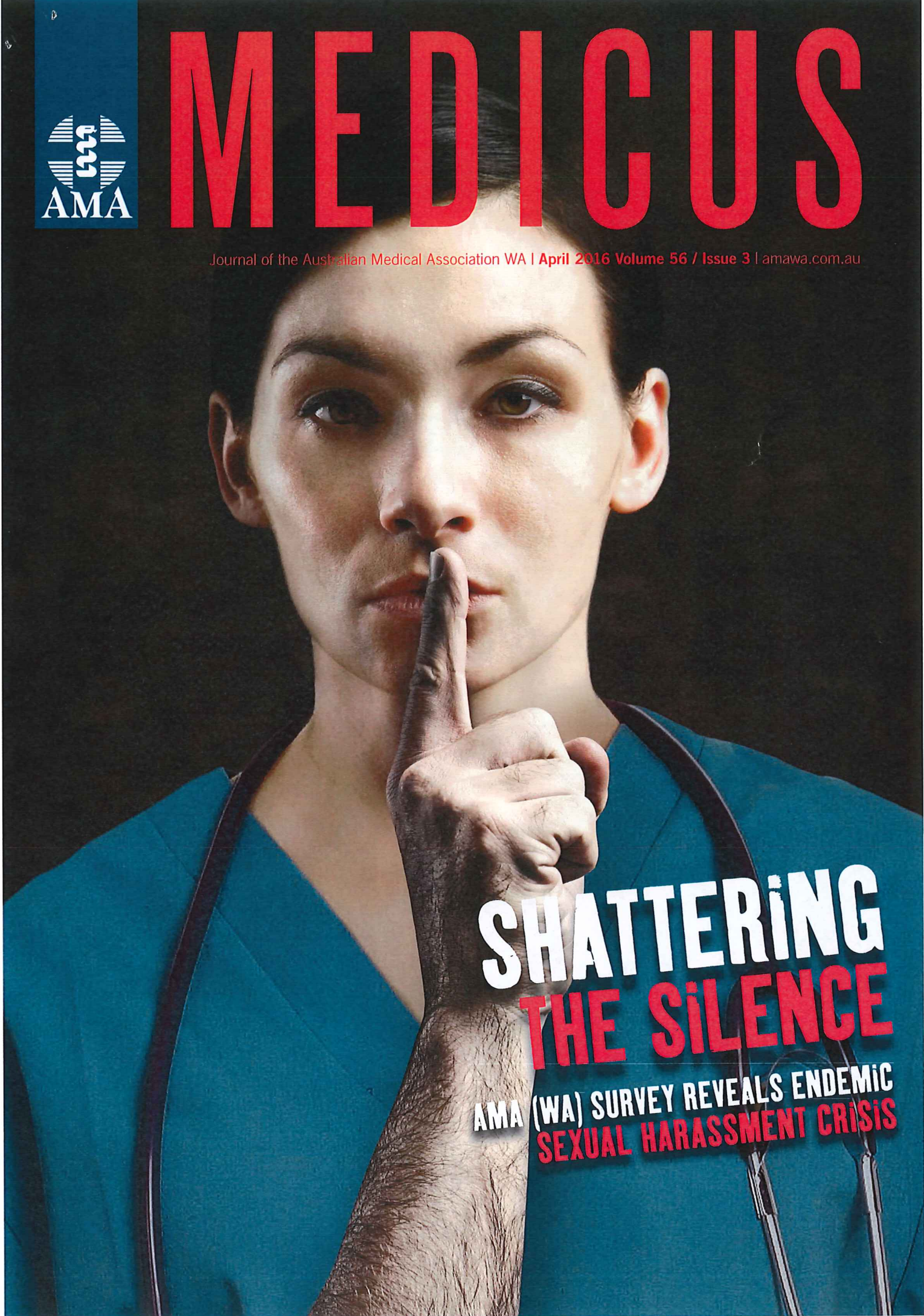
National Inquiry into Sexual Harassment in Australian Workplaces

**Appendix 2 - Medicus, Journal of the AMA (WA)
April 2016, "Shattering the Silence" Cover Story**



MEDICUS

Journal of the Australian Medical Association WA | April 2016 Volume 56 / Issue 3 | amawa.com.au



SHATTERING THE SILENCE

AMA (WA) SURVEY REVEALS ENDEMIC
SEXUAL HARASSMENT CRISIS

SHATTERING THE SILENCE

An AMA (WA) survey reveals sexual harassment is endemic across WA Health and Medicine, and it's time we all speak up

It is one of the most insidious practices in our society and no area of life or profession is immune, including the one in which most of the readers of *Medicus* work – the medical profession.

Sexual harassment in society has been with us for thousands of years. But the battle to end this demonstration of power must be a concerted campaign by all of us, including the Australian Medical Association (WA).

Most countries now have legislation making sexual harassment a crime – but still it goes on.

It goes on because we as a society basically are too self-programmed to not see it, tolerate it or completely ignore it.

There are many males out there who are disgusted by it, and yet have tolerated it – even joked about it in order to handle it. But there are many of us who would have seen people destroyed by it, leaving their jobs or their education.

Most of the time, perpetrators are believed first, with complainants forced to resign to make life easier for a company.

There is no area of society – no matter what we tell ourselves – that can claim “it doesn't happen here”.

As our front cover clearly shows, this issue of *Medicus* is about sexual harassment.

If anyone is not already aware of the pervasiveness of sexual harassment within the medical profession, then this edition will, unfortunately, clearly show that it is a serious and even an endemic problem.

Over the next few pages of commentary, concern and recommendations for action, we hope to shine some light on what continues to be one of the biggest and most serious issues that the profession continues to struggle with.

AMA (WA) ACTION

The AMA (WA) believes there is no place in the medical profession for sexual harassment. We are committed to a zero tolerance policy towards sexual harassment and will continue to play a role in tackling this issue. We are also fully committed to supporting the cultural and attitudinal changes that need to occur in the medical profession. We know that the will and determination to improve the profession exists.

In light of the heightened awareness and recognition of the damage caused by sexual harassment, the AMA (WA) determined it was incumbent upon us to ensure the issue is addressed. Ignorance and misunderstanding serve only to perpetuate inaction. We therefore made a decision to survey all medical practitioners and medical students in the State in order to establish the extent to which sexual harassment affects the profession in Western Australia.

A major part of this cover story is to report the results of one of the biggest surveys ever done by the AMA (WA) of its members and non-members about a single issue.

THE AMA SURVEY

When we sent out the **AMA (WA) Survey on Sexual Harassment in the Workplace** (the Survey) last year, we were aware that such an emotive issue would be likely to provoke a strong response. We were not prepared, however, for what

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SHATTERING THE SILENCE

was the largest response to an Association survey conducted to date – more than 950 medical practitioners and medical students responded in just three days.

If the response was remarkable, the results generated from the survey were staggering. They highlighted the plight of generations of medical students and doctors in training (DiTs), compounded by a systemic failure of responsible organisations to tackle the issues at hand.

All survey respondents were invited to complete the survey anonymously and the AMA (WA) was clear that it would not prosecute or take further, any individual accusations that were made or implied.

We asked the respondents a number of key questions in order to gauge the extent to which sexual harassment impacts on the profession, what action their employers have taken to create a workplace environment free from, and how effective current processes employed are in dealing with, incidents of sexual harassment.

Recognising that people have different opinions of what constitutes sexual harassment, we provided a definition, based on federal and state legislation (see definition on facing page). Further, we specified that all responses should relate to experiences between colleagues from the medical profession.

For survey results, see page 21.

AN AUSTRALIAN STORY... ONE OF MANY

In March 2015, Dr Gabrielle McMullin, a Sydney vascular surgeon, made comments regarding the extent of sexism amongst surgeons, stating that from a professional perspective, the safest thing a trainee could do when approached for sex is to comply; the worst thing they could do is to complain.

Dr McMullin's comments, linking the successful professional progression of medical trainees to unwavering obedience and stoicism, even in the face of unwelcome sexual advances, sparked a national conversation about sexual harassment, bullying and discrimination in the medical profession.

These sentiments ignited an introspective examination of the experience of current medical trainees, and those of their predecessors and successors. Media coverage has focused particularly on the Royal Australasian College of Surgeons. The case of the Victorian surgical trainee Dr Caroline Tan was held up by some, as a prime example of how inherent components of the medical profession and its institutions, such

as ab initio recruitment and its competitive, hierarchical training structure, have created an environment where inappropriate behaviour has been tolerated. Moreover, 'speaking up', even if the law and morality are on your side, can severely limit your career and the professional opportunities open to you.

A SYSTEMIC MALIGNANCY

However, it is naïve for anyone in the medical profession to think that these issues only exist in certain specialties or occur at specific locations. Many might not know of any incidents of sexual harassment or they may be blind to the spectrum of action or inaction that amounts to sexual harassment. Whatever the personal experiences of the practitioners, the profession has a responsibility to recognise that sexual harassment is a systemic issue that pervades the medical profession.

On a professional level, sexual harassment impacts the professional and personal relationships that exist between doctors; the high esteem in which the community holds the profession; and most importantly, the impact on the profession's ability to provide best care for patients. For a victim of sexual harassment, the impact can devastate their professional and personal life, and have a detrimental impact on their physical, emotional and mental wellbeing. There should be no understating the gravity of the problems the medical profession faces, or the level of resolve that will be needed to combat what has so far failed to have been tackled.

THE AMA (WA) RESPONSE

Following the four-month period where the AMA (WA) Survey on Sexual Harassment in the Workplace was open for respondents to complete, we have been compiling the data provided, reviewing independent testimonies left in the survey and engaging with our members and employers in relation to the survey results.

An action panel comprising of the AMA (WA) President Dr Michael Gannon, both AMA (WA) Vice Presidents and a number of male and female members from a range of specialties and positions, was formed in order to review the results to date and formulate a course of action that the AMA (WA) would take in relation to the issue of sexual harassment.

Since the meeting of this group, the Association (WA) has written to the Director General of the Department of Health (WA); the chief executive officers of both St John of God Health Care and Ramsay Health Care; and the respective Deans' of the University of Western Australia and the University of Notre Dame. Their responses are printed in this edition (*please turn to pages 25, 36, 38 and 39*).

The AMA has shared its concern, in addition to the survey data, with these organisations in order to collaborate with them to encourage positive change in workplace and training environments. It is incumbent on all employers to ensure that they provide a workplace environment free from discrimination and to enable reporting procedures for those who encounter sexual harassment. Our educational institutions owe a duty of care to their students, to ensure they remain supported and able to learn in an environment free from sexual harassment.

The AMA is dedicated to advocating on behalf of our members to ensure that their workplace or educational institution remains safe, productive and supportive.

As an initial step towards positive change and a zero tolerance approach towards sexual harassment, both the AMA (WA) and the Department of Health (WA) have committed to work together to tackle this. The Taskforce Against Sexual Harassment (TASH) will investigate this complex issue and propose a framework to act on and hopefully, substantially reduce incidences of sexual harassment in WA Health.

The AMA looks forward to engaging with all employers and educational institutions that wish to take similar action. We will also continue to engage with the medical profession in order to assess the rate at which positive change is occurring and to highlight deficiencies in the medical profession's approach towards inequality, discrimination and sexual harassment. In the meantime, the AMA remains available to anyone who wishes to discuss any of the issues raised in this edition of *Medicus*.

The AMA, your AMA, looks forward to playing its part in making a difference.

Obviously we cannot change this practice overnight, or single handed. But we must start.

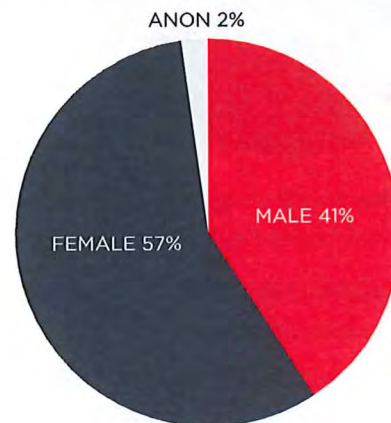
RESULTS OF THE AMA (WA) SURVEY ON SEXUAL HARASSMENT IN THE WORKPLACE

All survey questions were optional and the percentages displayed below, unless otherwise indicated, are based on the number of respondents who answered each question.

All respondents were asked if they have ever experienced sexual harassment in the workplace, including whilst applying for a job or a training program. The impetus behind asking this question was to establish the prevalence of sexual harassment in the medical profession in WA.

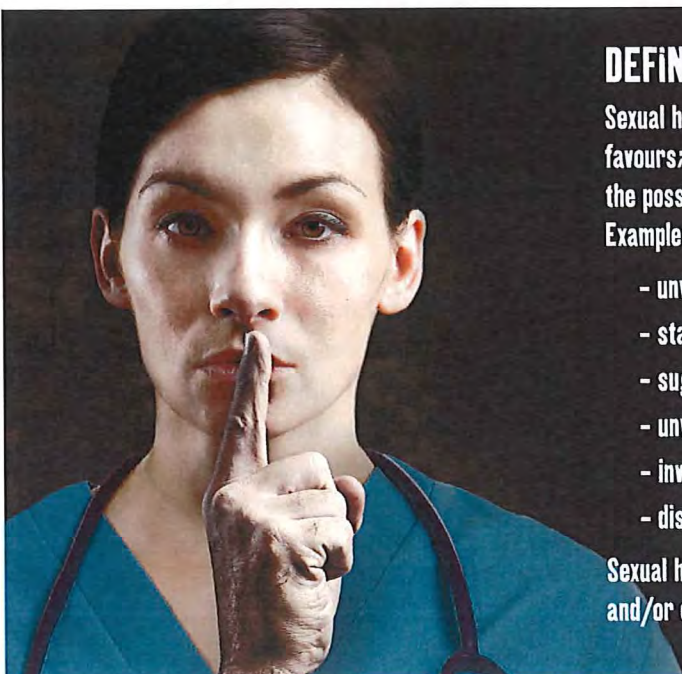
Demographics

All of those who provided a response to this question ('Yes', 'No' and 'I'm Not Sure') identified themselves as coming from the following demographics.



Consultant	36%	Intern	4%
Registrar	17%	Retired	3%
Student	14%	SMO	<1%
GP	11%	Medical Officer	<1%
RMO	10%	Specialist	<1%
Not Specified	5%	Clinical Director	<1%

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DEFINITION OF SEXUAL HARASSMENT

Sexual harassment is defined as any unwelcome sexual advance; request for sexual favours; or conduct of a sexual nature where a reasonable person would have anticipated the possibility that the person harassed would be offended, humiliated or intimidated.

Examples of such behaviour include, but are not limited to:

- unwelcome physical touching
- staring or leering
- suggestive comments or jokes
- unwanted requests to go out on dates, or requests for sex
- invasive questioning about your private life or body
- displaying posters, magazines or screen savers of a sexual nature.

Sexual harassment **does not include** situations where the behaviour was welcomed and/or engaged in, on a consensual basis.

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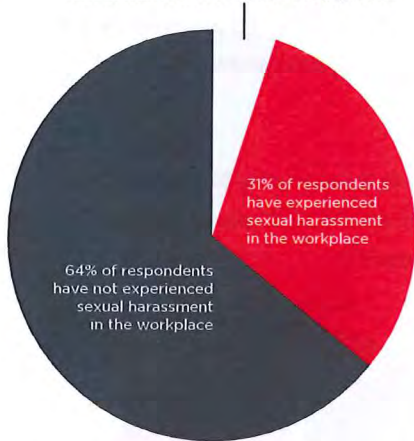
SHATTERING THE SILENCE

Sexual harassment in the workplace

The results indicated that almost a third of respondents have experienced sexual harassment in the workplace.

Respondents who have experienced sexual harassment in the workplace, including whilst applying for a job or training program

5% of respondents were not sure if they have experienced sexual harassment in the workplace.



44% of female respondents indicated that they have experienced sexual harassment.

13% of male respondents indicated that they had experienced sexual harassment.

If you have experienced sexual harassment, when did it happen? (multiple selections were possible):

In the past two years	37%
Between two to five years ago	29%
Between five to ten years ago	20%
Over 10 years ago	33%

Gender breakdown of those who have experienced sexual harassment in the workplace:

Male	17%
Female	81%
Anon.	2%

These results demonstrate the prevalence of sexual harassment in the medical profession. The results also demonstrate the extent to which sexual harassment disproportionately affects female medical practitioners, particularly given that women only account for approximately 42 per cent of medical practitioners in WA.

Sexual harassment in the past five years

When focusing on the issue of sexual harassment as it occurred in the past five years, the results of the Survey reveal the current prevalence of sexual harassment in the medical profession.

Percentage of total survey respondents who have experienced sexual harassment in the past five years, by gender:

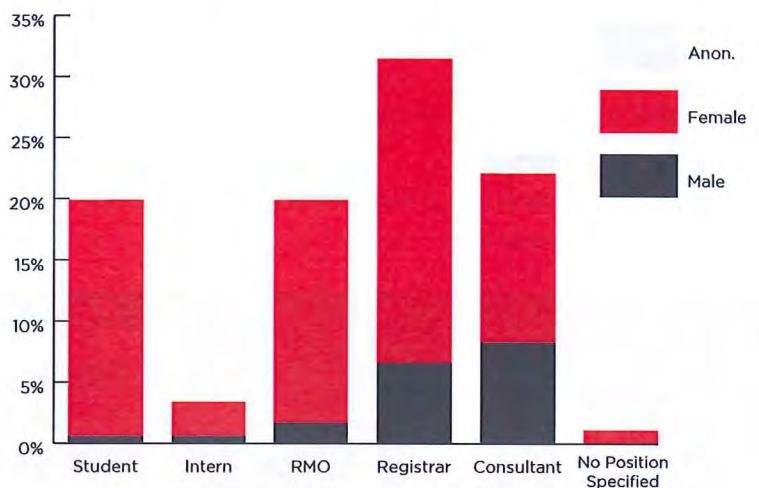
In 2012, the Australian Human Rights Commission carried out a national survey into prevalence rates of sexual harassment in the Australian workforce over the previous five years. It found that 25.3 per cent of women and 16.2 per cent of men have experienced sexual harassment in the workplace.

By comparison, as part of the *Australian Defence Force Review into the Treatment of Women* in the Australian Defence Force, 25.9 per cent of women and 10.5 per cent of men had experienced sexual harassment.

The AMA (WA) survey found that 27.8 per cent of female survey respondents and 8.5 per cent of male survey respondents had experienced sexual harassment in the past five years.

	AMA (WA) Survey	AHRC National Survey	ADF Review Survey
Male	8.5%	16.2%	10.5%
Female	27.8%	25.3%	25.8%
Anon.	25.0%	-	-
% of total survey respondents	19.8%	-	-

Of those respondents who have experienced sexual harassment in the past five years, breakdown by position and gender:



Of all respondents who have experienced sexual harassment in the past five years, 46 per cent of those are female DiTs. The fact that registrars were the largest group to encounter sexual harassment the most in the past five years, suggests that the hierarchical nature of specialty training programs, and the imbalance in power that exists within those training programs, may create an environment where perpetrators are able to take advantage of their professional influence.

Reporting Sexual Harassment

Survey respondents who indicated that they had experienced sexual harassment were asked about whether they had reported the sexual harassment. The reporting rates were woefully low, indicating that there was a lack of knowledge of and confidence in the current reporting procedures offered by employers.

Only 12.5 per cent of male respondents and 6.2 per cent of female respondents who have experienced sexual harassment in the past five years, have reported it. The lack of reporting is of great concern, given the personal impact of sexual harassment and the lack of accountability for perpetrators. However, the fact that females are less likely to report sexual harassment, indicates a worrying gender imbalance in attitudes towards reporting sexual harassment, demonstrating that employers must do more to adequately support female employees.

Of those who had reported an incident of sexual harassment that had happened in the past five years: 29 per cent were satisfied with the outcome; 50 per cent felt their concerns were taken seriously; and 21 per cent felt they were adequately supported during the reporting process.

The lack of satisfaction and support provided to victims of sexual harassment, goes some way in explaining the low reporting rates and indicates a level of impunity which exempts the harassers from any accountability.

Many respondents anecdotally noted the difficulty of being in a position where as a victim of sexual harassment, they experienced it at the hands of someone who will potentially hold influence over their career progression, due to the hierarchical nature of the medical training. The difficulties

are compounded for women, who operate in a male-dominated work environment.

Respondents highlighted that they felt it was pointless to report sexual harassment; were advised by colleagues just to endure the behaviour; make career decisions on the likelihood of encountering such attitudes; and primarily were concerned about the impact that reporting such behaviour would have on their future career and how they would be viewed by their colleagues.

Training, appropriate reporting structures, victimisation, workplace environment, policies and procedures

All survey respondents were asked to identify their current workplace, with multiple selections possible. A series of questions was asked to all respondents regarding any training they had received, the policies and procedures relating to sexual harassment at their place of employment, in addition to the workplace environment their employer has created (*see table below*).

Results indicate that there is an inherent lack of information and training that is available in the workplace on sexual harassment and that many do not feel that structures in place to allow reporting of sexual harassment, are appropriate.

The extent of the fear of victimisation may also explain low reporting rates of sexual harassment. The high level of respondents who are not aware of workplace policies and procedures that relate to sexual harassment, also serves to perpetuate the feeling of futility and helplessness for those who encounter sexual harassment. ■

Number of total survey respondents who have identified service location (multiple possible):		Respondents who stated that they have not received sexual harassment information or training at their current place of work & corresponding percentage of total survey respondents at specified location:		Respondents who feel there are appropriate structures in their workplace, to allow them to report incidences of sexual harassment & corresponding percentage of total survey respondents at specified location:		Respondents who feel they would be victimised as a result of reporting sexual harassment & corresponding percentage of total survey respondents at specified location:		Respondents who felt their employer has not created an environment where incidences of sexual harassment can be confidentially reported and managed effectively & corresponding percentage of total survey respondents at specified location:		Respondents who are not aware of workplace policies and procedures that relate to sexual harassment & corresponding percentage of total survey respondents at specified location:	
Metropolitan Public Schools	468	301	64%	182	39%	131	28%	81	17%	128	27%
WACHS	42	30	71%	21	50%	11	26%	5	12%	12	29%
Ramsay (Inc. JHC & PHC)	34	23	68%	13	38%	6	18%	5	15%	7	21%
SJOG	40	27	68%	16	40%	11	28%	5	13%	15	38%
UND	18	12	67%	7	39%	9	50%	3	17%	3	17%
UWA	68	51	75%	9	13%	36	53%	19	28%	29	43%
Private Practice	164	129	79%	72	44%	39	24%	18	11%	57	35%



DISCRIMINATION NOT TOLERATED IN WA HEALTH

Dr David Russell-Weisz
Director General, WA Health

I read the AMA's survey into sexual harassment in WA's medical workforce with great interest. This is a timely survey, given recent media reports about sexual harassment in Australia, and the formal apology issued by the Royal Australasian College of Surgeons (RACS) last September to everyone who had suffered discrimination, bullying or sexual harassment by surgeons.

The RACS report, following an investigation by its own Expert Advisory Group, found that nearly half of surgeons across all specialties had experienced discrimination, bullying or sexual harassment – with discrimination common during pregnancy and victims afraid to make formal complaints.

Discrimination in any form will not be tolerated at WA Health. Even one episode is too much.

Not only does this type of behaviour have a devastating impact on the personal and professional lives of those involved, it is underpinned by values that are in direct contrast to those we require in our staff; the values required to provide the best care to patients.

As the Director General of WA Health, it is my responsibility – along with the Health Service Chairs and Chief Executives – to provide a safe workplace.

An alarming part of the recent AMA survey into sexual harassment in WA's medical workforce was the proportion of people who reported not having the tools to deal with being sexually harassed.

WA Health works hard to ensure that staff are aware of the WA Health Code of Conduct, the Equal Opportunity Act and other policies and legislation, which clearly spell out the standard of behaviour we expect in our health system.

We also have robust policies on employee grievance resolution, managing misconduct, and preventing and responding to workplace bullying.

More than 42,000 staff have participated in our mandatory **Accountable and Ethical Decision Making** training program since its introduction in June 2010.

This online program provides specific information on the topics of bullying, discrimination, harassment and misconduct, and clearly outlines the pathways for WA Health employees who wish to report inappropriate or concerning behaviour in their workplaces.

The Department of Health's Ethical Advisory Line – 1800 000 224 – was established in 2009 for both employees and members of the public to report inappropriate behaviour or conduct in any WA Health workplace, confidentially and anonymously. To date, it has received more than 1,400 calls.

In addition, bullying awareness training is mandatory for all Health Service employees and is undertaken on a biannual basis.

The Department of Health also runs a range of workshops covering misconduct, misconduct management, reporting pathways and bullying behaviours for a variety of employment

“ The Department of Health's Ethical Advisory Line – 1800 000 224 – was established in 2009 for both employees and members of the public to report inappropriate behaviour or conduct in any WA Health workplace, confidentially and anonymously. To date, it has received more than 1,400 calls

groups on a regular basis.

While these initiatives set the tone for the standard of behaviour we demand at WA Health, there is obviously more to be done.

In the coming months, the Department of Health will join forces with the AMA (WA) to form a committee – the Taskforce Against Sexual Harassment (TASH) – to examine and implement some key strategies for further addressing sexual harassment and bullying in the healthcare sector, but specifically in the medical workforce. We are also committed to working with RACS in the same vein.

I look forward to these partnerships and to working together to ensure Western Australia's health system has the right approach and strategies to combat sexual harassment and bullying, underpinned by a zero tolerance to such behaviour. ■

SEXUAL HARASSMENT - DO YOU KNOW THE RULES?

Harassment can cover a wide spectrum of inappropriate behaviours. Some may be merely breaches of common courtesies, whilst others may fall under the umbrella of "unlawful harassment".

Legislative Background

Unlawful harassment is in Australia covered by anti-discrimination laws. These laws regulate behaviours specifically in the areas of employment, education, clubs, accommodation and the provision of goods, services and facilities.

By regulating workplace behaviour through legislation, the law recognises an individual's employment as one of the most significant considerations next to family and loved ones. The amount of time spent at work and the inability of most people to simply "walk away from the job" make it paramount to ensure that workplaces are safe and free from harassment.

Harassment is generally defined as unwelcome behaviour which offends, humiliates or intimidates a person. It will constitute unlawful harassment where a person is subjected to such behaviour in certain circumstances (e.g. at work) for a reason which is prohibited under the relevant anti-discrimination legislation.

What is sexual harassment?

Sexual harassment is a legally recognised form of sex discrimination. In Western Australia, sexual harassment in the workplace has been outlawed for over 30 years, by both Commonwealth and State legislation.

The definition of sexual harassment under both legislative instruments is similar, referring to unwelcome sexual advances or requests for sexual favours or any unwelcome "conduct of a sexual nature".

Sexual harassment under the *Equal Opportunity Act 1984 (WA)* also requires that the complainant is disadvantaged, or has reasonable grounds for believing he or she will be disadvantaged, by taking objection.

The Sex Discrimination Act 1984 (Commonwealth) requires the "reasonable person" test to be met, asking: would a reasonable person in the position of the complainant, taking into account his/her age, cultural, social and religious background, position and general attributes, have anticipated that the complainant would be offended, humiliated or intimidated.

Conduct of a sexual nature covers a wide spectrum ranging from inappropriate behaviours to criminal offences. Examples include touching, hugging, cornering or kissing,

NO EXCUSES, please!

"it was just a one-off"

Sexual harassment is commonly perceived to require repeated conduct. This is not so. A single act is capable of constituting sexual harassment, so long as the following criteria are met:-

1. Was the conduct sexual in nature?
2. Was it unwelcome?

3. Does it meet the reasonable person test (*Sex Discrimination Act*), or was the harassed person disadvantaged or had reasonable grounds for believing that they would be disadvantaged at work (*Equal Opportunity Act*)?

Under either instrument, the third test is easily satisfied where the harasser is in a position of power vis-a-vis the harassed person, such as an employer, supervisor, or mentor in a training program.

"They could have said something"

This power imbalance, as well as possible age differences and fear of

reprisals or victimisation, are all reasons why the law also does **NOT** require the aggrieved person to tell the harasser that the conduct is unwelcome.

"Just a bit of fun"

It is the aggrieved person who decides whether the conduct is unwelcome. The harasser's intention is irrelevant. It is similarly irrelevant that the same conduct may not have been unwelcome to others or even an accepted feature of the workplace in the past. What may be perceived as "fun" by one person, may be offensive to another, subject only to the "reasonable person" test.

sexually suggestive comments or jokes, inappropriate staring or leering at a person or at intimate parts of their body, sending sexually explicit e-mails, text messages or pictures, repeated or inappropriate invitations to go out on dates, intrusive questions into a person's private life, insults or taunts of a sexual nature, sexual gestures, indecent exposure or inappropriate display of the body, requests or pressure for sex or other sexual acts, stalking or actual or attempted rape or sexual assault.

Unwelcome v Consensual acts

The law does not prevent employees and co-workers from engaging in mutual banter. Flirtation, sexual attraction and even sexual interaction is not unlawful if it is not "unwelcome". The parties should, however, make sure that the interaction is truly consensual, mutual, invited and reciprocated, always being mindful of any potential power imbalance between the parties.

It is also important to be mindful of other co-workers who may be offended by having to share a workspace with individuals overtly and inappropriately displaying their affections. Whilst the conduct of the individuals involved may be completely consensual vis-a-vis each other, care must be taken not to create an unpleasant and sexualised workplace for the other workers.

Similarly, just because two individuals used to be in a consensual sexual relationship at one point in time, does not preclude the possibility of sexual harassment occurring following the breakdown of the relationship.

Liability

Whilst most employers have processes for employees to address grievances, an aggrieved person can at any stage opt to seek redress externally, either in lieu of, or additional to, an internal workplace grievance resolution process.

If a person takes their complaint to an external body (e.g. the State Administrative Tribunal or Federal Court), there are several different ways in which individuals and employers may be held liable for workplace sexual harassment:

- **Personal liability**
- **Accessory liability**
- **Vicarious liability; and**
- **Liability for victimisation** of a person in connection with a complaint of sexual harassment.

As the name suggests, **personal liability** applies to the offender personally, if he or she is proven, on the balance

of probabilities, to have engaged in sexual harassment as defined under the applicable State or Federal legislation.

Accessory liability applies in circumstances where an individual or an organisation by their action cause, aid or permit another person to engage in sexual harassment. Turning a blind eye or reckless disregard of the unlawful conduct may attract accessory liability, even if the person did not actively engage in any unlawful conduct him- or herself.

Vicarious liability is a form of strict liability and applies to an employer in respect of the acts or omissions of its employees in the course of their employment. The only time an employer will not be held vicariously liable for the sexual harassment committed by one of its employees is where the employer can show that they have "taken

all reasonable steps" to prevent the harassment from occurring. This may be demonstrated if the employer can show that they have anti-harassment policies and grievance procedures in place, have effectively communicated these to their employees, and have at all times acted in a manner consistent with their policies and procedures in addressing any inappropriate behaviour brought to their attention.

Victimisation occurs where a person connected to a complaint of unlawful harassment (i.e. the complainant or a witness assisting in the investigation) is subjected or threatened to be subjected to detriment in the workplace because of the fact that they have made a complaint or are acting as a witness. Victimisation is unlawful in its own right and punishable with a fine or even imprisonment.

So what does this all mean?

Employers: Make sure you have a policy in place setting out clear expectations of behaviour and committing to a safe workplace free from harassment.

The policy should be complemented with a grievance resolution process, and be effectively communicated to all employees, also outlining the consequences of any breach.

If you receive a complaint, you must deal with it fairly.

“ Conduct of a sexual nature covers a wide spectrum ranging from inappropriate behaviours to criminal offences

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SEXUAL HARASSMENT – DO YOU KNOW THE RULES?

confidentially, transparently and in a timely manner. If necessary, use external HR support to assist in the process.

Employees: Sexual harassment is not acceptable. It is unlawful, and you are protected.

If you are not personally subjected to it, but witness sexual harassment in your workplace, do not stay silent. By speaking out and leading by example, we can all take a big step towards affecting change in the organisational culture of our workplace. ■

CASE STUDIES

On 5 December 2013, the Federal Court ordered an accountant to pay \$476,000 in damages for sexual harassment of a co-worker. The Court accepted that the female accountant had been both verbally and physically harassed, causing her to resign from her employment in late 2009. She was found to have suffered from post-traumatic stress disorder and other psychiatric illness as a result of the events, which had long-lasting effects on her ability to function both in a social and a work environment. The complainant was awarded \$293,000 for loss of past earning capacity, \$63,000 for loss of future earning capacity, \$110,000 in general damages for pain and suffering and \$10,000 for past and future medical expenses. (*Ewin v Vergara (No3)*[2013] FCA 1311)

In October 2013, a tribunal ordered a male traffic controller who sexually harassed a female colleague to pay her \$102,217 compensation, having found that the traffic controller had engaged in sexual harassment "dozens of times a day" over a five-month period when the woman resigned. The tribunal rejected the respondent's defence that the complainant did not appear to mind his conduct because she had at times participated in risqué banter and word games, and that his "jokes" helped break up the otherwise boring work day. Instead, the tribunal found that the comments made and invasive questioning of the complainant's sex life were such that a reasonable person would have anticipated the possibility that she would be offended, humiliated or intimidated by the conduct.

(*Nunan v Aaction Traffic Services Pty Ltd* [2013] QCAT 565)

Recognising that community standards have changed to demand higher compensation for non-economic loss in sexual harassment cases, the Full Court of the Federal Court increased a manager's overall damages award on appeal from \$20,000 to \$130,000 in July 2014. In making the award, the Full Court acknowledged the manager's physical and psychological injuries in the context of other recent decisions involving awards of common law damages ranging between \$250,000 and almost \$600,000 and comprehensively rejected "the tired old argument that compensation for such damage must fit within an outdated, inferior and self-perpetuating range".

(*Richardson v Oracle Corporation Australia Pty Ltd* [2014] FCAFC 82)



TIME TO CLOSE DOWN THE BOYS' CLUB

Dr Andrew Miller
AMA (WA) Vice President

Now and then, we experience a reset of our views on an issue that we thought we understood before.

A famous local example would be that stomach ulcers no longer need surgery and ranitidine. This seems normal now but was still considered radical in the 80s.

Some of the inertia on many issues is due to our natural reluctance to admit we are wrong, as well as the number of other urgent issues we all face, which leave us little time and patience for "causes".

But when the evidence is overwhelming we usually accept it, change our views and move on.

Sexual harassment of our female colleagues is a scourge. It has been and remains endemic in society, but our business is medicine. Medical men have failed and continue to fail to respond adequately to calls to lift their game. Some male doctors remain publicly or privately resistant to this political correctness, this trendy agenda of the intelligentsia. If you don't believe it is an important issue, then please read the results of the AMA (WA) survey. Then go and ask a few women if what it says is true, because it is shocking.

A few weeks ago, I was in the change room when a respected colleague came in with a co-worker. I have chatted to them both before and they

are good guys, solid in their work. Both are popular and have families. They proceeded to have a good old fashioned 1970's chat about a female colleague who had been in theatre with them. They were oblivious to my immediate presence, and that of two other men who were also in there.

Men and women do this and in a social context, that is their business. But in the modern workplace, it can no longer be tolerated. We used to think this was harmless fun, boys being boys, a bit of a laugh.

In fact, though, it has the potential to cripple a career and destroy peoples' futures. If you wouldn't say it in front of your wife or daughter or sister, then think twice before sharing at work.

We need to find a new landscape in which men and women can still be human, still have fun, still tell a bad joke but remain professional. We should never have anyone uncomfortable because of our attitude or conversation.

Science is wonderfully brutal and it is the most basic of statistics that confirm that many medical specialties are not just heavily but overwhelmingly dominated by men in the highest ranking and best paid positions.

We have not managed to fix it yet with "merit based" appointment and advances made by many women who ignore or subdue the male dominance. Inherent bias toward male

“ Inherent bias toward male appointees needs to be countered with quotas in my view

appointees needs to be countered with quotas in my view. Merit is not distributed predominantly to men. Those who are resistant to quotas as somehow demeaning or condescending or likely to dilute "quality" need to move beyond their hesitation or explain how they will deliver results. Once women have an even representation, perhaps we can remove the need for quotas, as others will feel welcome and know they do not need to fight every step of the way to succeed on an uneven playing field.

An equal distribution of jobs has a moral imperative, but also it has benefits for all involved. A diverse range of thinking is important in complex organisations and problem solving at any level. We owe it to our patients to ensure that they have the opportunity to be looked after in a system that has the best chance of solving their problems.

So for the men out there who think there is no problem, or that they are not part of the problem, sorry but I think the science is pretty clear it was us all along. Let's all just get on with fixing it. ■



STANDARDS – ABOUT TIME WE ALL UPHOLD THEM!

Dr Omar Khorshid

AMA (WA) Vice President

Chair, Education and Training, Australian Orthopaedic Association

Member, Board of Surgical Education and Training, Royal Australasian

College of Surgeons

Head of Department, Fremantle Hospital

When vascular surgeon Dr Gabrielle McMullin called out the surgical profession on sexual harassment, I was shocked and upset by her claims. It seemed that she was being unnecessarily provocative.

However, the survey conducted last year by the AMA (WA) demonstrates conclusively that we do have a problem with sexual harassment in the medical profession in Western Australia. The vast majority of conduct goes unreported and medical students, junior doctors and surgical trainees seem to be at the highest risk. We deliberately focused that survey on sexual harassment as we felt that inclusion of bullying and discrimination would dilute the results. But we are certain that the rates for bullying and discrimination would be even higher, as reflected in the survey by the Royal Australasian College of Surgeons (RACS).

Whilst we have plenty of legislation requiring safe working environments, it is clear that the culture of our profession has permitted inappropriate (and illegal) conduct to occur. We hear that it is not worth it for an affected junior doctor to report harassment when it has occurred due to the small chance of meaningful action against the perpetrator and an almost inevitable risk to career progression.

Much of the attention has been focused on the RACS and it does seem that surgeons are over represented

as perpetrators of sexual harassment and bullying. The College has committed to action on this issue but my belief is that the responsibility for changing the culture of the medical profession needs to be borne by all members of the profession, and specific action is required from the AMA, employers, colleges and all of us.

Most of us are aware of conduct that has occurred, but we seldom take action to call colleagues out on inappropriate conduct. Formal reports are vanishingly rare.

One of the common excuses heard around surgeons who behave badly is that their conduct has to be accepted due to their technical skill as surgeons and the risk that we could lose their talents from our hospitals.

As a trainer of surgeons, I have to say that any surgeon who has the poor judgement and lack of integrity to sexually harass or bully junior doctors or medical students cannot be regarded as a good surgeon and the likelihood is that this lack of professionalism will also manifest itself in behaviours that put patients at risk.

The RACS has defined competencies of surgeons along the same lines as the CANMEDS roles and these domains can be applied to all doctors just as much as they can be applied to surgical trainees. Technical skill forms a small proportion of the skills, attributes and knowledge required to be a safe and competent doctor.

Continued on page 32



As a trainer of surgeons, I have to say that any surgeon who has the poor judgement and lack of integrity to sexually harass or bully junior doctors or medical students cannot be regarded as a good surgeon.

- DR OMAR KHORSHID

Continued from page 31

STANDARDS – ABOUT TIME WE ALL UPHOLD THEM!

The AMA has recognised that it has a role to play, and a key part of that role is to make sure that employers are taking their responsibilities seriously when reports are made.

Another part is to help create an environment where medical students and junior doctors feel empowered to complain about inappropriate conduct and to make reports when they are required, safe in the knowledge that the report will be taken seriously and that there will be no impact on the junior doctor's career progression.

We also need to uphold these standards ourselves and not rely on junior members of the profession to call out inappropriate conduct on the part of their senior colleagues.

In terms of practical steps, we have decided to convene a working group – the Taskforce Against Sexual Harassment (TASH) – with representatives of employers, junior doctors, senior members and the AMA to discuss these issues and plan an appropriate response. We are very pleased to have the support of WA Health's Director General, Dr David Russell-Weisz and I understand that he will be attending the first meeting of the working group in the near future.

It is time for our profession to take a stand on sexual harassment and the working group will be making concrete recommendations to ensure that this issue is resolved for good.

I hope that this discussion in *Medicus*

“ In terms of practical steps, we have decided to convene a working group – the Taskforce Against Sexual Harassment (TASH) – with representatives of employers, junior doctors, senior members and the AMA

has helped members to consider the issues we have raised and we would be pleased to receive any feedback you may like to provide. ■



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GENDER EQUILIBRIUM BUT NO GENDER EQUALITY

Dr Melita Cirillo

Clinical Haematology Registrar
Royal Perth Hospital

As an intern, I remember scrubbing into the operating theatre hearing a pair of registrars snigger about their female colleague who “was a terrible mother” for returning to work, wanting to finish her training after having a child.

I remember thinking how hard it must be for her, knowing the whisperings of criticism for wanting good training; and feeling powerless to change the circumstance. I watched this dedicated doctor work twice as hard as some of her colleagues to prove herself “worthy” of the opportunity.

When the Royal Australian College of Surgeons (RACS) released its survey results confirming nearly half of surgeons have experienced bullying, discrimination or harassment, the fraternity could not be surprised. It confirmed a deeply rooted malignancy which persists in the background of hospital corridors, tea rooms and operating rooms around Australia. It’s not just surgery, of course – but the College should be commended for being open enough to publish their survey results. It exists across all parts of medicine, in hospital and community settings. And trainees in small community settings, rural/remote locations or single (state-based) training centres are more at risk of the detrimental effects. Avoiding “career suicide” is on the trainee’s mind in the workplace every day.

Although writing from a trainee’s perspective, I can’t help but be taken back to medical school. In an AMSA survey on

sexual harassment, more than a third (38 per cent) of all medical students reported experiencing sexual harassment (80 per cent of those female)¹.

I am not surprised by this evidence, given local experiences. I recall it not uncommon for sexual innuendo and connotation during clinical placements. Though events may have been small in isolation, in summation, they depict a bubbling culture of sexism that persists despite feminisation of the medical workforce.

I had been made to feel uncomfortable by sexual comments from seniors and colleagues alike. But like many young doctors, it’s difficult to know how to manage the scenario when it occurs. And there is room for improvement in the way we are prepared (by medical school) for the clinical workplace. So these things may not be let to pass, and change can be grown from within the heart of the system.

As the breadth of this problem has been made public, what does one do with that information? There is an uneasiness that comes from knowing a problem, and not knowing how to truly change the culture that breeds this. This got me thinking. How does this aspect of hospital culture actually affect one’s choice of training program? Does being exposed to a sexist culture change the way trainees view their career prospects? Surely this wouldn’t be enough of a deterrent for a dedicated trainee to be put off from pursuing their chosen vocation?

An open question...Why, are some specialties still training a single-gender

“ I had been made to feel uncomfortable by sexual comments from seniors and colleagues alike. But like many young doctors, it’s difficult to know how to manage the scenario when it occurs

dominant group, when the graduating workforce is near gender equilibrium? I have heard the argument that trainees choose their path and the Colleges are not to blame for the gender composition of trainees. However, I disagree. I think the Colleges need to accept some responsibility for providing supervision and mentorship that promotes a more balanced workforce.

If all the players in the national softball team were females, how would a young male rookie recruit feel training to try out for the next World Championships? Does he really want to pitch in that team, or would he just decide to play basketball instead? In honesty, when choosing my training, I was lucky to find something that matched my interests with a relatively open culture.

But I know of young doctors who have loved a specialty and given up pursuing it because of a culture that made it seem unachievable. From my observations, gender equilibrium in the workforce has not equated with gender equality in training, but here’s hoping for the future. ■

Reference available on request.



NO PLACE FOR PREJUDICE IN ADDRESSING SEXUAL HARASSMENT

Dr Chris Wilson and Dr Michael Page
Co-Chairs, AMA (WA) Doctors in Training Committee

A simple, conservative knee-jerk reaction to any type of change, is to declare that political correctness has gone mad. This may be true in some areas. Meticulous attendance to political correctness in all of its right and wrong forms has certainly provided a boon for employment in government middle management.

So, have modern definitions of sexual harassment gone too far? Have the community, judiciaries and legislators created a situation in which harmless behaviour can be twisted into vexatious allegations? We would argue that this is not the case.

Sexual harassment has existed, in all of its currently recognised forms, since the dawn of time. It has always been based on the exploitation of power differentials, and inappropriate behaviour has always been considered inappropriate by those at the receiving end, whether it occurred in 1916, 1986 or now. The spectrum of deleterious effects experienced by

the victim – from mild discomfort or unease through to outright physical and psychological injury – has not changed. What has changed is the empowerment of the vulnerable party in an imbalanced power relationship to seek redress for alleged violations. The community, through its recognition of the underlying causes of sexual harassment, has rightly facilitated the empowerment of victims in this regard, while equally importantly maintaining the presumption of innocence on behalf of the accused.

Clearly, this is why medicine has a problem. Largely self-regulated and with deeply ingrained hierarchical structures, it has neither fully allowed the contemporary broader community's expectations to shape its culture, nor itself gone far enough to genuinely empower individuals who have been unjustly treated.

Concerns that allowing modern standards to apply to cases of alleged sexual harassment within the medical profession will lead to a

“Concerns that allowing modern standards to apply to cases of alleged sexual harassment within the medical profession will lead to a flurry of vexatious claims constitute, in essence, systematised victim-blaming and a denial of unbiased hearings to claimants

flurry of vexatious claims constitute, in essence, systematised victim-blaming and a denial of unbiased hearings to claimants. Both claimants and accused parties deserve to be heard, have a presumption of innocence, and have a strictly confidential hearing, conducted independently and to the standards and expectations expected by the community at large of a profession that it holds in high regard. ■



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MULTI-FACETED APPROACH NEEDED TO TACKLE SEXUAL HARASSMENT



Professor Shirley Bowen

Dean, School of Medicine Fremantle
University of Notre Dame Australia

Associate Professor Angela Alessandri

Lead, Positive Workplace Behaviours Initiative
School of Medicine Fremantle
University of Notre Dame Australia

The AMA Survey highlights the size of the sexual harassment issue in the Western Australian medical workforce. The fact that 31 per cent of 913 respondents have experienced sexual harassment at some point in their medical training or career is concerning. A total of 181 respondents (or 20 per cent of those responding to the question) had experienced sexual harassment in the past five years. This represents 8.5 per cent of males and 27.8 per cent of females.

These figures are shown in context in the table below where they can be compared to figures from the general Australian population and the Australian Defence Force (Australian Human Rights Commission data).

Table 1: Experience of Sexual Harassment in the last five years

	Male (%)	Female (%)
AMA (WA) Survey	8.5	27.8
Australian Population	16.2	25.3
Australian Defence Force	10.5	25.9

Of those experiencing harassment in the last five years, 80 per cent were female.

Overall, 14 per cent (or 124) respondents were medical students. Only 17 (<2 per cent) of respondents identified the School of Medicine Fremantle UNDA as their place of work or study.

Given the small number of potential Notre Dame medical students, it is not possible to make any reliable conclusions from the analysis of questions by place of work/study.

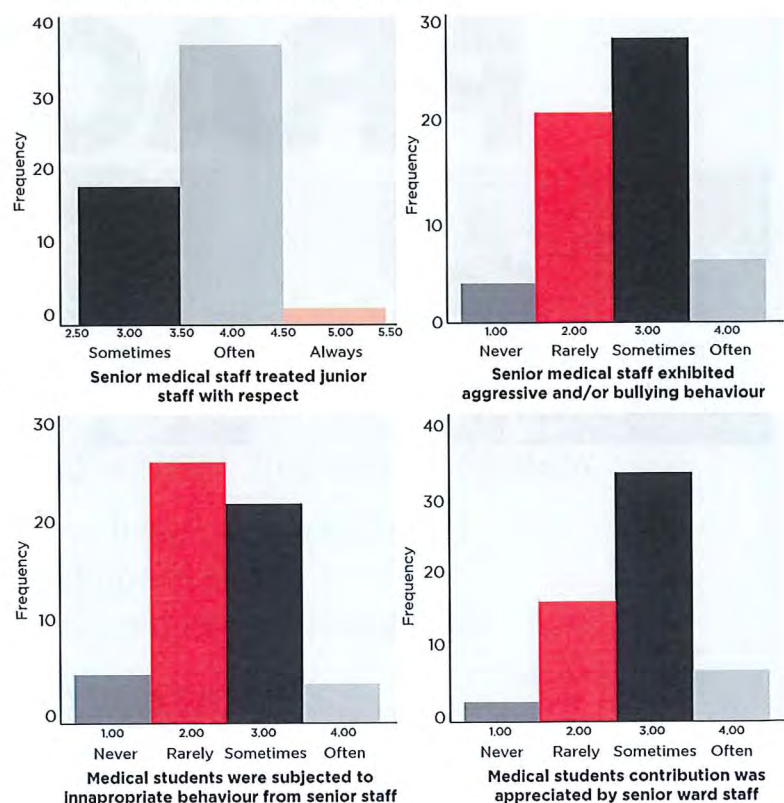
It is readily acknowledged that sexual harassment information and training can be improved at Notre Dame for both staff and students. Further work is also required on the structures to assist students in particular in reporting sexual and other harassment during both their pre-clinical and clinical training. In response to the media and professional concerns regarding harassment in general in the medical workplace, Notre Dame undertook a survey of its third year students concerning their experiences in the clinical setting in late 2015. While there is

relatively comprehensive international data on the experience of sexual and other harassment in national and international literature, there is a paucity of information on medical students' experience of broader workplace behaviours exhibited by senior medical staff. This is important as such behaviours form the basis of the 'hidden curriculum' in medicine and influence students' future professional behaviour.

The survey received ethics approval from the UND Human Research Ethics Committee. It consisted of 22 questions in total with a five-point Likert scale response and will be formally published later this year.

A total of 57 of a possible 84 third year students completed the Professionalism Survey in October of 2015 (response rate 68 per cent). Several aspects of senior medical staff behaviour were considered and the data revealed that students observed a variety of behaviours but suggest that

Selected results from the Professionalism Survey, School of Medicine Fremantle, UNDA



respect for junior staff is not consistent and the majority of students witnessed aggressive or bullying behaviours at least sometimes. A significant proportion of students were subjected to inappropriate behaviour sometimes or often, although their contribution was appreciated at least sometimes in the majority of cases (See graphs).

While these data are limited to a single survey of students at the end of their first year of clinical rotations, they do provide a snapshot of their experiences and assessment of senior medical staff behaviour. It is recognised that the data represent the students' unchallenged perceptions, however, it is of great concern that expected professional behaviours such as respect for junior staff are far from universally displayed by senior medical staff.

In addition, medical students are experiencing inappropriate behaviour. These experiences are having a negative impact on female students in particular who are concerned about their future treatment and progress in the medical profession.

Clearly, there is a need to address the issues of bullying, sexual and other harassment and gender inequality in the medical profession. At the medical school level, this requires a curriculum that provides students with skills to effectively deal with negative behaviours. Notre Dame is meeting this challenge with a multi-faceted approach which includes the following:

- Establishment of a **Positive Workplace Working Group** with a

combined membership of faculty and students.

- Hosting a forum on bullying and harassment in medicine in the 2016 academic year.
- Consolidating the curriculum in the clinical years with workshops on topics such as assertive communication, conflict resolution, developing resilience and practical approaches to bullying and harassment.
- Incorporating elements of the established first year Physician Wellness Program (ESSENCE+) into the latter years with an emphasis on mindfulness and reflective practice.
- Consolidation of the structures and supports for reporting bullying and harassment both within the school and the clinical setting.
- Improved dissemination of policies and procedures with respect to bullying and all types of harassment.

While the aim of these initiatives is to equip students with skills to improve their practice and experience of the medical workplace, it is recognised they alone will not change the culture that has enabled bullying and harassment to reach such alarming levels. Notre Dame like any other institution or college involved in the training of healthcare professionals, must review its own practices and model the humility, respect and compassion required to support the significant cultural change that the Australian healthcare system urgently requires. ■

GENERAL PRACTICE



Applications for the 2017 Australian GP Training (AGPT) program open from:

Monday 11 April - Friday 9 May 2015

To apply go to: agpt.com.au

For more information contact (08) 9473 8200 or gpcareers@wagpet.com.au

WAGPET 

CLEAR POLICIES, PROCESS & SUPPORT AT UWA

UWA is committed to a zero tolerance approach on the matter of Sexual Harassment in the Workplace as is the AMA.

The University has many measures in place for students and staff to ensure high standards of professional behaviour are upheld.

These include:

- A Code of Conduct and Code of Ethics for staff and students (<http://www.hr.uwa.edu.au/policies/policies/conduct/code>)
- A Faculty Policy on Professional Behaviour for students and Faculty Advisory Panel
- Regulations for Student Conduct and Discipline
- A Health Promotions Unit educating students in relation to matters such as consent

- Material on Conduct in Unit Handbooks
- A Student Guild webpage with advice on discrimination and harassment.

Much of this material is brought to the attention of all students at Orientation with the policy describing standards, support available and processes to follow.

The University has a number of policies and resources for staff to ensure standards are clear and support is available. In addition to the Code of Conduct and Code of Ethics, staff will in 2016 be required to complete training modules on sexual harassment, bullying and health and safety in the workplace.

The University takes this matter seriously and welcomes further engagement with the AMA and other professional bodies to address the matters identified in the survey. ■



SUPPORT AND EDUCATION FOR UWA STUDENTS

The University Health Promotions Unit provides information and guidance to students on matters relating to sexual consent at <http://www.student.uwa.edu.au/life/health/fit/share/sexual-health/assault>

The Unit also offers training for students via the UWA Student Guild Leadership Program on Reducing the Risk of Sexual Violence. A session can be requested by contacting the unit via email at healthpromotion@uwa.edu.au

The Faculty Policy on Professional Behaviour for Students is published on UWA's faculty webpage at <http://www.meddent.uwa.edu.au/teaching/policies/professional-behaviour>. Unit Guide books also refer to the professional behaviour. All students are advised of the Policy at Orientation. The Policy will be reviewed in relation to student misconduct to modernise and address current day issues.

UWA POLICY ON SEXUAL HARASSMENT

<http://www.hr.uwa.edu.au/policies/policies/conduct/sexual-harassment>



SJG COMMITTED TO VALUES, IMPROVEMENTS AND ACTION

Dr Michael Stanford
Group Chief Executive Officer
St John of God Health Care

St John of God Health Care has a zero tolerance approach to bullying and harassment in the workplace and we welcome the opportunity to work with the AMA (WA) and others to prevent them happening and/or address any issues of this nature that arise.

We are a values-based organisation and we work extremely hard to maintain a culture that is consistent with our mission. We take quick and decisive action on any behaviour that is made known to us that is not in keeping with our values, including claims of sexual harassment.

Our policies, procedures and Code of Conduct, to which our employees and medical practitioners sign up to on commencing work with us, reinforce that bullying and harassment are unacceptable and will not be tolerated in our workplace.

If any of these behaviours are reported, we undertake an investigation, including in many instances, an independent investigation. We encourage the person making the claim to reach out to a support person, including their union or professional body to assist them through the investigation.

To further support this process, the orientation program that all employees must complete on commencing work with us includes a mandatory education module specifically on bullying and harassment and that mandatory

education is repeated every two years. Our policies and educational materials on bullying and harassment are readily accessible throughout our workplaces.

We recognise that not all issues of harassment will be reported and we have mechanisms in place to monitor culture in our workplaces and help to identify issues, like staff and doctor satisfaction surveys. These can also lead to the initiation of further investigation and consequent action.

There are a number of outcomes that could result if a behaviour is found to be in breach of our Code of Conduct including termination of employment or contract, further education or the provision of counselling and mentoring. With regard to the AMA's Sexual Harassment Survey, it seems likely that our accredited Visiting Medical Officers may be unfamiliar with how to access information on harassment. We look forward to working with our various Medical Advisory Committees to remedy this.

In the last 10 years, of our 3,000 plus accredited doctors and 300-plus employed doctors, we have had one complaint about sexual harassment (not in WA). It was effectively dealt with. The AMA survey implies significant underreporting has taken place, so we will review our systems with regards to doctors so as to maximise the appropriate use of our policies and procedures. ■

BREACHES TAKEN VERY SERIOUSLY



Kevin Cass-Ryall
Operations Executive Manager - WA and SA Hospitals
Ramsay Health Care

Sexual Harassment in the workplace is not tolerated at Ramsay Health Care facilities. We are a values-based organisation guided by "The Ramsay Way" and our motto is "We are People Caring for People".

In the broadest sense, discrimination, bullying and harassment in the workplace are not acceptable. We are on a journey to educate our doctors and staff, and education is the key to eliminating unacceptable behaviours. Reporting of breaches in a timely and factual manner is taken very seriously within our facilities. We appreciate the role that the AMA plays in encouraging all hospitals to work toward eliminating sexual harassment in the workplace. ■



Australian Medical Association (WA)

National Inquiry into Sexual Harassment in Australian Workplaces

**Appendix 3 - AMA (WA) & Department of Health
(WA) Sexual Harassment OUT Campaign Posters**

SEXUAL HARASSMENT



Sexual Harassment **is unacceptable**

There is no excuse for sexual harassment. It is unlawful and unprofessional and will not be tolerated in our workplace.



Department of Health

www.sh-out.com.au



SHOUT
Sexual Harassment **OUT**

CALL IT OUT



THERE IS NO EXCUSE

This is **sexual harassment**

There is no excuse for sexual harassment. It is unlawful and unprofessional and will not be tolerated in our workplace.



Department of Health

www.sh-out.com.au



SHOUT
Sexual Harassment **OUT**

SEXUAL HARASSMENT



Sexual Harassment is unacceptable

There is no excuse for sexual harassment. It is unlawful and unprofessional and will not be tolerated in our workplace.



Department of Health

www.sh-out.com.au



SHOUT
Sexual Harassment **OUT**



Australian Medical Association (WA)

National Inquiry into Sexual Harassment in Australian Workplaces

Appendix 4 - Sexual Harassment OUT Campaign Launch, Media Coverage

Hospitals to fight sexual harassment

EXCLUSIVE

■ **Cathy O'Leary**
Medical Editor

Confronting posters depicting male doctors leering at female colleagues will be posted on hospital walls in a Government-backed campaign to stamp out sexual harassment.

It comes after an Australian Medical Association WA survey of almost 1000 doctors and medical students, which revealed widespread sexual harassment and intimidation in the workplace, particularly against young women.

The campaign, to be launched today by Health Minister Roger Cook, will tell staff how to deal with unsavoury behaviour and deal with recalcitrant colleagues, and has a website called SH-OUT.

One poster depicts two male doctors leering at a woman bending over, while another shows a doctor putting his arm around a woman as he reads over her shoulder.

The AMA said the campaign was timely, given the unprecedented spotlight on sexually inappropriate behaviour in politics and the entertainment industry.

Its survey in 2015 found 31 per cent of doctors had experienced sexual harassment, while almost half of women said they had been harassed.

The results suggested perpetrators often took advantage of their

seniority and ability to intimidate junior doctors.

The results prompted the establishment of a special task force 18 months ago, led by the AMA and the WA Health Department, one of the State's biggest employers of doctors.

AMA WA president Omar Khorshid said the campaign would tackle the "insidious and damaging" practice of sexual harassment in medical workplaces.

While it was a problem throughout the community, particularly where people abused their power, it was crucial there was no sexual harassment in hospitals.

"This is a harmful, deep-rooted practice and it must be called out and stopped wherever and whenever it is seen or experienced," he said.

"Sexual harassment is against the law but for too long it has either been tolerated, or the practice has been swept under the carpet.

"There are a few bad eggs who really need to change their behaviour, but there are also unconscious behaviours or little comments that are not meant to be nasty or vindictive but can still have a huge impact on individuals."

Dr Khorshid said most new doctors were women and they were encouraged to call out inappropriate behaviour.

■ ALSTON, OPINION P54-55



Posters warning against harassment.



WESTERN AUSTRALIA

CAMPAIGN TO TACKLE SEXUAL HARASSMENT LAUNCHED



WESTERN AUSTRALIA

MEDIA RELEASE

Friday 15 December 2017

A new campaign jointly prepared and funded by the Australian Medical Association (WA) and the WA Health Department will tackle the insidious and damaging practice of sexual harassment in medical workplaces.

The campaign, to begin immediately, follows a landmark survey of doctors by the AMA (WA) which found a worrying prevalence of sexual harassment in WA hospitals.

“There is no place for sexual harassment in any workplace, especially in WA medicine. This is a harmful, deep-rooted practice and it must be called out and stopped wherever and whenever it is seen or experienced,” AMA (WA) President Dr Omar Khorshid said today.

“Everyone has the right to feel safe at work and employers have an obligation to ensure their workforce is safe from sexual harassment,” Dr Khorshid said.

“It is time to focus a spotlight on the damaging issue of sexual harassment in the medical workplace and this campaign is the start of doing exactly that.”

“I am proud that the AMA (WA) has taken the lead on this issue. This is a subject and a practice that cannot be ignored any longer.”

“It might have been easy to ignore reports of sexual harassment in the medical workplace. Instead, we decided to confront it and the first step was to measure it.

The response to the survey was the biggest response to any AMA (WA) survey conducted to date, with more than 950 medical practitioners and medical students responding in just a few days.

This survey of doctors showed 31 per cent had experienced sexual harassment in the workplace, while a very high 44 per cent of female respondents said they had experienced the practice.”

“The AMA (WA) survey made for extremely uncomfortable reading and it demonstrated that there was a very real problem and it needed to be acted on,” Dr Khorshid said.

The survey was followed by the formation of a joint taskforce with representatives from both the WA Health Department and the AMA.

The Taskforce recommended the next step, a campaign to ensure everyone was aware of the issue, their rights, their obligations and to recommend actions for anyone who suffers sexual harassment.

SH-OUT CAMPAIGN LAUNCHED

It took many meetings, a major survey and seemingly hundreds of possible designs for the final posters, but the Australian Medical Association (WA)'s campaign to end sexual harassment in the workplace was formally launched late last year.

The SH-OUT (or SEXUAL HARRASMENT – OUT) campaign followed a landmark survey of doctors by the AMA (WA) which found a worrying prevalence of sexual harassment in WA hospitals.

The survey showed 31 per cent had experienced sexual harassment in the workplace, while a very high 44 per cent of female respondents said they had experienced the practice.

"Sexual harassment is against the law but for too long it has either been tolerated, or the practice has been swept under the carpet," Dr Khorshid said at the launch, alongside Health

Minister the Hon. Roger Cook.

Held at Sir Charles Gairdner Hospital in front of an audience of senior clinicians, junior doctors and health managers, Dr Khorshid

described the many months of work spent developing the campaign.

"This is actually a deeply ingrained issue in hospitals, our profession and probably, as we have seen recently, our society," Dr Khorshid said.

"We can't run from this problem," he said.

Dr Khorshid and Mr Cook formally endorsed the first steps in the campaign, the launch of a website and the release of a series of confronting posters to be placed around medical worksites.

The website, SH-OUT.com.au offers details on the definition of sexual harassment, how to recognise it, how to fight it as a fellow employee and, if necessary, how to report it.



The website also carries a detailed guide on how to deal with and report any sexual harassment depending on the hospital.

The confronting A3 sized posters are aimed at increasing awareness and communicating to all employees that sexual harassment will not be tolerated.

"There is no place in the medical profession for sexual harassment. We will no longer turn a blind eye to this sort of activity," Dr Khorshid said.

He thanked Mr Cook, Health Department Director General Dr David Russell-Weisz, AMA (WA) members especially junior doctors and hospital staff for their assistance in the campaign.

Mr Cook commended the AMA (WA) and the Health Department for organising the campaign.

"Sexual harassment can impact across the whole of our medical workforce. Adopting a zero tolerance stance and making every effort to stamp out sexual harassment is vital to the wellbeing of our health system and the people who work within it," Mr Cook said.

Dr Khorshid said the next step would be to roll the campaign out to include private hospitals. ■



AMA (WA) DiTC representatives: Dr Michael Page and Dr Rebecca Wood.



CALL IT OUT CLEARLY, STRONGLY

Dr Denise Glennon
Geriatric Medicine Specialist
Sir Charles Gairdner Hospital

Recent media attention has highlighted the fact that sexual harassment is prevalent in many industries and unfortunately, the AMA (WA) medical workforce survey has shown that such behaviour is not uncommon in our profession.

I have personally had the distressing task of mentoring junior medical staff who have experienced sexual harassment and been advised by senior colleagues to "put up with it" and "keep quiet".

This attitude of tolerance and silence is unacceptable and should not be encouraged by anyone, at any level in the medical profession.

I am confident that the vast majority of doctors would find the existence of sexual harassment in the workplace totally unacceptable. Yet to date we – as a profession – have not led the way in preventing or eradicating it.

I believe the medical profession finds itself in a unique and somewhat challenging position as we try to tackle this problem for two reasons.

First, important values that our profession considers core, such as ethical behaviour and advocacy for all sectors of society, are in stark contrast to how we appear to treat our own colleagues.

This apparent contradiction shouldn't make us ignore or conceal the issue but rather tackle it head on and be seen as leaders when it comes to setting high standards in the workplace. We need to set an example by sending a clear, strong message to our colleagues that sexual harassment will not be tolerated in our profession.

Secondly, more so than in other professions, the career paths we choose are strongly influenced by our senior colleagues.

Often the perpetrators are in supervisory positions, responsible for performance appraisals and are perceived to be in a position to influence future job opportunities, including highly competitive training programs.

For this reason, junior doctors are often reluctant to renounce let alone report sexual harassment for fear of retribution or hindering career opportunities.

It is so important then that senior doctors take a leading role in addressing this problem and challenge their colleagues when they witness inappropriate behaviour.

The *Call It Out* campaign is a powerful first step in addressing sexual harassment in our workplace.

I would like to congratulate the AMA (WA) and the Department of Health for recognising and addressing this important issue.

I feel privileged as a member of the Sexual Harassment Taskforce to play a role in the development of the SH-OUT campaign. I look forward to the improvements we can collectively make in this area.

I now encourage our employers and our professional colleges to support those who aim to do the right thing by "calling out" inappropriate behaviour and to work with us to improve the working environment for all our doctors. ■

“ Often the perpetrators are in supervisory positions, responsible for performance appraisals and are perceived to be in a position to influence future job opportunities, including highly competitive training programs





Australian Medical Association (WA)

National Inquiry into Sexual Harassment in Australian Workplaces

**Appendix 5 - Medicus, Journal of the AMA
(WA), February 2019, "Making Her Move"**

MAKING HER MOVE

**Women are increasingly having an impact on medicine
despite entrenched systems and casual sexism**



There's a good reason why the most powerful piece in the game of chess is on this month's cover of *Medicus*. An enduring symbol of strength, skill and flexibility, it was only fitting that we chose the 'Queen' to pay homage to the female doctors in Western Australian medicine.

This year, Western Australia welcomed 317 new doctors into its public health system – the majority, 188 to be precise, are women.

Year on year, the number of females entering the medical training pipeline has been growing. A quantum leap from 1966 when just 10 women graduated from the University of Western Australia's medical school.

Well-known child psychiatrist Dr Margaret Doherty is a proud member of that original group, and says a few people did treat her and her female colleagues differently.

"Most often it was a surgeon who would make some disparaging reference to female doctors wasting their education by not working after marriage," she says.

"On the whole though, there was a lot of support."

Thankfully, since the 1960s, support has not withered. More and more women are embracing medicine in all capacities and increasingly are becoming role models for one another.

We believe the women featured in this edition of *Medicus* are representative of female clinicians everywhere. We have chosen champions of medical care, advocates of patient care and most significantly, trailblazing leaders. Some have achieved extraordinary success in their field. Others have courted success more quietly, labouring behind the scenes to change entrenched systems and drive new initiatives. And then there are those who are just embarking on their clinical journeys.

Newly-minted intern Dr Danielle Meyrick stepped away from an impressive role in innovation with an international organisation to choose medicine and has already established a formidable reputation in nuclear oncology. She is among the first radiochemists in Australia to produce targeted therapies such as Lutetium-177 and Actinium-225 octreotate for neuroendocrine tumour treatment as well as Lutetium-177 and Actinium-225 PSMA for prostate cancer treatment.

Dr Jasmin Korbl was named the 2018 Australasian Junior Doctor of the Year for her contribution to teaching, junior medical officer welfare and community service. Dr Korbl helped to develop a new program for clinical debriefing at Sir Charles Gairdner Hospital and an escalation pathway to

assist junior doctors in crisis. Project Pow Wow has been running successfully for over a year now. (For more on Dr Jasmin Korbl, turn to page 24).

Drs Korbl and Meyrick are part of an elite group of women in WA. Over the years, our State has churned out some of the best-known female doctors in the nation, and even the world.

Professor Fiona Wood is one of Australia's most respected plastic surgeons and burns specialists. Professor Fiona Stanley is an eminent epidemiologist noted for her public health work, and her research into child and maternal health.

PROFESSOR SHIRLEY BOWEN

Chief Executive

St John of God Hospital Subiaco



Back in 1998, I became Chief Medical Officer in the ACT. This was very unexpected as I had taken the Director of the Sexual Health Service and ID Physician role at the Canberra Hospital. I was asked to act in the CMO role and loved the public health opportunities

and the politics.

After that, I realised how good policy can improve healthcare for many, rather than just one person.

From then on, I was hooked on managing and leading healthcare reform.

Associate Professor Rosanna Capolingua, a passionate general practitioner, was the first woman to lead the WA branch of the Australian Medical Association. A few years later, she went on to become the federal AMA's first female president.

Yet another dedicated GP, Adjunct Professor Janice Bell has been the Chief Executive of WAGPET, the sole provider of the Australian General Practice Training Program for GP registrars in WA, since 2004.

These are just some of the women who have indelibly changed the course of health in WA, and who continue to create waves in their particular fields of medicine.

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MAKING HER MOVE

DR LINDY ROBERTS

Anaesthetist and Pain Medicine
Physician
Sir Charles Gairdner Hospital



I had always seen leadership as the prerogative of extraverts. It took me quite some years to realise that introverts can be leaders too. It's okay to be a different leader – develop a style that stays true to yourself (and for us introverts ensures enough quiet time, away from people, to recharge!).

“I really wanted to become a veterinarian.”

The good news is that the community of female doctors is continuing to thrive. For most women (and men), medicine remains a calling.

Chief Executive of St John of God Subiaco Hospital, Professor Shirley Bowen felt she was “called” to the profession of medicine.

For O&G Consultant Dr Anne Karczub and Cardiologist Dr Jenny Deague, medicine was the opportunity to help people and do something useful.

Breast cancer researcher and surgeon Professor Christobel Saunders decided to choose medicine when she was about 11 for all the usual reasons of “helping the world” but also because she “was always fascinated by science but not good enough at math to do physics”.

Career choices aren't always forged in the campfires of childhood.

Dr Lindy Roberts, a former president of the Australian and New Zealand College of Anaesthetists, was initially ambivalent about studying medicine.

“Part-way through the course, I became quite disillusioned and needed some time out. A year doing epidemiological research, and the final clinical years, helped to reinspire me,” she says.

Clinical Professor Michaela Lucas, an immunologist, also harboured doubts about human medicine.

“I really wanted to become a veterinarian,” she says.

“In fact, I spent my holidays from the age of 14 volunteering at a local vet practice. My significant cat allergy stopped me from pursuing this career further.”

Inspiring male and female doctors have also been a drawcard for many.

Dr Robyn Lawrence, Chief Executive of the North Metropolitan Health Service, says her decision to study medicine came about after meeting some amazing doctors during her childhood.

“I had a complete phobia of anything medical – needles, doctors, hospitals – when I was young. So these doctors had a big impact on me, such that I overcame my fear and wanted to work in a hospital,” she says.

“Unfortunately, equal representation does not always mean equal voice.”

Many of the doctors *Medicus* contacted for this cover story have breached those clichéd soaring glass ceilings and have risen to the very top of their specialties. Navigating the course of their careers, however, did reveal barriers tinted with gender bias.

Professor Christobel Saunders clarifies that in her experience, these did not constitute conscious personal bias.

“Rather they were entrenched systems that make it very hard as a woman, and mean you always have to perform that much more, and give up other bits of your life,” she says.

In-built cultural barriers exist, concurs Dr Danielle Meyrick.

“I have often worked in technical fields that have been heavily male dominated in terms of workforce numbers. Along with that has come a historical male-oriented culture, where it can at times feel awkward to be a woman,” she says.

“The natural response in those circumstances can be to keep a low profile, which can ultimately mean there are fewer opportunities for growth and development.”

Dr Meyrick, who is a First Among Equals winner of the WA Women in Technology Awards last year, says strategies must be developed to combat such deep-rooted mores.

“For people who are in a minority in any setting, it can be difficult to have one's voice heard, and I have certainly found that as a woman during my career.

“Unfortunately, equal representation does not always mean

DR ROBYN LAWRENCE

Chief Executive North Metropolitan Health Service



The greatest risk for women in a career is that we put everything else ahead of ourselves. This often means that when time is short, it is the things we do for ourselves (exercise/relaxation) that we compromise on. Obviously, this is not good and the outcomes can be catastrophic. I encourage all women to think about this as they traverse their career/life journey.

equal voice. This may not be a popular view, but I believe it is real. Cultural changes and strategies are needed to create opportunities for women to reach their fullest potential and consequently make their very best contributions to their employing organisations.

"Sadly, it more often than not falls to women to create and enact those strategies, when the real key is a united approach.

"I have been to countless events involving women telling women what needs to be done – these are well-meaning and can be vitalising, but I think more inclusive events and discussions will be more productive," she says.

"Casual sexism is alive and well in the health system"

Like countless other women in medicine, Dr Meyrick admits to having experienced misogyny and sexism during her career because "it has been accepted and almost expected".

"Earlier in my career I handled these situations badly and let them go; these days my skin is thicker and I challenge sexism when I can," she says.

"I think there is only one way to handle this, and that is to calmly and respectfully speak up. But I accept that is far easier said than done, and sadly we can still not be sure of the consequences."

In 2015, the ABC's *Four Corners* program on bullying and sexual harassment in surgery shone a light into medicine's darkest corners. While not limited to surgery, awareness of such insidious behaviour and the wider "Me Too" movement have made it harder for misogynistic culture to thrive and

easier to stand against it.

Despite these significant turning points, anaesthetist Dr Lindy Roberts says casual sexism is alive and well in the health system.

"I handle it by role-modelling good behaviour, supporting junior colleagues and speaking up when I witness it," she says, adding this definitely gets easier as one gains seniority.

"It will probably take a generation for things to really shift."

Prof Shirley Bowen recalls a particular incident, which clearly a man would never encounter.

"As a young registrar, I was asked at an interview about the form of contraception I used so that I would not have a child during training.

"It was a landmark moment because I refused to answer the question, and immediately advised my mentor Professor Tania Sorrell, who 'dealt' with it in no uncertain terms.

"I am sure no female registrar has been asked that question at that hospital since the 90s!" Prof Bowen says.

Prof Saunders and several other doctors interviewed for this story say their experiences of misogyny or sexism haven't been overwhelming or that they have refused to rate them.

"If I have experienced it, I have shrugged it off and not let it affect me – and in fact, often being the 'token' woman on a surgical team meant everyone remembered who you were!" Prof Saunders says.

While Dr Jenny Deague, Director of Cardiology at Joondalup Health Campus, says she hasn't experienced any misogyny or sexism in her career, certain "minor issues" still rankle.

"I do get frustrated when I am referred to as a 'female cardiologist' rather than a 'cardiologist'."

PROF CHRISTOBEL SAUNDERS

Professor of Surgical Oncology, Academic Surgeon and Cancer Researcher, UWA



Surgery always seemed a natural choice in terms of my temperament but also it seemed the hardest speciality for a woman in the mid-80s – so naturally I wanted to do it.

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MAKING HER MOVE

DR KATE STANNAGE

Head of Department
Orthopaedic Surgery
Perth Children's Hospital



My Dad was really involved in the Swan Districts Football Club when I was a kid, so I spent a lot of time at the footy. I loved the game, but really loved it when someone got injured! I'm pretty sure this is where my desire to study medicine came from!

"We owe it to those we care for to be the best we can be."

Continuing their journeys in the face of challenges and adversity, the doctors in this feature nominated their families, colleagues and significantly, their patients as their biggest supporters.

Prof Bowen's reason for keeping her surname after marriage is deeply personal.

"My grandfather and father have always been a source of great inspiration to me. They believed that there are no barriers in life that cannot be overcome and that a girl, especially from the country, should be able to do whatever career she chose," she says.

Prof Saunders recognises her patients as an endless supply of inspiration.

"I do believe medicine is a vocation and we doctors are a very privileged bunch of individuals. We owe it to those we care for to be the best we can be," she says.

Colorectal surgeon Dr Stephanie Chetrit finds motivation in her patients too and recalls a young mother who visited her for haemorrhoid management.

"I saw her break down as I had to tell her that she in fact had a very low rectal cancer requiring chemotherapy, radiotherapy and surgery with a stoma. Still, she is fighting it with courage, grace and faith," Dr Chetrit says.

Head of Department, Orthopaedic Surgery at Perth Children's Hospital and Australian Paediatric Orthopaedic Society President, Dr Kate Stannage finds inspiration in volunteer work. She considers the privilege of being involved in teaching management of clubfoot and establishing clinics to treat the condition in Madagascar as a particular career highlight.

"I remember having tears in my eyes when I saw the first child treated completely by our staff in Madagascar with no input from the Australian team. She had beautiful straight feet, and the pride of our local Malagasy staff was overwhelming," Dr Stannage recalls.

While patients rank at the very top for every doctor, Dr Deague points out that being a patient advocate does not always go smoothly.

"I am lucky to work in a supportive environment at Joondalup Health Campus but outside this environment, shared patient care can sometimes be challenging.

"This saddens me about our healthcare system as I believe we need to be less combative and more collaborative when it comes to patient care."

"It is clear that in some specialties it is still extraordinarily hard to train part-time."

Many in the health arena agree that the pot-holed road to gender diversity requires more than just patchwork. Some

DR ANNE KARCZUB

O&G Consultant
King Edward Memorial Hospital



My father was gender blind and believed in me and would have supported any career I chose. My mother was a very strong woman and emphasised self-respect and self-reliance. Hence, I always saw myself first through the prism of my humanity, rather than my gender. Perhaps this fire-proofed me and I failed to recognise discrimination on the basis of gender.

DR JENNY DEAGUE

Director of Cardiology Joondalup Health Campus



The first woman in medicine who inspired me was the late Professor Priscilla Kincaid-Smith from Royal Melbourne. I had renal rotations with her and it was a true privilege. When she married, Prof Kincaid-Smith was unable to be employed as a physician

due to rules around married women at that time. But when the rules changed, she became the head of the Nephrology Unit at the Royal Melbourne Hospital and eventually President of the Royal Australasian College of Physicians and Head of the World Health Organisation. She was a truly remarkable and inspiring woman who was very supportive of younger female colleagues, their careers and their family.

suggest adopting targets and quotas for women in leadership positions.

Prof Saunders argues that "positive discrimination until we reach a minimum of 25 per cent gender (and other) equity makes diversity normal after this percentage". And she refuses to buy the argument that this will result in unqualified people in jobs.

"After all, we have a great talent pool to pick from."

Dr Robyn Lawrence says that while women are well represented in the health system, the final gap to close is medical heads of department.

"To ensure better representation, I encourage young specialists to put their hands up for these roles. As a leader, there are many rewards that are intangible, especially the impact you can then have on your younger colleagues."

Dr Lawrence also believes considerable work needs to be carried out collaboratively with the Colleges.

"It is clear that in some specialties it is still extraordinarily hard to train part-time. It is this training period that would appear to be the toughest nut to crack!" she says.

Certainly better access to part-time and flexible training positions was the overwhelming recommendation from most

of the doctors interviewed by *Medicus*.

According to Dr Deague, colleges such as the Royal Australasian College of Physicians need to encourage and facilitate job sharing.

"Experience is vital in medicine so part-time doctors will take longer to achieve the necessary hours. But I believe the work-life balance benefits will outweigh the time delay," she says.

Dr Deague also recommends a return to undergraduate medicine to enable female medical students to graduate and specialise earlier in age than with current postgraduate courses.

"It is discouraging to see bright young female residents think they will be too old to have children if they specialise."

Dr Kate Stannage takes it a step further, saying gender diversity on selection panels for training positions should also be improved.

Dr Meyrick recommends that men make use of part-time opportunities until "we reach a point where it is considered just as normal for men to work part-time as it is women". "This may in turn equalise the playing field in terms of career breaks and access to advancement opportunities, where women have historically been disadvantaged," she says.

Dr Anne Karczub says that men in medicine should be encouraged to work in women's health.

"Encourage male medical students when doing O&G to be involved and to see the importance of the specialty, and encourage male RMOs to spend a period of time working in O&G.

"This promotes the importance of women's health, and also promotes respect for women. Encourage men to rate O&G as a desirable and honourable specialty. We need better gender balance in O&G," Dr Karczub says.

Dr Lindy Roberts encourages us to look beyond gender parity and consider other diversities.

"This ensures that society gets the most out of its disparate talents. Practical solutions include ensuring flexible and 'life-friendly' ways of undertaking senior roles, as well as promoting mentoring at all career stages."

"We need to work at actively supporting each other."

The value of mentorship was another overriding theme of the interviews that contributed to this cover story. Many spoke of the indelible impact other women have had on their careers.

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MAKING HER MOVE

CLINICAL PROFESSOR MICHAELA LUCAS

Immunologist/Immunopathologist
Sir Charles Gairdner Hospital



During my Dermatology training in 1996, I travelled to Venice for a dendritic cell meeting with a handful of Nobel Prize laureates attending, meeting Immunologist Charles Janeway and celebrating Rolf Zinkernagel and Peter

Doherty's joint Nobel Prize that year. There was no doubt that I was hooked on Immunology. I found a flyer in the conference booklet advertising nine post-doctoral positions for a prestigious Marie Curie Fellowship on dendritic cell biology, applied for it (never thought I would, but got it). This took me to a full-time research position at the Pasteur Institute in Greece and Oxford University in the UK. During the same time, I married an Australian Immunologist PhD, whom I met at a conference – no surprise, really!

Prof Michaela Lucas acknowledged Helen Chapel, from Oxford University, under whom she began her Clinical Immunology training and closer to home, Drs Patricia Martinez and Wendy Cheng.

"Both Patricia and Wendy are some of the most dedicated and kindest doctors I know, and they continue to mentor me."

According to Dr Meyrick, men manage to build very supportive career networks.

"I think they do this far better than women. We need to work at actively supporting each other."

She says that while informal, ad hoc mentor programs exist, a more structured approach involving women at advanced points in their careers as mentors for female junior doctors would be valuable.

"Both mentor and mentee could be given time in their working week to meet and discuss issues; and this time could be protected in much the same way as, for example, intern teaching time is."

"The guilt can sometimes be really hard"

If developing a strategy to address gender parity in medicine seems arduous, try balancing family commitments with a demanding medical career. Yet many female doctors have done the best they can and continue to walk this precarious tightrope every single day.

Mother of four children, Dr Jenny Deague acknowledges her husband, fellow cardiologist Professor David Playford for his support as she became Head of Cardiology at Joondalup Health Campus and a Director of the National Heart Foundation.

Prof Michaela Lucas worked across several countries with her research fellowship and obtained her Australian Physician and Pathology Fellowships after completing full basic and advanced Physician and Pathology Training in Australia, after seven years in research and while having children.

We all make choices about how we wish to manage our career and family, says Prof Shirley Bowen.

"It is a gift to be able to give birth to a child but it can be a juggle to make it all come together."

According to Dr Stephanie Chetrit, women at times erect "our own barriers".

"The guilt can sometimes be really hard – you can feel like you are being judged as not being a good mother if you work hard, and as not a good surgeon if you do not work long hours.

"The truth is no one can win that battle and so I decided long ago to let go of the guilt and enjoy family and work!" she says.

Dr Jasmin Korbl believes having children marked a turning point in her career.

"I have become a more reflective clinician," she says.

DR DANIELLE MEYRICK

Intern
Sir Charles Gairdner Hospital



Increasingly, men are speaking up as champions for gender diversity. This is needed not because women need men to speak on our behalf, but because men need other men on whom to model behaviour, and to create a critical mass of men working for diversity.

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BEHIND THE SCENES



A lack of teaching and support for junior doctors inspired Dr Stephanie Chetrit to develop the Basic Surgical Program at Royal Perth Hospital

Hospital's post-graduation department as a junior consultant, she became aware of a sense of neglect felt by junior doctors.

"It is usually during those resident years that one decides where they may end up and I felt that there was not enough teaching and support for those young doctors," Dr Chetrit says.

The hospital had also received feedback that junior doctors wanted specialised non-didactic teaching.

"If you want to become a cardiologist, you don't want to hear about the art of doing a bowel anastomosis and that's fair enough!" says Dr Chetrit, a colorectal surgeon.

Able supported by fellow consultants Dr Cecilia Wee and Dr Lucy Kilshaw, Dr Chetrit set about engaging with junior doctors within RPH to work out their specific needs.

"It became obvious that they needed mentors, workshops and help with research."

The Basic Surgical Program was developed as a result of this engagement and has since earned an enviable reputation within the hospital itself and around Australia.

"As with everything, RMOs get out what they put in and our

RMOs at RPH have been very involved."

Dr Chetrit says the team driving the Basic Surgical Program tries to involve more surgical specialties and surgeons in order to cater to the interests of all interested RMOs.

She adds that the application process and interviews for advanced training can be daunting experiences.

"This year, we are introducing a separate program to help junior doctors with these. This will include having the help of an experienced psychologist to guide RMOs with practice, as well as setting up videos and a data bank for previous questions and experiences."

So how did Dr Chetrit decide on her chosen specialty of colorectal surgery?

"It is a good question and I often wonder whether specialties attract doctors or doctors are attracted to specialties.

"I enjoyed my time tremendously on the colorectal unit at Sir Charles Gairdner Hospital as an intern. I admired the surgeons I worked with then and I blame Mr Michael Levitt for being so keen on this particular specialty!" Dr Chetrit says.

"From a clinical point of view, it is not the most glamorous specialty, but I feel there is great diversity as well as challenges and rewards. That makes for a great career!" ■

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MAKING HER MOVE

"My kids have also incentivised my efficiency at work. Of course, there are days that I need to stay back unexpectedly late but overall, I work hard during the day so that I can get home to the real joie de vivre."

"Don't sweat the small stuff."

One of the final questions we put to our panel of female doctors was around the best advice they had received, and the responses were beautifully simple.

"Have a break for lunch, drink water, enjoy the journey and

don't sweat the small stuff," says Dr Chetrit.

Prof Lucas reminds us that medicine is a long-term race: "Pace yourself and make your journey sustainable."

Dr Roberts suggests training for roles taken on outside your clinical practice.

"There's a wealth of resources, many from non-health sectors, that can make you a better leader, researcher, teacher, mentor or whatever you choose. And a better person!" ■

Medicus would like to thank all the doctors who participated in this feature for contributing their valuable time and views.

PACKING A PUNCH



Australia & New Zealand Junior Doctor of the Year Dr Jasmin Korbl is determined to shine a light on the under-recognised issue of junior doctor welfare

The issue of dangerous workloads and untenable rosters has once again been highlighted following a searing blog by young Sydney surgeon Dr Yumiko Kadota. Dr Kadota was on call for 180 continuous hours and worked up to 70 hours a week. She repeatedly raised concerns about her untenable hours, which included being rostered on 24 days in a row and over 100 hours of overtime in a month.

Across the country, there are junior doctors experiencing, if not in equal measure as Dr Kadota, certainly shades of great strain and stress as a result of their demanding training schedules.

One Western Australian junior doctor, however, decided to do something about it.

Dr Jasmin Korbl, a resident medical officer at Sir Charles Gairdner Hospital, developed a new program for clinical debriefing at SCGH as well as an escalation pathway to assist junior doctors in crisis. Project Pow Wow has been running successfully for over a year now at the hospital and a formal evaluation of the program's impact is underway.

"To be honest the idea was not mine, I was simply the curator," Dr Korbl says.

"The ideas and structure for the program came from the junior doctors who voiced the need for opportunities to talk about clinical and

non-clinical issues that they face at work, in a supported and facilitated environment."

Dr Korbl says it is crucial that doctors find time to look after themselves and one another.

"Contemporary literature suggests that a third of junior doctors are suffering from burnout and over the last few years, we have witnessed the tragic consequence of this with the suicides of some of our colleagues who have suffered alone, in a silent crisis."

Dr Korbl's work in the areas of junior medical officer welfare, community service and teaching was acknowledged last year when she was named 2018 CPMEC Australia & New Zealand Junior Doctor of the Year.

Humbled by the recognition, Dr Korbl says she is eager to use the award as a platform to bring to light the important and under recognised issue of junior doctor welfare.

"One of the biggest challenges when we think about junior doctor welfare is that there are just so many problems and the sheer volume in itself can seem too daunting and discouraging for anyone to tackle.

"I have often needed reminders that small interventions can make a large-scale impact and can build a platform for further change."

Dr Korbl says there are male and female doctors who have supported and mentored her but she is keen to point out the many women in the hospital who inspire her on a daily basis. "There is the medical education officer at Charlie's who knows every single junior doctor by name and provides a nurturing environment for anyone to seek assistance; a hard-working female cleaner in the C-block who has been doing the same job for 30 years and still takes so much pride in her work and of course, the women behind the scenes who unwaveringly support the men in medicine and enable them to flourish."

Even as Dr Korbl works towards acceptance into a specialty, she plans to continue advocating for the wellbeing of junior doctors.

"I am also adamant not to let my chosen career define who I am. I am a mum and have many interests outside of the hospital – it just so happens that I am also a doctor." ■

A DOCTOR FIRST

The oldest female member of the AMA (WA), Dr Nerida Dilworth AM tells us why her gender had almost no impact on her medical career

Paediatric anaesthetist Dr Nerida Dilworth makes it crystal clear – she is a doctor first. The fact that she is a woman is of little consequence.

She also believes that her gender has had almost no impact on her medical career.

But she does believe that she had to work harder than other doctors who happened to be male to demonstrate her skills and abilities.

Now in her nineties, Dr Dilworth holds the distinction of being the oldest female member of the Australian Medical Association (WA).

While not a formal title, or one that carries a badge or ceremonial medal, Dr Dilworth's experiences in medicine and her views about health and the role of women are certainly worth hearing as part of the broader discussion about women in medicine.

Arriving to interview Dr Dilworth finds her surrounded by national newspapers as she keeps up with the news and as an example, she has strong views on recent developments in health, especially the Perth Children's Hospital.

"I am not sure why but I wanted to be a doctor since I was a child. And at great hardship to my parents, I became one,"

Dr Dilworth says.

"The cost of sending a child away to Adelaide for their medical education was financially very difficult even with a Commonwealth scholarship."

Graduating in 1950, Dr Dilworth headed to the UK for further training in Anaesthesia for five years, before returning to Perth and taking up a position at Royal Perth Hospital.

Dr Dilworth says her choice of specialty was not an especially popular one at the time and was seen by some as a "soft option".

But she can look back on her medical career as one filled with great achievements. She was a pioneer in Paediatric Anaesthesia and pain management for children and babies and set the



Dr Nerida Dilworth.

benchmark for paediatric care over many decades.

Dr Dilworth nominates the establishment of the acute care unit at Princess Margaret Hospital as her greatest achievement in her years as a clinician. And she is especially proud of being part of the team that established an intensive care unit at PMH.

"It was a pretty hard slog but it was a very good move overall. It was hard work to achieve it, not because I was a woman but because of the conservative nature of some of the senior medical staff," she said.

"I was also the first female chairman of the Division of Surgery at PMH. If there was ever anything that wasn't a feminist move, that was it!

"It was a position elected by the surgery staff. Nobody cared a thing about having a woman doing the job, even an anaesthetist!"

Dr Dilworth has seen some dramatic change in medicine since the 1950s, not just generally but in her specialty of Paediatric Anaesthesia.

"There were many myths about pain and children, including the belief that babies didn't really feel pain at all."

What about discrimination based on gender?

"I have struck it but not to the extent that some people think existed. I still believe that it is what you know rather than gender," Dr Dilworth says.

"I guess what I found over the first few years was that you had to be a little bit better than the men at things. Perhaps work harder at it is another way of putting it."

But there were still barriers for many.

"It is harder for some if they want to have – or already have – a family. But I didn't and that may have made it a little easier for me. I wasn't rushing from domesticity to work all the time and I often thought that I couldn't have done what I did if I did have a family." ■

POSTSCRIPT

After this article was written and prepared for publication, the AMA (WA) was informed that Dr Dilworth had sadly died on 11 February 2019. Dr Dilworth had a dramatic impact on medicine in WA, none more so than in her specialty of Anaesthesia, especially Paediatric Anaesthesia. Our thoughts are with her family: brother Professor Michael Dilworth, sister-in-law Mary and their children.