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Inappropriate behaviours experienced by doctors while undertaking specialty training

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The results of this study have been presented as an oral presentation at the Royal Australasian College of Medical Administrators Annual Conference, Melbourne, October 2017.

Received 28 May 2018

Revised 15 October 2018

Accepted 2 November 2018

ABSTRACT

Purpose To explore inappropriate behaviours experienced during specialty training in Australia and their implications for doctors' training experiences and outcomes. This is a subset of data from a larger study exploring experiences of doctors in Australian specialty training—a qualitative study of enablers, stressors and supports.

Methods In this qualitative study, registrars in specialist training programmes in Australia were invited and interviewed between August 2015 and August 2016. Semistructured open-ended questions were used to explore topics of relevance to their workplace, training, support service use and personal lives. Interviews were transcribed verbatim, de-identified and content and thematic analysis undertaken. Recruitment was ceased when data saturation was reached and no new themes emerged. Key themes related to inappropriate behaviours experienced during specialty training are reported in this study.

Results 17 participants were recruited (including one Indigenous and one international medical graduate). A total of six specialty training programmes across multiple states at various locations across Australia were represented in this cohort. Almost all participants reported confronting (personally experienced or witnessed) inappropriate behaviours during their training, perpetrated most commonly by senior doctors. Key themes of inappropriate behaviour that emerged were belittling and humiliation, sexually inappropriate behaviour, inappropriate behaviour as part of the 'culture' of medicine, reluctance to raise concerns due to fear of recrimination, and impacts of inappropriate behaviour.

Conclusion Varying inappropriate behaviours were experienced by doctors in specialty training, having implications for their psychological well-being. A multidimensional and multisystem approach is required in the management of this serious issue.

INTRODUCTION

Bullying and harassment (including sexual, psychological and verbal), most often perpetrated by other doctors/consultants, have been reported in up to 85% of doctors in training worldwide.^{1–3} Directors and consultants have been reported to make up almost half of the perpetrators along with others including administrators and training colleges.⁴ A meta-analysis of 57 studies demonstrated that close to 60% of medical trainees worldwide experience at least one form of harassment or discrimination during their training.² Surveys of bullying and harassment in Australian junior doctors revealed

up to 60% of all junior doctors have been bullied, discriminated against or harassed.^{5–8}

Degrading experiences and harassment at work by a senior have been strongly associated with suicidal ideation.⁹ Workplace bullying has been associated with lower performance, higher levels of illness, absenteeism and lower job satisfaction,^{4 10} and in Australia costs \$180 million per year.¹¹

The aim of this study was to explore inappropriate behaviours experienced during specialty training and their implications for doctors' training experiences and outcomes. This is a subset of data from a larger study exploring experiences of doctors in Australian specialty training—a qualitative study of enablers, stressors and supports.

METHODS

Participant recruitment and data collection

Mixed purposeful sampling was used. Sample size was calculated using the principles advocated by Malterud et al. (2016)¹². The sample size required was determined by assessing the specificity or narrowness of both the research aim and the participants, what was already known about the phenomena, the quality of the interview dialogue, i.e. the depth and richness of participants' responses and, in-line with the cross case the matic analysis processes applied. All registrars employed in specialty training posts at the health networks with ethics approval were invited to participate via email. Snowball sampling was undertaken to increase specialty programme heterogeneity and diversity of participants. Data were collected and audio-recorded between August 2015 and August 2016 via semistructured interviews in person. The interview schedule consisted of open-ended questions covering topics of relevance to their workplace and working conditions, specialty training and college-related factors, the impact of their career and training on their personal lives, coping strategies and support services used. Retrospective information sought was relevant to any experience at any training hospital in Australia during the course of their registrar training. Interviews were conducted by one investigator (SA), a medical doctor.

Data analysis

All audio-recorded interviews were transcribed verbatim and de-identified. Transcripts were analysed in NVivo Software (QSR international, Durham, UK) using established complementary techniques of content and thematic analysis to identify common themes.^{13 14} Open coding, using respondents' own words, identified emerging



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To cite: Abhary S, Botti M, Dhulia A, et al. *BMJ Leader* 2018;**2**:140–143.

Table 1 Characteristics of the registrars interviewed

Characteristics	Number of participants
Sex	
Female	12
Male	5
Ethnicity	
Caucasian	9
Non-Caucasian	8
Training programme	
Surgery	3
Emergency	2
Physician	6
Paediatric	3
Psychiatry	2
Pathology	1

themes. Similar codes were grouped and key themes identified. To increase rigour of the analysis, independent data analysis by SA and MB was undertaken.

RESULTS

Twenty-five registrars showed interest in participating, of which 22 were registered in Australian specialty training programmes. A final 17 participants (table 1) were recruited into this study and consisted of 12 female and 5 male registrars. A total of six training programmes (surgery, emergency, physician, paediatric, psychiatry and pathology) were represented among participants, having undertaken training at multiple locations. One international medical graduate and one Indigenous doctor were represented in this sample. Due to the snowballing methodology, the final cohort of participants recruited had undertaken training across and shared experiences from training in various states in Australia.

Almost all participants reported confronting (personal experience or as a bystander) disruptive workplace behaviours, often on multiple occasions at various institutions during their training.

The key themes of inappropriate behaviour that emerged were:

Belittling and humiliation

Belittling and humiliation was the most commonly reported inappropriate behaviour, and was accepted as a common part of training and being a junior doctor. Most reported this type of behaviour to be overt and occurring in front of other people, including doctors, students, nurses and patients.

One participant (ID - 151205-0166) recalled “a consultant took us for tutorials and they would have these meetings where they’d bring in a patient with an interesting case and the trainees would need to examine them in exam sort of circumstances and they would be critiqued on their performance. And so I was critiqued a number of times, and it just destroyed me, destroyed me publicly. And it’s just like 15–20 people in the room, patients, patients’ family, lots of other doctors, and it was just devastating, and completely erodes any confidence you have in your capacity to do it”.

Sexually inappropriate behaviour

All participants who had experienced sexually inappropriate behaviour were women, with the behaviour inflicted by senior male doctors. The behaviour ranged from sexually inappropriate comments such as (ID - 151209-0175) “That’s nice. You’ve got

your legs out today” to (ID - 151208-0172) “I was sexually assaulted by a colleague”. Some participants were not willing to disclose any further information for the purpose of the interview.

None of the victims reported the behaviour or confronted the perpetrator, with one commenting (ID - 151211-0179) “I guess I didn’t want to make a big deal about it. And I knew that the next person after me was a male and so I figured he definitely wouldn’t have that behaviour towards him”.

Culturally inappropriate behaviour

Culturally inappropriate behaviour, including racism, was the least commonly reported inappropriate behaviour. Non-Caucasian participants reported being on the receiving end from senior colleagues and patients. This behaviour ranged from being subtle, such as (ID - 151204-0165) “they are not normally direct, but it’s just the way they talk to you and behave around you” to overt (ID - 151203-0162) “it’s viciously racist. If you’re not white, then you don’t belong”. At one institution, this trainee witnessed regular racist behaviour by senior doctors towards non-Caucasian patients and fellow doctors, stating “one of the consultants at hospital X refuses to see anyone from a non-English speaking background or anyone in a wheelchair. One of the other consultants openly calls Aboriginal people racist names to their face.... Whenever a non-Australian trained doctor would phone through, you know there may be language barriers, those stories were relayed in public amongst the registrars mocking those people”.

Inappropriate behaviour part of the ‘culture’ of medicine

The culture of medicine itself was considered to be one that commonly allows inappropriate behaviour to be tolerated. This was often also linked to the culture of a unit or organisation, accepting and harbouring inappropriate behaviour.

One participant elaborated (ID 151203-0163) “Just the culture within different hospitals that I’ve worked in, I feel like some places more than others, it’s still very much based on old school, this is how it used to be done. And I don’t know if that will ever change, because I think the people that make the rules are always going to stick to the rules and be those people that were pushed around and bullied and now suddenly they’re in charge and they’re going to do the same thing” and another (ID - 151208-0172) “They’re not just older people who do this. There are young people as well who do this. It’s not just men it’s women too. It’s just a part of this bloody cultural problem.... That’s how we were brought up, so you can suck it”.

Inappropriate behaviour was described as occurring in a hierarchical fashion, most often from a senior to a junior doctor. Participants held the belief that inappropriate behaviour was cyclical, with those on the receiving end of inappropriate behaviour continuing to perpetrate that behaviour to their juniors and colleagues (ID 151208-0173) “Realistically we are and going to be copping it from seniors”.

Specialties represented in this cohort did not appear to have had different have had different experiences of inappropriate behaviour.

Reluctance to raise concerns due to fear of recrimination

The majority of participants who had experienced inappropriate behaviour chose to endure and did not report incidents. The fear of recrimination and negative impacts on their careers (including failing examinations and fear of being denied trainee positions) were common reasons for not reporting inappropriate behaviour, (ID - 151207-0171) “Probably the same thing that

prevents everyone else is fear of the impact it will have on your career because, particularly these days, I mean training positions, let alone consultant positions, are very competitive and the people who rock the boat, they're not considered employees".

Lack of trust in the confidentiality and procedural fairness in reporting pathways also played a role in apprehension about reporting incidents. Lack of trust was also related to doubts about whether the problem would be taken seriously or resolved. One participant (ID - 151209-0174) stated "I think it's the culture of medicine and just dealing with things and just getting through, and you know, not complaining. It's the competitive nature that you don't want to stand out in that way. You know, the fear of repercussion with bosses. And I guess for me, personally, I don't really trust the system is going to have my interests at heart".

Most participants were unaware of appropriate reporting pathways in their training hospital when personally experiencing inappropriate behaviour or as a bystander. Only one participant reported inappropriate behaviour (via an incident reporting system) and only felt safe to do so as the perpetrator was not the senior they directly reported to, with no direct impact on their career progression. Fear of long-term consequences to their reputation, career and training prospects were reported influences leading to silence.

Impacts of inappropriate behaviour

Participants described a range of mental health and performance impacts as a result of being a victim of inappropriate behaviour, including embarrassment, feeling of incompetence, being demoralised, anxiety, stress, fear and damage to self-confidence. One participant explained (ID - 1151203-0162) "Although I was meant to be preparing for my final exams, I actually spent the weekend hiding from the world, it was that distressing. It was an awful experience". And another (ID - 151205-0166) "So I felt pretty lost and trapped and scared, and just anxious. It was awful. And because this was before my clinical exam so it's really, it's all performance based, and you've got to be confident and I wasn't.... It was devastating, and again just completely erodes any confidence you have in your capacity to do it. That year I failed the clinical exam".

DISCUSSION

Inappropriate behaviour experienced by registrars in this study have been reported previously as bullying and harassment, discrimination and racism in other studies.² Inappropriate behaviour was reported across several training programmes and did not appear to occur more frequently in any particular specialty. This is similar to other studies where bullying and harassment have been found to occur across various training programmes,^{5,7,15} which may be a true reflection of the medical culture, rather than a specialty-specific factor.

Inappropriate behaviour in this study, and bullying and harassment in the medical profession in other studies, have been found to occur in a hierarchical fashion with perpetrators in positions of relative power.¹⁶ In our study, sexually inappropriate behaviour was always perpetrated by senior male doctors to female trainees.

Mental impacts such as stress and anxiety were found to be associated with inappropriate behaviour in this study, echoing positive associations between workplace bullying and mental health problems shown in other studies.^{1,4,17} Bullying and harassment have previously been found to be factors that may impair clinical judgement and performance, and have been associated with prescriber error¹⁸ and lower patient safety

outcomes.^{16,18,19} These findings were not replicated in our study, which could have been due to our semistructured rather than a direct questioning technique.

The doctors participating in this study did not report inappropriate behaviour (personal or witnessed) due to fear of recrimination, intimidation, career repercussions and lack of trust in reporting systems. Silence and failure to raise concerns regarding inappropriate behaviour is a common part of medical culture,¹⁶ and in keeping with our findings, the reasons are often fear of repercussions and retaliation.^{3,19} In support of our findings, as few as 12% of doctors worldwide have been reported to have the courage to report personally experienced or witnessed bullying and harassment.¹³

The majority of our participants did not know what pathways were available to them to undertake reporting of inappropriate behaviour. In fact, up to 60% of Australian medical trainees report feeling there are inappropriate structures in place to allow safe reporting without recrimination,^{4,7,15} and of those who have made complaints, up to 33% reported that the inappropriate behaviour continued.¹⁵ Additionally, 30% of Australian medical administrators feel they are only partly equipped to respond to an allegation.²⁰ These concerns were highlighted by our participants, who reported lack of trust in the reporting system and doubts about whether the problem would be taken seriously or resolved.

Addressing the culture of inappropriate behaviour is complex and requires a multidimensional and multisystem approach. Drawing on current experience and evidence from the literature,^{18,21-24} we propose the following key recommendations:

1. Health organisations and training colleges should:
 - a. Adopt a zero tolerance policy and culture for inappropriate behaviour, with policies, procedures and codes of conduct highlighting behavioural expectations (including for bystanders).
 - b. Incorporate mandatory bullying and harassment training for all employees and supervisors, clearly defining accepted behaviours and reporting pathways.
 - c. Regularly survey staff and trainees to monitor rates of inappropriate behaviour.
 - d. Implement gender and workplace diversity plans and cultural safety programme.
 - e. Robust confidential reporting pathways should be available to all staff, including bystanders, together with transparent investigatory mechanisms (including external and independent).
 - f. Counselling and accessible doctor health assistance programmes must be provided for victims and perpetrators
 - g. Develop Memorandums of Understanding to allow for exchange of information regarding perpetrators and victims.
2. Health organisations to have clear pathways for performance management for perpetrators and options for mediation.
3. Training colleges should remove training posts and fellowship status of repeat perpetrators of inappropriate behaviour.
4. The Australian Medical Council to increase their role in monitoring and auditing educational and training colleges for inappropriate behaviour of their fellows. Removal of offending training posts on identification, as per the General Medical Council counterpart, should be an option.
5. Federal medical professional and healthcare regulation agencies (such as the General Medical Council, the Australian Health Practitioner's Regulation Agency, the Care Quality Commission and Australian Commission on Safety and Quality in Health Care) should incorporate gov-

ernance requirements with penalties on perpetrators and healthcare services if they allow inappropriate behaviour to persist.

6. A national health training ombudsman should be appointed to address the issue (reporting, investigating and managing) in a systematic and standardised way.

We acknowledge the limitations of our study. Despite the recruitment method of snowballing and the use of reminder emails, higher proportion of female and non-surgical trainees were recruited. A possible reason for our male to female imbalance may be a greater propensity for female doctors to discuss their issues more openly. More surgical trainees expressed interest in participating than those that were actually recruited, most commonly with lack of available time as a reason. Similarly, more Indigenous doctors initially agreed to participate than those agreeing to participate in the final cohort.

In conclusion, in this study, doctors in training reported their experience of varying inappropriate behaviours, with implications for their psychological well-being and training outcomes. Reporting or seeking assistance was unlikely because of fear of repercussions. A multidimensional and multisystem approach is needed to address these behaviours. Further studies in this area are necessary to explore the nature of inappropriate behaviour in the medical profession, its impacts and the effectiveness of mitigation strategies.

Acknowledgements The authors wish to thank Anusha Chander as a research assistant for her assistance to authors SA and MB with thematic analysis of the data of this study.

Contributors SA, MB and JC have contributed to the study design, ethics submission to Epworth and Monash Health institutions, and writing and reviewing this manuscript. SA conducted all interviews and along with MB equally undertook thematic analysis of the results. AD and EL have contributed to ethics submission at Monash Health and writing and reviewing this manuscript.

Funding This study was supported by a 'grant in aid' from the Avant Doctor In Training Research Scholarship Program.

Disclaimer This support was monetary and has in no way influenced the methodology or results of this study.

Competing interests None declared.

Patient consent Obtained.

Ethics approval Ethical approval has been granted for studies involving human subjects. Ethics approvals were obtained from two Human Research Ethics Committees: Monash Health HREC Ref 16124L and Epworth HealthCare HREC Ref 695-15.

Provenance and peer review Not commissioned; externally peer reviewed.

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