Summary of Facts

Research commissioned by:
The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) into Discrimination, Bullying, Sexual Harassment, and Harassment (DBSH)

Report prepared by:
BPA Analytics

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EXECUTIVE SUMMARY

BPA Analytics (BPA) was commissioned to develop, administer, and analyse the Discrimination, Bullying, Sexual Harassment and Harassment (DBSH) Survey on behalf of The Royal Australian & New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

The purpose of the survey was to investigate the prevalence, extent and nature of DBSH within the Australian and New Zealand context experienced by College members.

The survey instrument was designed by BPA in consultation with RANZCOG's Chief Executive Officer, Vase Jovanoska, Carly Moorfield (RANZCOG Training Support Liaison) and Clare Wells (RANZCOG Wellbeing Coordinator). The foundation of the survey questions came from a number of sources:

- RANZCOG's 2016 Member Survey into Bullying and Sexual Harassment – conducted by RANZCOG at the time
- The Royal Australian College of Surgeons – 2015 Survey into DBSH. Questions were used with permission from Dr John Biviano, CEO of the College.
- BPA Analytics questions (qualitative and quantitative) that focus specifically on DBSH

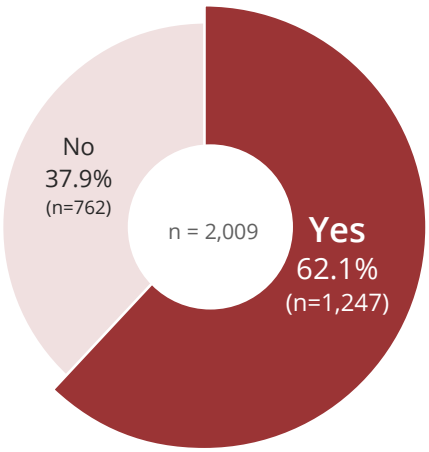
2,105 members took the time to respond to the survey out of a total of 6,605 surveys administered.

This represents a **32%** response rate. When limited to FRANZCOG Trainees and Fellows, this response rate rises to 45.3%.

At the request of RANZCOG the prevalence questions were conditioned to DBSH experienced by a professional colleague not from patients and did not include a time span (for example in the last 5 years).

62.1% (1,247 respondents) answered 'yes' they have been subjected to DBSH in the workplace by a professional colleague. The numbers speak for themselves in the report and reveal this is a significant historical problem.

Have you ever been subjected to DBSH?



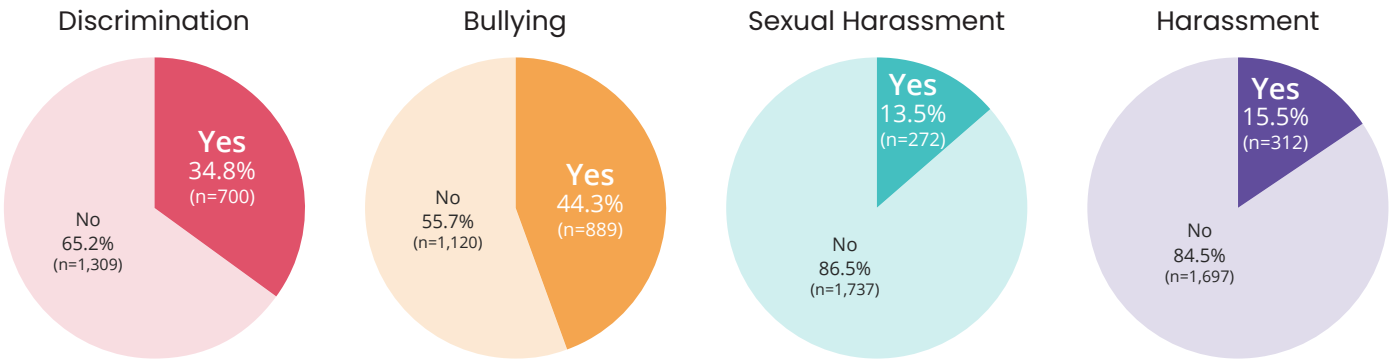
In terms of member's Status with the College:

- **71.5%** or 196 FRANZCOG Trainees have been subject to any one of the four DBSH behaviours.
- **73.5%** or 314 Fellows <10 years have been subject to any one of the four DBSH behaviours.
- **58.6%** or 364 Fellows >10 years have been subject to any one of the four DBSH behaviours.

The behaviour of highest prevalence is Bullying at **44%** from 889 responding members, of which only 6.6% agree the behaviour has been resolved to their satisfaction. **69.6%** answered 'none of the Bullying instances have been resolved'.

The Prevalence rating for the three other unreasonable behaviours in 2021 are:

- **34.8%** for Discrimination
- **13.5%** for Sexual Harassment
- **15.5%** for Harassment



A low percentage answering 'yes' is a good outcome as the question is a reverse value question.

In addition to RANZCOG, BPA has conducted similar DBSH Prevalence Surveys in four other Medical Colleges:

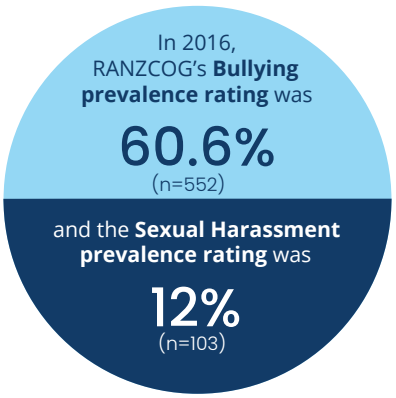
- Royal Australian College of Surgeons – 2015
- Royal Australian and New Zealand College of Ophthalmologists – 2015 and a condensed Pulse version survey in 2018
- Australasian College of Dermatologists - 2016
- Australasian College of Emergency Medicine (ACEM) – 2017

As a third party Benchmarker, BPA has been able to produce Specialty norms and Medical College norms to enable RANZCOG to compare their results. It provides a sense of perspective.

When RANZCOG's Prevalence Statistics for DBSH were compared against the norms from all specialties within these colleges (a dataset of 8,420 respondents), RANZCOG's results benchmark:

- Average for Harassment at 15.5% - the norm is 17%
- Low for DBSH at 62.1% - the norm is 51%
- Low for Bullying at 44.3% - the norm is 38%
- Very low for Discrimination at 34.8% - the norm is 23%
- Very low for Sexual Harassment at 13.5% - the norm is 9%

Where possible, in this Summary document, BPA has compared metrics with RANZCOG's 2016 Survey results. Whilst it is not a direct 'apples with apples' comparison as questions were asked in slightly different context, it does appear that the prevalence of Bullying may have slightly improved over the past 5 years. The prevalence for Sexual Harassment remains relatively the same.



In addition to the metrics already mentioned in these opening words, a summary of key finding from this survey are …

- 64.4% of respondents identify as a woman. This increases to 86.4% for Trainees and 73.7% for Fellows<10 years.
- 60.2% of respondents' primary workplace is a public hospital (Metropolitan or Regional).
- 58% of respondents were born in Australia or New Zealand, 20% were born in another English speaking country and 22% were born in a Non-English speaking country.
- 26% of respondents obtained their primary medical degree in a country other than Australia or New Zealand.
- 17.3% did the majority of their O&G specialist training in a country other than Australia and New Zealand.
- FRANZCOG Trainees purport the highest prevalence of Bullying and Sexual Harassment when compared against other membership groups.
- The 35-44 year age group has the highest prevalence rating for DBSH at 70.9%.
- Women have significantly higher prevalence ratings for DBSH at 70.2% than men at 47.5% and almost 6 times the Sexual Harassment rating at 19.3% versus 3.4%.
- In terms of recency of experiencing DBSH, the dominant timeframe from the respondents is more than 5 years, however up to 380 respondents have experienced DBSH in the last 6 months.
- 2-5 times is the predominant number of times respondents have experienced DBSH throughout their career.
- Gender discrimination is the #1 form of discrimination selected by respondents at 59%, followed by Race at 30.9%.
- *Sexually explicit or offensive jokes, inappropriate physical contact* and *unwelcome sexual flirtations* are the top 3 forms of Sexual Harassment.
- Respondents identify the primary perpetrator of any of the four DBSH behaviours as being a Senior O&G Consultant.
- The gender of the perpetrator does vary slightly between the form of DBSH. 87.9% identify a male for Sexual Harassment, and 44% for the other behaviours. 35.7% identify Females are perpetrators of bullying behaviours.
- The Operating Theatre is the predominant setting where any 4 of the DBSH behaviours occur, followed by wards.
- More than 40% of respondents have never reported DBSH. This increases to almost 75% for Sexual Harassment.
- For those who do take action on any of the behaviours most discuss it with a peer, their family, friends or personal network, or bring it to the attention of the supervisor/manager.
- Overwhelmingly, almost 70% of respondents answered 'none of the instances have been resolved to their satisfaction'.
- The effect on future career options is the number #1 barrier to taking action.
- 50.2% of respondents have been bystanders and observed a colleague experience DBSH and over 60% didn't report the behaviour.
- Over 600 respondents provided a (narrative) reason as to why they wouldn't report as a bystander. These reasons were coded by BPA, the top 5 being Power imbalance, Fear, Retaliation, Not my place, Impact on career.

- Only 26% agree that Hospital Executive deal effectively with people who display DBSH.
- Going forward, 53.6% would advise a colleague who has been subjected to DBSH to file a formal complaint.
- In the last 5 years 43.2% have attended training on how to deal with DBSH in the workplace.
- 61.4% believe they are equipped with the skills to effectively respond to DBSH if they were subjected to it.
- The awareness of the 10 initiatives that RANZCOG has put in place to address DBSH ranged from 47% to 81%. Awareness with the Code of Conduct ranks first.
- Over 300 respondents provided suggestions for other ways in which RANZCOG could better support their members.

Finally, 913 respondents provided by way of narrative response a Message to the RANZCOG Board and BDH Advisory Working Group.

The messages are powerful.

Whilst BPA doesn't code messages, some of the themes that are presented in this narrative include:

- Congratulatory themes – many thank RANZCOG for taking on this serious issue and keep at it!
- The impact of reporting DBSH on a respondent's career – many respondents unpack why they wouldn't report DBSH - in their words it is 'career limiting' or 'career suicide'.
- The awareness of the initiatives RANZCOG are doing have been enhanced through the survey as some members were not aware of them.
- The conundrum between what is RANZCOG's responsibility versus the hospital's responsibility when dealing with DBSH.
- The survey 'triggered' some respondents, events are still very raw in their mind.
- The reputation and culture of RANZCOG is not positive in some eyes.
- The words 'stamp it out' and deal with the perpetrators are used frequently.
- Women and their careers, the mistreatment of female trainees pursuing pregnancy comes up.
- How Fellows perceive that Trainees can't take on feedback, or Fellows won't give feedback because they may be dubbed a perpetrator of DBSH.
- How Trainees perceive that Fellows can't deliver the feedback constructively.

What follows is a Summary of the Facts from the 2,105 RANZCOG members who took the time to complete this survey, many of whom have taken a very brave and courageous position by telling their story.

Thank you for the opportunity to conduct this significant and meaningful research.

Jacqui Parle
Owner/Director
BPA Analytics

PROCESS

The survey was designed electronically and administered by BPA Analytics. The survey was optimised for a mobile phone.

The survey census commenced on Friday 6th August 2021, initially for a 3-week period and then extended to 4 weeks in order to achieve the best possible response rate. BPA officially closed the survey at 9am on Monday 6th September.

The sequence of activities for the mail-out of survey links, via email and SMS, to RANZCOG members by BPA is outlined in Table 1 below. The content and timing of each event was negotiated with RANZCOG.

The first two reminders were only sent to members who had not opened their survey, or who had opened it but not completed it. At the request of RANZCOG, BPA did not continue text messaging after the second reminder, and the final email reminder was sent only to Fellows and FRANZCOG Trainees who had not yet opened their unique survey.

Table 2 illustrates the volume of data and personal stories derived from this survey.

Table 1: Email activity by BPA for the 2021 RANZCOG DBSH Survey

Activity conducted by BPA	No. of emails/SMS sent	Day/Date Administered
Initial email & SMS to RANZCOG members containing the individual eSurvey link	6,807 / 5,767	Friday, 6 August 2021
First reminder email sent by BPA	6,310	Thursday, 12 August 2021
First reminder SMS sent by BPA	5,254	Friday, 13 August 2021
Second reminder email sent by BPA	5,923	Thursday, 19 August 2021
Second reminder SMS sent by BPA	4,841	Friday, 20 August 2021
Third reminder email sent by BPA	5,417	Thursday, 26 August 2021
Final reminder email sent by BPA	2,646	Thursday, 2 September 2021

Table 2: Data Volumes for the 2021 RANZCOG DBSH Survey

Indicator	Data Volumes
No. of quantitative questions asked on the survey	579
No. of qualitative questions asked on the survey	69
Pieces of quantitative data	328,620
Piece of narrative text data	10,325
Pieces of demographic data	23,432
Personal messages from respondents to the RANZCOG Board & the Advisory Working Group	913

No. of case studies/personal stories from respondents on:

Unreasonable behaviour	
Discrimination	522 stories
Bullying	676 stories
Sexual Harassment	221 stories
Harassment	206 stories

UPTAKE

From the original email and SMS distribution of the survey instrument by BPA to 6,829 RANZCOG members:

- 132 members selected the Ethical Option '*I do not wish to participate in this survey. Please unsubscribe me from any future communications about the survey*' and were removed from the survey process by BPA. No reminder emails or SMS messages were sent to these people.
- 114 members were removed due to bounced emails and inability to provide the member with access to the survey instrument.

32% response rate overall.

With these 246 exclusions the denominator became 6,583.

22 new participants were added during the census period, making the final denominator 6,605.

2,639 members opened the survey.

534 chose not to answer any questions (either quantitative or qualitative) and were subtracted from the number who opened the survey.

In the end, a total of 2,105 RANZCOG members provided usable data, a response rate of 32% (2,105/6,605).

Of the 2,105 responses, 96 (4.5%) participants chose not to answer any questions beyond the first 9 demographic options.

A critical decision applied to this data set (relevant only in Choice Research and is due to the nature of the design of the questions asked on this survey) is if a respondent ignored a question they are not included in the denominator for that question. This is a validity safeguard to ensure that the percentages are representative of the respondents who answered a set of questions. Not all responding RANZCOG members answered each question.

There are questions where respondents were able to select more than one option for a given set of attributes.

The membership status was provided by RANZCOG, hard-wired and mapped to each individual member by BPA at the outset of administering the electronic survey. The table below outlines the response rate to the survey by each hard-wired membership category.

Table 3: Response Rates for the 2021 RANZCOG DBSH Survey

Membership Status	No. of surveys administered	No. of respondents	Response Rate
Diplomate	2,339	428	18%
DRANZCOG Trainee	606	114	19%
Educational Affiliate	34	16	47%
Fellow	2,384	1,112	47%
FRANZCOG Trainee	760	314	41%
Retired Fellow	481	121	25%
Total	6,605	2,105	32%

DEMOGRAPHICS – STATUS WITH THE COLLEGE

Respondents were invited to answer a set of 9 demographic questions.

Whilst RANZCOG provided BPA with each participant's membership status from their database (which BPA was able to use to provide RANZCOG with daily updates on the response rates during the survey census period by membership status), members were also asked to self-disclose their status by way of a demographic question.

There are slight differences between the status self-disclosed by the member and the information RANZCOG provided to BPA, in terms of numbers and the categories themselves.

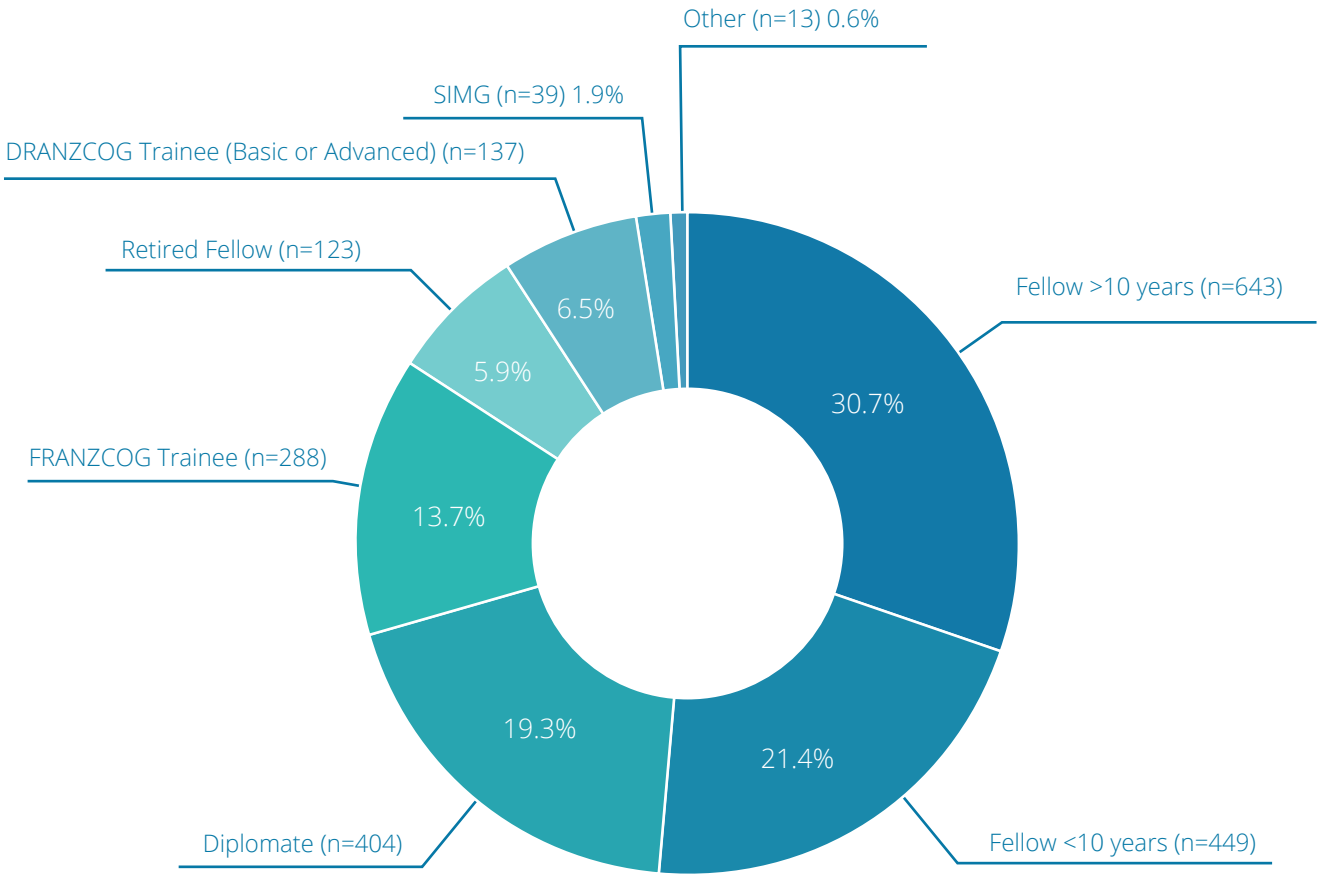
The self-disclosed membership status was deemed most appropriate to use for the purpose of analysing the Prevalence data.

As demonstrated in the chart below, in terms of membership category with RANZCOG, more than half the respondents to this survey were Fellows - when combining the responses from Fellow < 10 years and Fellow > 10 years.

Respondents were asked:

Q1: 'What best describes your status with the College?'

Figure 1: What best describes your status with the College?



9 respondents did not answer.

DEMOGRAPHICS – YEARS IN THE TRAINING PROGRAM

Of the 228 respondents who self-disclosed their status with RANZCOG as a FRANZCOG Trainee, they were also asked to nominate the number of years they have been in the training program.

BPA grouped and clustered years nominated by way of free text response, the outcome of which for all trainees is illustrated in the table below. As is evident in the data, 3-5 years in training is the cohort with the most trainees.

Table 4: How many years have you been in the training program?

Years in the training program	No. of respondents	Percentage represented
< 1 year	7	2.5%
1 - 2 years	80	28.9%
3 - 5 years	131	47.3%
6 - 10 years	58	20.9%
> 10 years	1	0.4%
Years not provided	11	
Total	288	

68.6%
(190)
of FRANZCOG Trainees who responded to this survey have been in the training program for more than 3 years.

DEMOGRAPHICS – GENDER IDENTITY

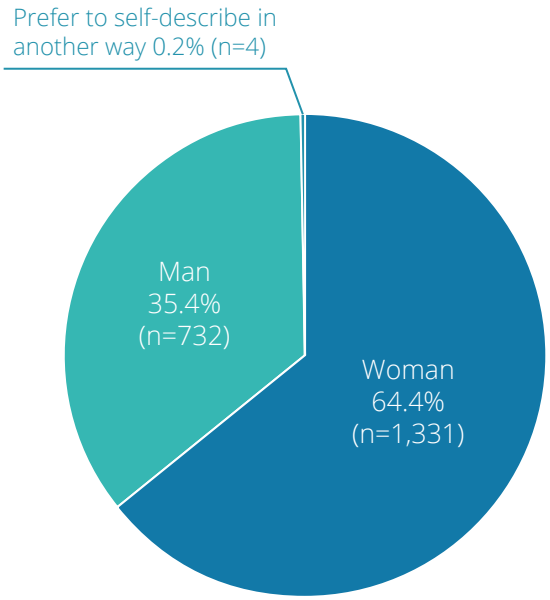
Respondents were asked:

Q2: 'What best describes your gender identity?'

Of the respondents, 35.4% (n=732) identify as men and 64.4% (n=1,331) identify as women. Less than 1% self-describe in another way.

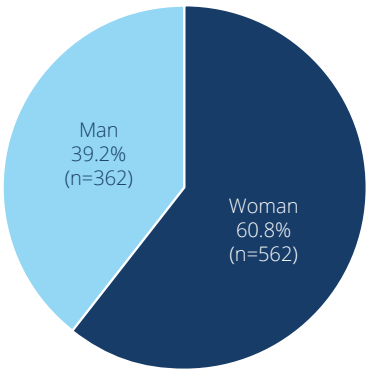
Compared to the data from RANZCOG's previous survey conducted in 2016, the numbers are similar but the proportion of members identifying as women has increased by 3.6%, and for men has decreased by 3.8%.

Figure 2: What best describes your gender identity?



38 respondents preferred not to say or did not answer this demographic.

Figure 3: Gender identity as per RANZCOG's 2016 survey

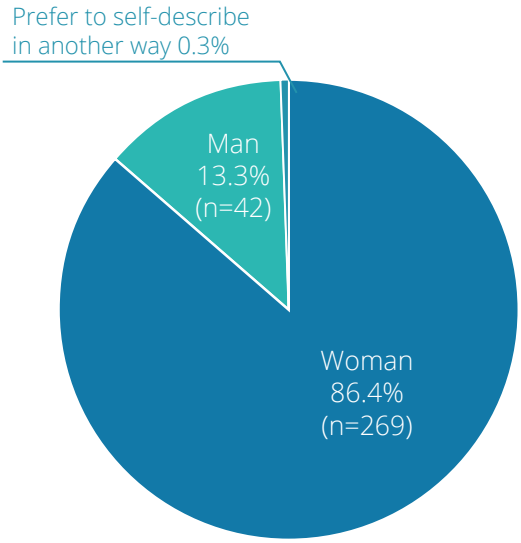


DEMOGRAPHICS - GENDER IDENTITY BY MEMBERSHIP STATUS

The breakdown of the gender profile by membership status produces significant findings.

86.4% of FRANZCOG Trainees identify as women, a difference of 22% to the overall total.

Figure 4: Gender identity of FRANZCOG Trainees



There is a difference in gender representation in Fellows of <10 years and >10 years, with the proportion of women significantly higher in the <10 years cohort - a difference of 24.9%.

The proportion of FRANZCOG Trainees identifying as women, plus the Fellow <10 years, indicates that the gender representation in O&G is likely to become further dominated by women in the future.

Figure 5: Gender identity of Fellow <10 years

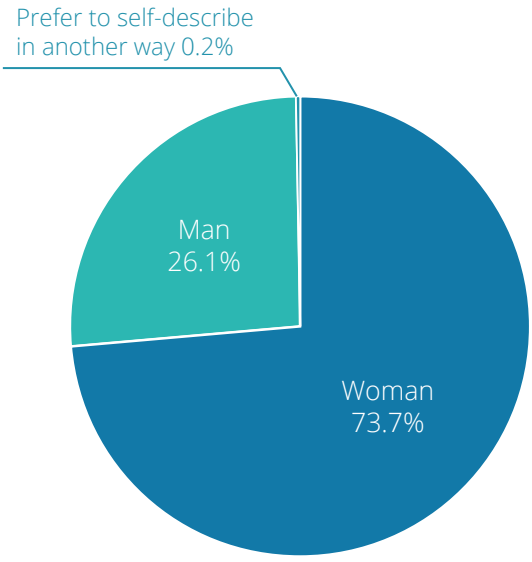
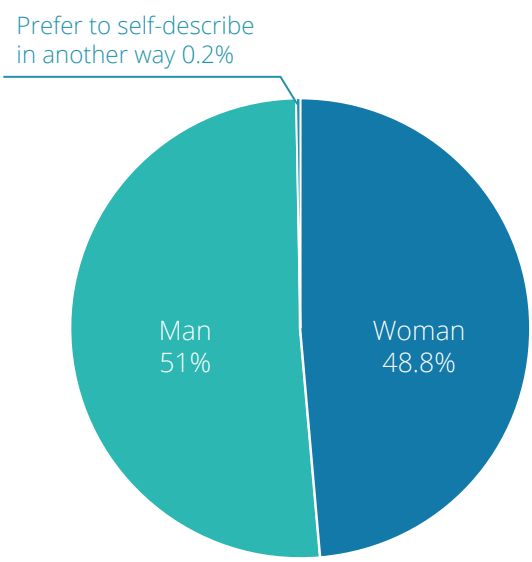


Figure 6: Gender identity of Fellow >10 years



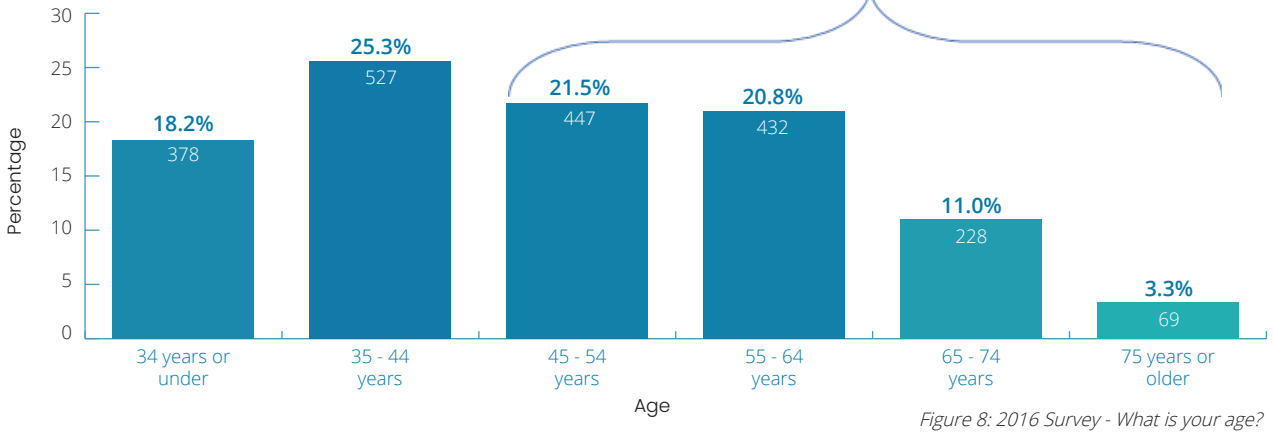
DEMOGRAPHICS – RESPONDENT AGE PROFILE

Respondents were asked:

Q3: 'What is your age?'

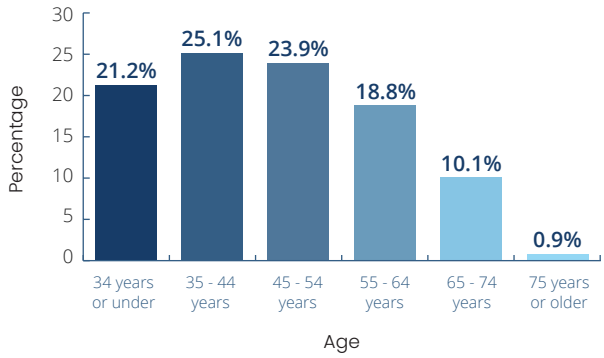
56.6% of respondents are over 44 years of age.

Figure 7: What is your age?



24 respondents preferred not to say or did not answer this demographic.

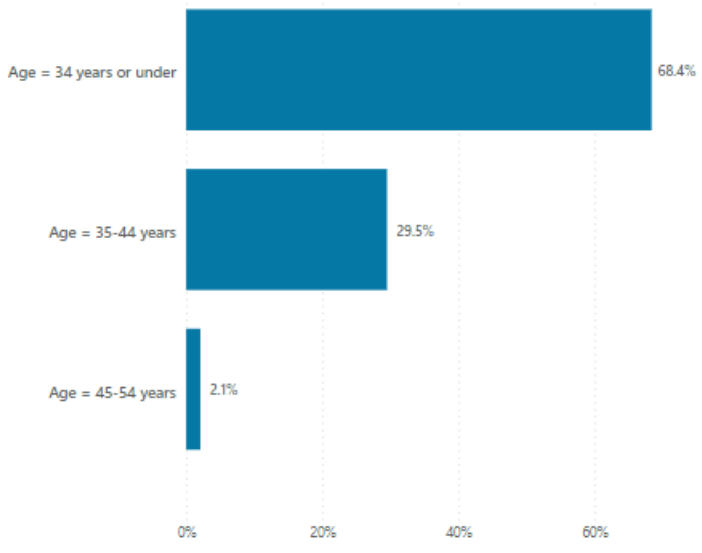
Figure 8: 2016 Survey - What is your age?



As with gender, the breakdown by membership status reveals differences. Fellows >10 years and Retired Fellows make up the majority of the over 44 year age brackets.

As illustrated in the graph below, 97.9% of FRANZCOG Trainees are under 45 years of age.

Figure 9: Age profile of FRANZCOG Trainees



97.9% of FRANZCOG Trainees are **under** the age of 45.

67.7% of Fellows <10 years are **under** the age of 45.

97.8% of Fellows >10 years are **over** the age of 45.

DEMOGRAPHICS – ORIGIN OF PRIMARY MEDICAL DEGREE

Respondents were asked:

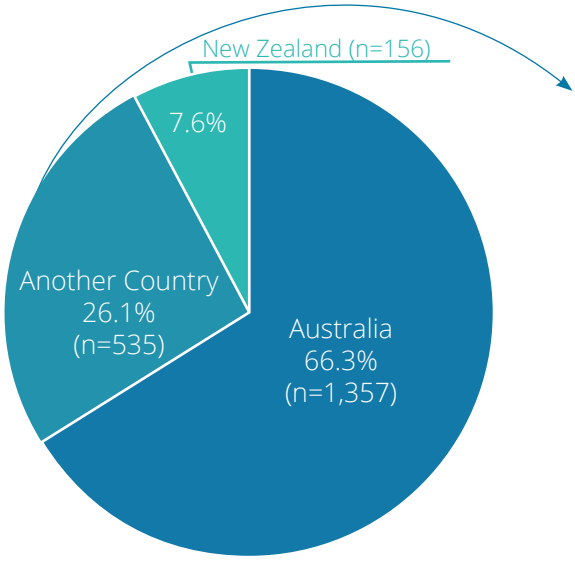
Q4: 'Where did you obtain your primary medical degree?'

66% of respondents obtained their primary medical degree in Australia, and a further 7.6% in New Zealand.

Where respondents selected 'another country', they were given the opportunity to specify where their primary degree was obtained.

Of the 535 members who selected 'another country', 394 supplied a name. The top 15 countries, with 5 or more mentions, are represented in the table below.

Figure 10: Where did you obtain your primary medical degree?



57 respondents preferred not to say or did not answer this demographic.

Table 5: Another Country where primary medical degree was obtained (where specified)

Country *(top 15)*	No. of respondents
United Kingdom *(includes England, Scotland, Northern Ireland)*	105
India	74
South Africa	34
Sri Lanka	27
United States of America	14
Iraq	13
Egypt	12
Pakistan	12
Germany	8
Ireland	7
Bangladesh	7
Fiji	6
Nigeria	6
Malaysia	5
Russia/USSR	5

A further 34 countries were identified, with between 1 and 4 mentions each.

DEMOGRAPHICS - ORIGIN OF SPECIALIST TRAINING

Respondents were asked:

Q5: 'In which country did you undertake the majority of your O&G specialist training?'

73.6% of respondents to this survey did the majority of their O&G specialist training in Australia.

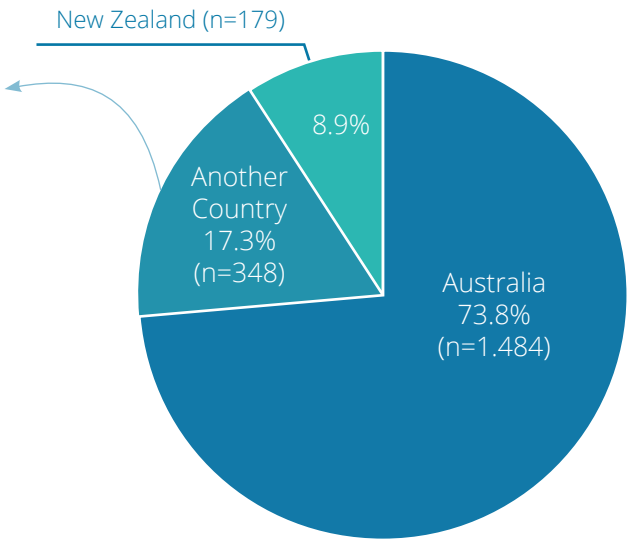
Where respondents selected 'another country', they were given the opportunity to specify where their specialist training was completed.

Of the 348 members who selected 'another country', 288 supplied a name. The top 10 countries, with 4 or more mentions, are represented in the table below.

Table 6: Another Country where a majority of specialist training was completed

Country *(top 10)*	No. of respondents
United Kingdom *(includes England, Scotland, Northern Ireland)*	144
India	32
South Africa	27
England	23
United States of America	17
Sri Lanka	16
Germany	6
Canada	4
Ireland	4
Pakistan	4

Figure 11: In which country did you undertake the majority of your specialist training?



40 respondents preferred not to say or did not answer this demographic.
54 identified the question as not applicable.

A further 24 countries were identified, with between 1 and 3 mentions each.

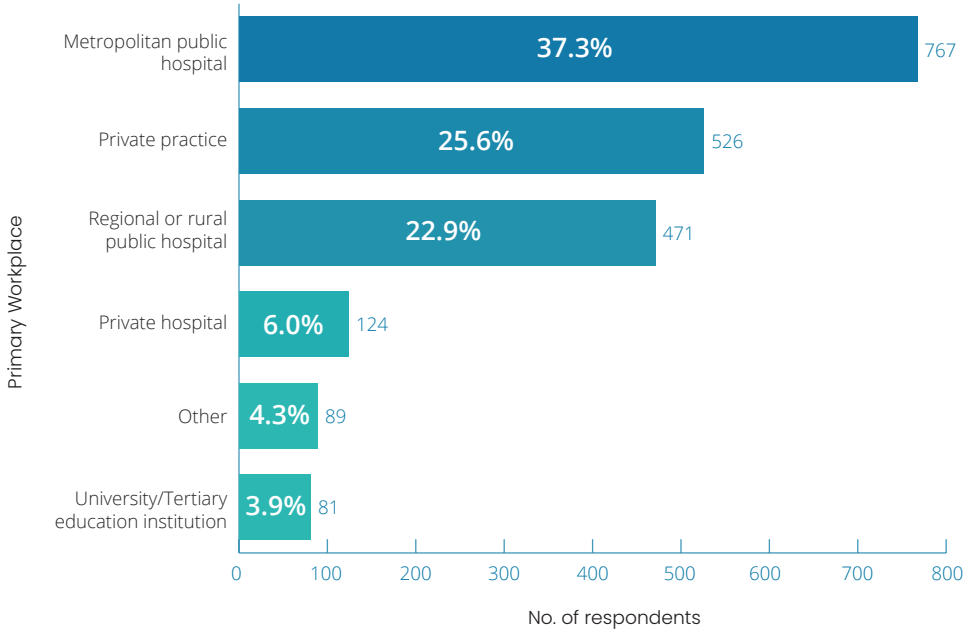
DEMOGRAPHICS - PRIMARY WORKPLACE

60.2%
of respondents' primary workplace is a Public Hospital (Metropolitan or Regional)

Respondents were asked:

Q6: 'What is your primary workplace?'

Figure 12: What is your primary workplace?



47 respondents preferred not to say or did not answer this demographic.

Where respondents selected 'other' they were given the opportunity to specify their primary workplace. Some of the workplaces identified include:

- RFDS (Royal Flying Doctor Service)
- Aboriginal health service
- Rural general practice
- Public & private split
- Retired

DEMOGRAPHICS - STATE & COUNTRY OF RESIDENCE

RANZCOG provided BPA with member non-personal demographic data for their current location (Australian state, and country of residence). BPA hard-wired this information for each respondent to their survey.

Figure 13: Of the respondents in Australia, the distribution across each State is represented below.

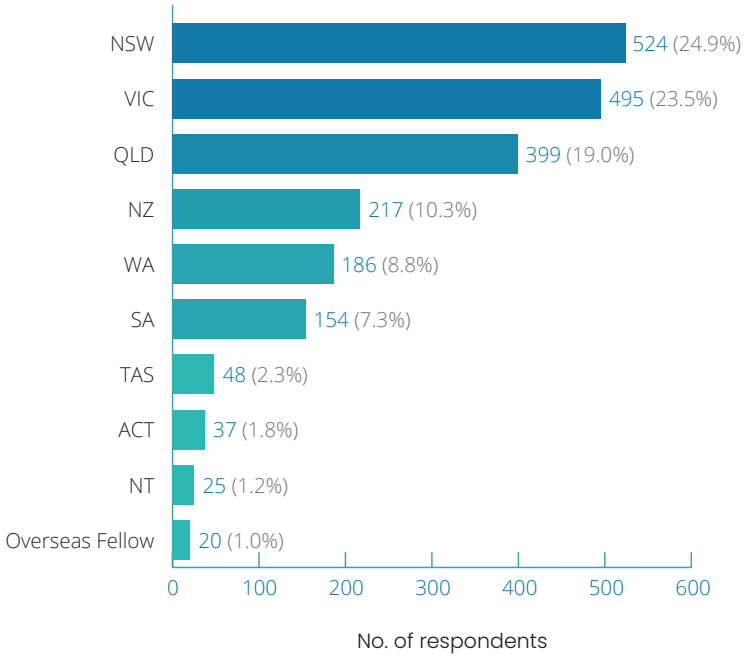


Table 7: Respondents country of residence

Country*	No. of respondents
Australia	1,868
New Zealand	217
United Kingdom	6

**Country of residence is not listed where there were less than 5 respondents*

DEMOGRAPHICS - COUNTRY OF BIRTH

Respondents were asked:

Q7: 'What country were you born in?'

58% of respondents were born in Australia or New Zealand, and 42% were born overseas.

Table 8: What country were you born in?

Country	No. of respondents	Response Rate
Australia	1,036	50.9%
New Zealand	140	6.9%
Another English speaking Country	412	20.3%
A Non-English speaking Country	446	21.9%

71 respondents preferred not to say or did not answer this demographic.

Where respondents selected 'another English speaking country' or 'another Non-English speaking country', they were given the opportunity to specify their country of birth.

For the 20.3% who identified as being born in **another English speaking country**, the top 4 countries provided by the respondents in the narrative comments are outlined in the table below:

Table 9: Another English speaking country of birth (where specified)

English speaking country *(top 4)*	No. of respondents
United Kingdom *(includes England, Scotland, Northern Ireland)*	129
South Africa	74
United States of America	24
Canada	13

For the 21.9% who identified as being born in **another Non-English speaking country**, the top 5 countries provided by the respondents in the narrative comments are outlined in the table below:

Table 10: Another Non-English speaking country of birth (where specified)

Non-English speaking country *(top 4)*	No. of respondents
India	81
Sri Lanka	26
Malaysia	19
Germany	15
Egypt	12

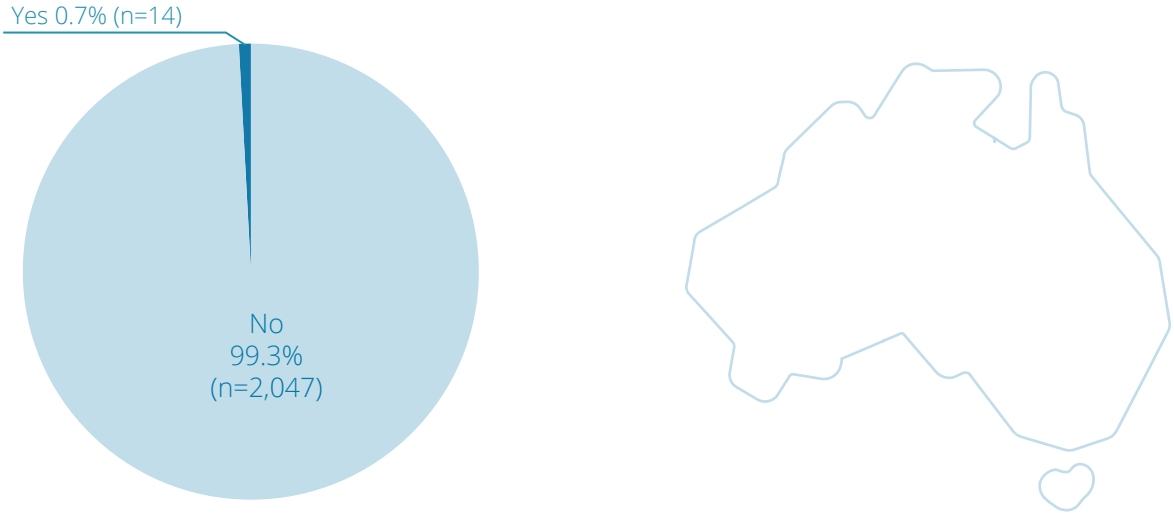
DEMOGRAPHICS - CULTURAL HERITAGE

Respondents were asked:

Q8: 'Do you identify as being of Aboriginal and/or Torres Strait Islander descent?'

Of the respondents, 0.7% (n=14) identify as being of Aboriginal and/or Torres Strait Islander descent.

Figure 14: Respondents who identify as being of Aboriginal or Torres Strait Islander descent



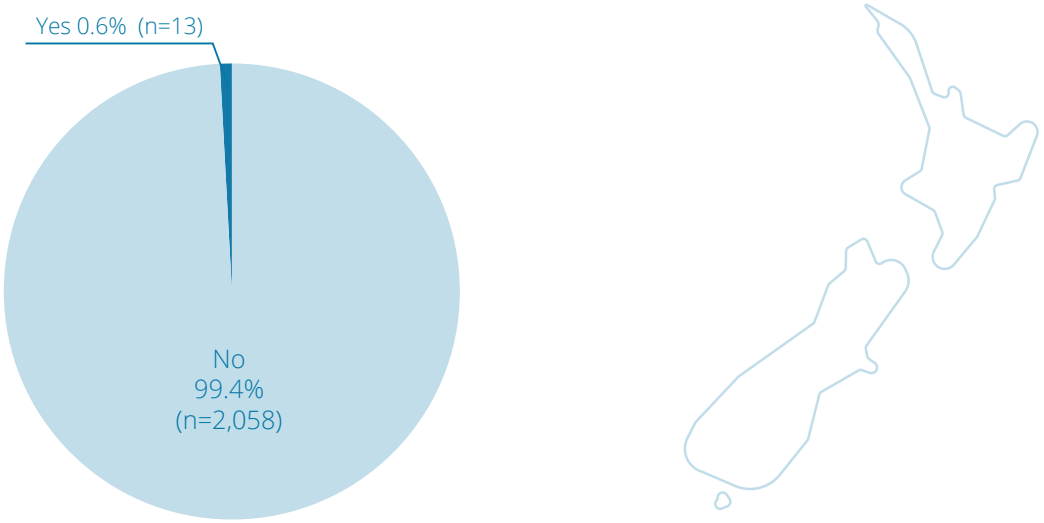
44 respondents preferred not to say or did not answer this demographic.

Respondents were asked:

Q9: 'Do you identify as Māori?'

Of the respondents, 0.6% (n=13) identify as Māori.

Figure 15: Respondents who identify as Māori



34 respondents preferred not to say or did not answer this demographic.

PREVALENCE OF DISCRIMINATION, BULLYING, SEXUAL HARASSMENT OR HARASSMENT (DBSH)

Respondents were asked:

Q10: 'Have you ever been subject to DBSH in the workplace by a professional colleague?' A Yes/No rating scale was provided.

62.1% answered 'Yes' which equates to 1,247 people.

As evidenced below, a number of respondents have been subjected to more than one type of behaviour with Bullying in the workplace by a professional colleague ranking highest at 44.3%.

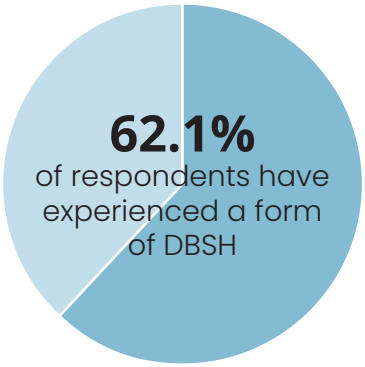


Table 11: Have you ever been subject to DBSH in the workplace by a professional colleague?

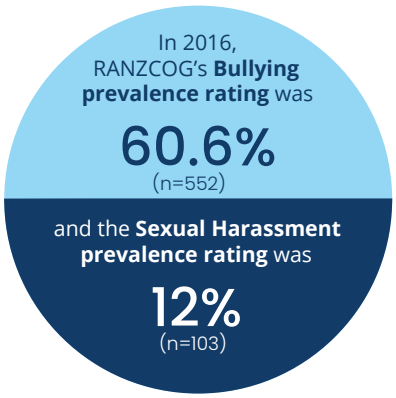
Unreasonable behaviour (by a professional colleague)	No. of respondents	No. of respondents who answered 'Yes' in RANZCOG in 2021	% answered 'Yes'	BPA Benchmarking comparison (norm)
DBSH	2,009	1,247	62.1%	51%
Discrimination	2,009	700	34.8%	23%
Bullying	2,009	889	44.3%	38%
Sexual Harassment	2,009	272	13.5%	9%
Harassment	2,009	312	15.5%	17%

For a sense of perspective, BPA has asked this set of questions in surveys conducted in 4 other Medical Colleges.

BPA is able to benchmark RANZCOG's results against the set of norms derived from these datasets.

As illustrated below, RANZCOG's results in 2021 benchmark...

- On the norm/average for Harassment
- Low (bottom quartile) for DBSH and Bullying
- Very low (bottom decile) for Discrimination and Sexual Harassment



Attributes	Survey Responses	Agreed %	Disagreed %	Compared with the Benchmarking Partner Norms	Benchmarking Norm Responses	Benchmarking Norm
Q10. I have been subjected to Discrimination, Bullying, Sexual Harassment or Harassment (DBSH) in the workplace by a professional colleague.	2009	62.1%	37.9%	Low	n = 8,420	51.3%
Q11. I have been subjected to Discrimination in the workplace by a professional colleague.	2009	34.8%	65.2%	Very Low	n = 8,420	23.0%
Q11. I have been subjected to Bullying in the workplace by a professional colleague.	2009	44.3%	55.7%	Low	n = 8,420	37.8%
Q11. I have been subjected to Sexual Harassment in the workplace by a professional colleague.	2009	13.5%	86.5%	Very Low	n = 8,420	8.9%
Q11. I have been subjected to Harassment in the workplace by a professional colleague.	2009	15.5%	84.5%	Average	n = 8,420	16.9%

PREVALENCE OF UNREASONABLE BEHAVIOURS BY MEMBERSHIP STATUS

Each piece of quantitative data has been segmented by the membership status of the respondents.

The table below outlines the number and status of the respondents who answered 'yes' to having been subject to any one of the 4 DBSH behaviours in the workplace by a professional colleague.

The figures in this table are based on the self-disclosed membership status.

For guidance on the statistical significance ratings, please refer to the key outlined further down the page.

Table 12: I have been subjected to Discrimination, Bullying, Sexual Harassment, or Harassment in the workplace by a professional colleague.

Membership Status	No. of respondents	No. of respondents who answered 'Yes' to DBSH	% answered 'Yes'	Statistical significance
Overall (all members)	2,009	1,247	62.1%	
DRANZCOG Trainee *(Basic or Advanced)*	129	79	61.2%	E
FRANZCOG Trainee	274	196	71.5%	H
Diplomate	379	206	54.4%	L
SIMG	38	27	71.1%	E
Fellow < 10 years	427	314	73.5%	H
Fellow > 10 years	621	364	58.6%	E
Retired Fellow	121	50	41.3%	L
Other	13	7	53.8%	E

FRANZCOG Trainees and Fellows <10 years purport the highest prevalence of having experienced any of the 4 DBSH behaviours. Both are statistically higher scores when compared against the overall prevalence rating of 62.1%.

Whilst all prevalence statistics appear relatively high, when statistically tested, the Diplomates and Retired Fellows ratings were lower scores (a low prevalence score is a good outcome).

Each quantitative question was tested for statistical significance using a t-test at the 95% Confidence Interval (CI). Each question was reported as either statistically higher, lower ($p < .05$), or as having no significant difference ($p > .05$).

Depending on the question asked, a 'higher' or a 'lower' outcome may be perceived as a good result, as some questions asked on the survey were reversed (negatively worded).

The key to understanding the **statistical significance** reporting is:

H = **Higher**. The sample (cohort) score was significantly higher ($p < .05$) than that of the population (full census).

E = **Equal** (no difference). There was no significant difference ($p > .05$) between the sample (cohort) score and that of the population (full census).

L = **Lower**. The sample (cohort) score was significantly lower ($p < .05$) than that of the population (full census).

For the purposes of the Prevalence reporting in this summary, we have colour coded the statistical significance labels for ease of comparison. This legend is **not** used in sections where a higher statistical difference is a better result.

PREVALENCE RATING BY MEMBERSHIP STATUS

The table below illustrates the number of respondents who answered 'Yes' they have been subject to any one of the 4 behaviours Discrimination, Bullying, Sexual Harassment or Harassment cross matched by RANZCOG membership status.

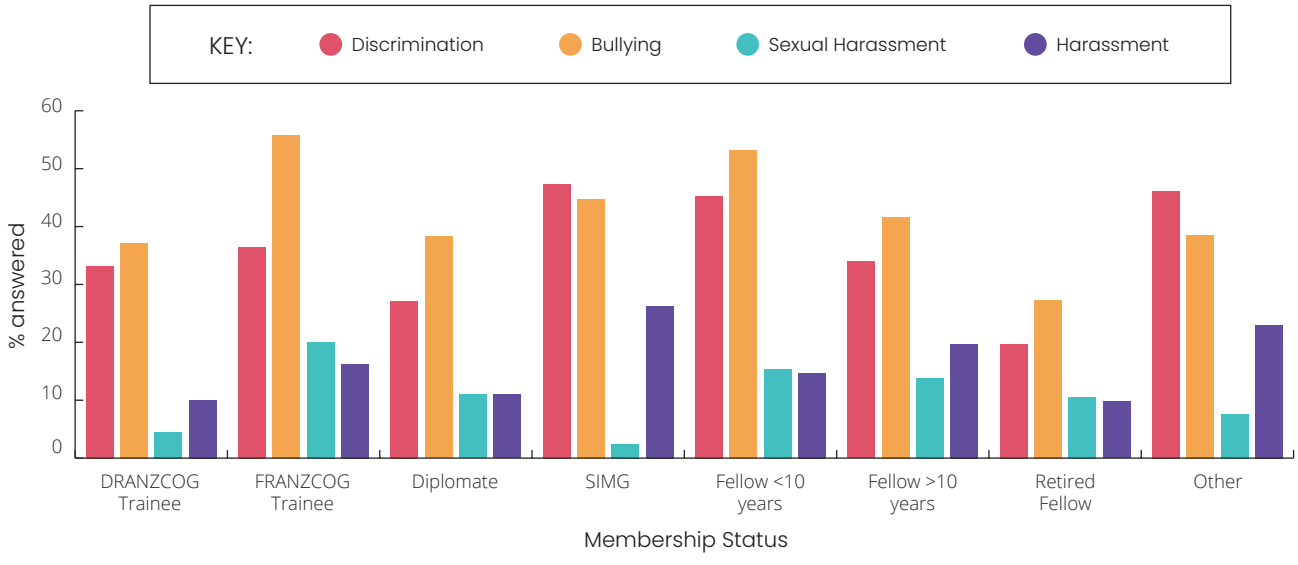
Table 13: I have been subject to Discrimination, Bullying Sexual Harassment or Harassment in the workplace? (Yes/No question)

KEY: L = Statistically **Lower** E = Statistically **Equal** H = Statistically **Higher**

Membership Status	Discrimination		Bullying		Sexual Harassment		Harassment	
DRANZCOG Trainee (n=129)	33.3% [43]	E	37.2% [48]	E	4.7% [6]	L	10.1% [13]	L
FRANZCOG Trainee (n=274)	36.5% [100]	E	55.8% [153]	H	20.1% [55]	H	16.4% [45]	E
Diplomate (n=379)	27.2% [103]	L	38.3% [145]	L	11.1% [42]	E	11.1% [42]	L
SIMG (n=38)	47.4% [18]	E	44.7% [17]	E	2.6% [1]	L	26.3% [10]	E
Fellow <10 years (n=427)	45.2% [193]	H	53.2% [227]	H	15.5% [66]	E	14.8% [63]	E
Fellow >10 years (n=621)	34.0% [211]	E	41.7% [259]	E	14.0% [87]	E	19.8% [123]	H
Retired Fellow (n=121)	19.8% [24]	L	27.3% [33]	L	10.7% [13]	E	9.9% [12]	L
Other (n=13)	46.2% [6]	E	38.5% [5]	E	7.7% [1]	E	23.1% [3]	E

The graph below cross matches each of the four types of unreasonable behaviours by membership status.

Figure 16: Cross match of Membership Status and unreasonable behaviour experienced



PREVALENCE OF DBSH RATING BY KEY DEMOGRAPHIC

The percentage of respondents who answered 'yes' they have been subject to DBSH by a professional colleague in the workplace cross-matched by key demographic options produce some stand out facts.

- By **Country** – New Zealand's overall Prevalence Statistic is 8.6% higher than Australia (and a statistically higher score).
- By **Workplace** – Metropolitan public hospitals have a prevalence statistic of 65.5%, along with University/Tertiary education institutions at 76.9% - both of which are statistically higher scores.
- Respondents who have been **in training** from 1 to 5 years have the highest prevalence statistics (statistically higher scores).
- By **Gender** – women rate 22.7% higher than men for DBSH and this is a statistically significant difference.

PREVALENCE RATING BY KEY DEMOGRAPHIC

The table below illustrates the number of respondents who answered 'Yes' they have been subject to any one of the four behaviours Discrimination, Bullying, Sexual Harassment or Harassment, cross-matched by primary workplace and years in training and whether these differences are statistically significant.

KEY: L = Statistically **Lower** E = Statistically **Equal** H = Statistically **Higher**

Table 14: Prevalence by primary workplace

Primary Workplace	No. of respondents	No. of respondents who answered 'Yes'	Prevalence Statistic % who answer YES I have been subject to DBSH	Statistical significance
Metropolitan public hospital	730	479	65.6%	H
Regional or rural public hospital	453	280	61.8%	E
Private hospital	117	72	61.5%	E
University/Tertiary education institution	78	60	76.9%	H
Private practice	503	279	55.5%	L
Primary workplace – other	87	45	51.7%	L

Table 15: Prevalence by years in training program

Years in training program	No. of respondents	No. of respondents who answered 'Yes'	Prevalence Statistic % who answer 'Yes'	Statistical significance
1 - 2 years	78	58	74.4%	H
3 - 5 years	126	95	75.4%	H
6 - 10 years	54	34	63.0%	E

Table 16: Prevalence by age

Age	No. of respondents	No. of respondents who answered 'Yes'	Prevalence Statistic % who answer YES I have been subject to DBSH	Statistical significance
34 years or under	354	236	66.7%	H
35 - 44	498	353	70.9%	H
45 - 54	431	278	64.5%	E
55 - 64	417	242	58.0%	E
65 - 74	220	109	49.5%	L
75 years or over	69	69	23.2%	L

PREVALENCE RATING BY KEY DEMOGRAPHIC

Women have a significantly higher level of prevalence for experiencing any one of the 4 DBSH behaviours when the question is asked as DBSH overall.

Table 17: Prevalence by gender

Gender	No. of respondents	No. of respondents who answered 'Yes'	Prevalence Statistic % who answer YES I have been subject to DBSH	Statistical significance
Man	716	340	47.5%	L
Woman	1.256	882	70.2%	H

When we drill-down into the specific type of behaviour experienced, the prevalence rates are higher for women than men for experiencing Discrimination, Bullying and Sexual Harassment, but closely aligned for Harassment.

Table 18: Prevalence by gender and specific type of behaviour

Gender	Discrimination		Bullying		Sexual Harassment		Harassment	
Man	25.1% [180]	L	33.8% [242]	L	3.4% [24]	L	14.1% [101]	E
Woman	39.8% [500]	H	50.1% [629]	H	19.3% [243]	H	16.2% [204]	E

Figure 17: Prevalence by gender and specific type of behaviour

RECENCY OF EXPERIENCING UNREASONABLE BEHAVIOUR

Respondents were asked:

Q12: 'When did you experience this behaviour?'

Respondents were provided with 5 options to nominate when they experienced the unreasonable behaviour.

- In the last 6 months
- Between 6 months and 1 year ago
- Between 1 year and 2 years ago
- Between 2 years and 5 years ago
- More than 5 years ago

Table 19: When did you experience this behaviour?

When this behaviour was experienced	Discrimination (n=688)	Bullying (n=879)	Sexual Harassment (n=270)	Harassment (n=303)
In the last 6 months	20.9% [144]	18.4% [162]	5.6% [15]	19.5% [59]
6 months - 1 year ago	14.5% [100]	12.7% [112]	5.6% [15]	21.8% [66]
1 - 2 years ago	16.6% [114]	16.8% [148]	13.0% [35]	21.1% [64]
2 - 5 years ago	31.4% [216]	29.9% [263]	21.2% [57]	31.0% [94]
More than 5 years ago	48.7% [335]	44.5% [391]	69.3% [187]	39.3% [119]

NB: The percentages will not tally to 100% because the respondents could select all that apply, based on the number of times they have experienced the behaviour.

In addition, at the request of RANZCOG, BPA constructed recency figures for respondents who experienced DBSH in the last 2 years and in the last 5 years.

These numbers were constructed based on respondents experiencing DBSH …

- In the last 2 years – either in the last 6 months, and/or 6 months-1 year ago, and/or 1-2 years ago.
- In the last 5 years – either in the last 6 months, and/or 6 months-1 year ago, and/or 1-2 years ago, and/or 2-5 years ago.

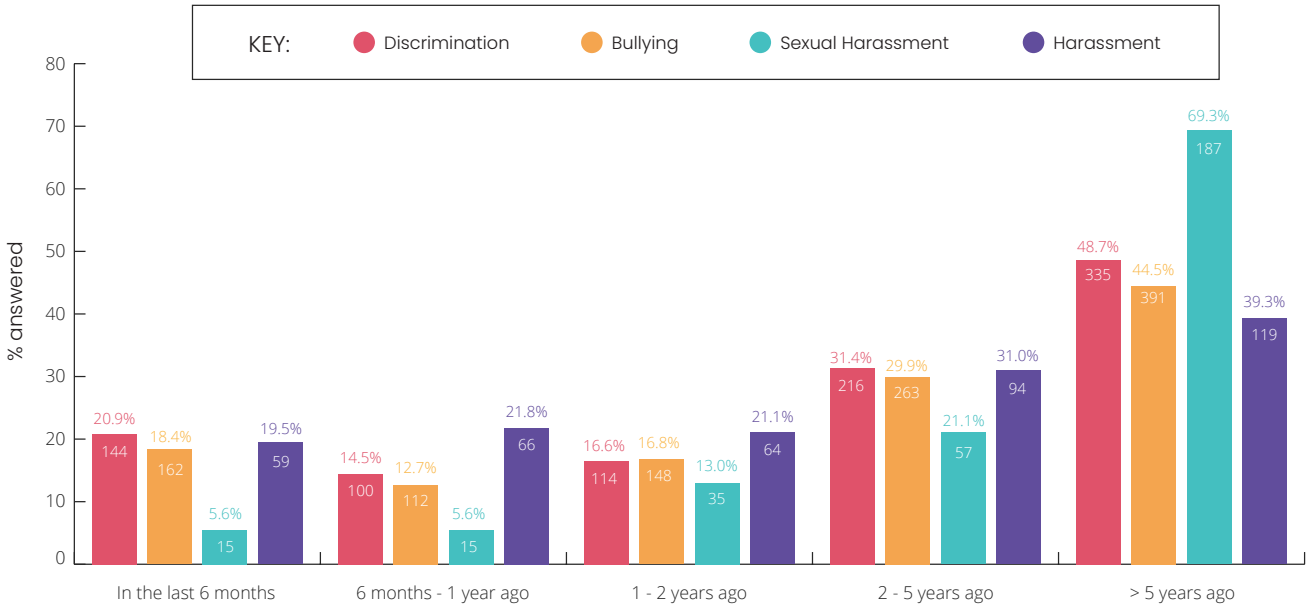
Table 20: When did you experience this behaviour?

When this behaviour was experienced	Discrimination (n=688)	Bullying (n=879)	Sexual Harassment (n=270)	Harassment (n=303)
In the last 2 yrs	40.4% [278]	39.4% [346]	18.5% [50]	46.5% [141]
In the last 5 yrs	62.1% [427]	62.3% [548]	36.7% [99]	67.7% [205]

RECENCY OF EXPERIENCING UNREASONABLE BEHAVIOUR

There are differences in the pattern of when the event occurred as illustrated in the graph below. Incidences relating to Sexual Harassment in almost 70% of occasions have occurred more than 5 years ago. Whilst most have occurred more than 5 years ago, there is still a pattern of behaviour (with the exception of Sexual Harassment) occurring in the last 6 months, with 380 respondents having experienced a form of DBSH.

Figure 18: When did you experience this behaviour throughout your career?



FREQUENCY OF EXPERIENCING UNREASONABLE BEHAVIOUR

Respondents were asked:

Q13: 'How many times have you experienced this behaviour throughout your career?'

Figure 19: How many times have you experienced this behaviour throughout your career?

RESPONDENTS' EXPERIENCES OF DBSH

Respondents were asked by way of open ended qualitative question:

Q14: 'Please describe one of the times that stands out in your mind when you were subjected to this behaviour, but please do not name specific individuals.'

1,669 personal stories were received across all four behaviours:

- 522 personal stories of being discriminated against;
- 676 personal stories of being bullied;
- 221 personal stories of being sexually harassed;
- 206 personal stories of being harassed.

The descriptions of the behaviours experienced by the respondents are compelling and powerful. The pain and emotion experienced is evident throughout their narrative. Regardless of how long ago the incident occurred, the victim lives with the consequences today.

Regardless of how long ago the incident occurred, the victim lives with the consequences today.

BPA applied its Linguistic Analysis Methodology to each of the case studies and coded the verbatim text of the respondent's personal experiences using the same dictionary across all four behaviours.

Whilst there is some overlap in the coding of each behaviour, there are also noticeable differences.

To demonstrate, the top coding category for …

Discrimination is Sexual or gender discrimination, defined through BPA's coding as discrimination based on gender or sexual orientation.

Bullying is Belittling, defined as putting people down in front of others, humiliating others, name-calling, being derogatory, condescending, ridiculing, insulting or degrading.

Sexual Harassment is Inappropriate comments defined as comments or 'jokes' that are inappropriate - including comments that are negative, derogatory, belittling, sexist, racist, sarcastic, demeaning or containing sexual references. In terms of coding, this is closely followed by Sexual advances (unwanted) and Sexual innuendo.

Harassment is Belittling, followed by Accusations, defined as inappropriate or false accusations, allegations, criticism, blame or reprimand. May also include victimisation, targeting, scapegoating or vilification.

The next 4 pages of this summary include a graph of the coding categories for each of the DBSH behaviours.

Included with each graph is BPA's definition of each coding concept – the words that make up the coding category.

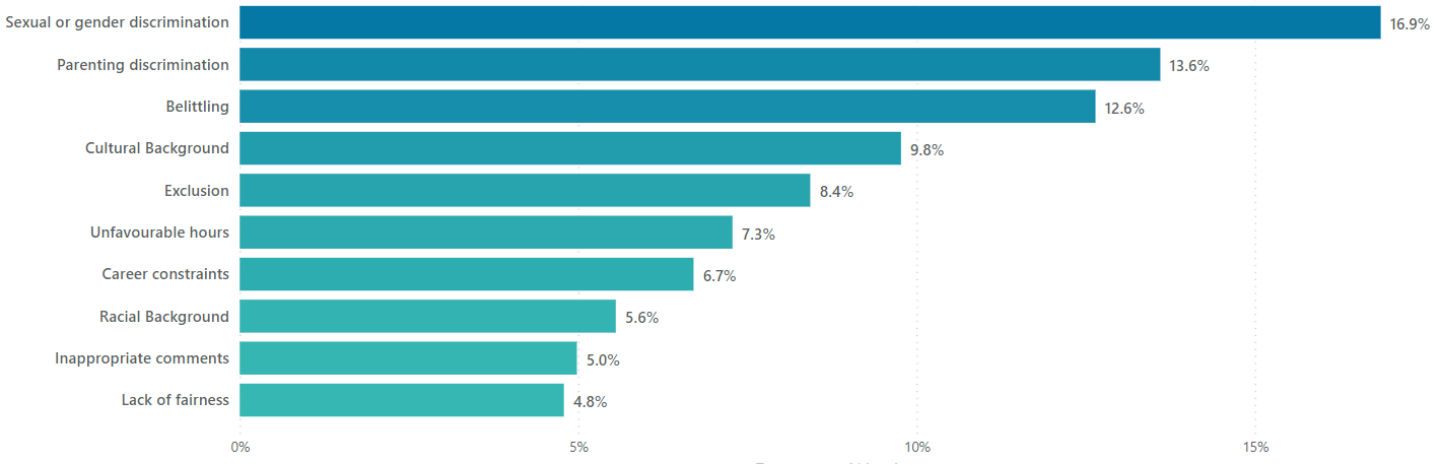
RESPONDENTS' EXPERIENCES OF DISCRIMINATION

522 personal stories from respondents produced the following 10 coding categories.

The prevalence statistic for **Discrimination** is:

34.8%

Figure 20: Episode of Discrimination - Description of Behaviour (n=522)



NB: The percentages on the bar chart are the % of respondents who triggered each category (needs a minimum of 4 respondents to trigger a category). The percentages will not tally to 100% because individual responses can be coded to multiple categories.

Definitions: Episodes of Discrimination - Description of the Behaviours experienced

Sexual or gender discrimination | Discrimination based on gender or sexual orientation.

Parenting discrimination | Discrimination based on pregnancy or parenting status.

Belittling | Belittling, putting people down in front of others, humiliating others, name-calling, being derogatory, condescending, ridiculing, insulting or degrading.

Cultural background | Being treated differently related to their cultural or ethnic background.

Exclusion | Being excluded, ignored, isolated, overlooked, dismissed, denied access, marginalised, left out, sidelined or ostracized.

Unfavourable hours | Unfavourable decisions about working hours, shifts or rosters.

Career constraints | Constraints or impact on career advancement opportunities.

Racial Background | Being treated differently related to their race or skin colour.

Inappropriate comments | Comments or 'jokes' that are inappropriate - including comments that are negative, derogatory, belittling, sexist, racist, sarcastic, demeaning or containing sexual references.

Lack of fairness | Unfair or unequal treatment, personally or in terms of work processes.

RESPONDENTS' EXPERIENCES OF DISCRIMINATION

Respondents were asked:

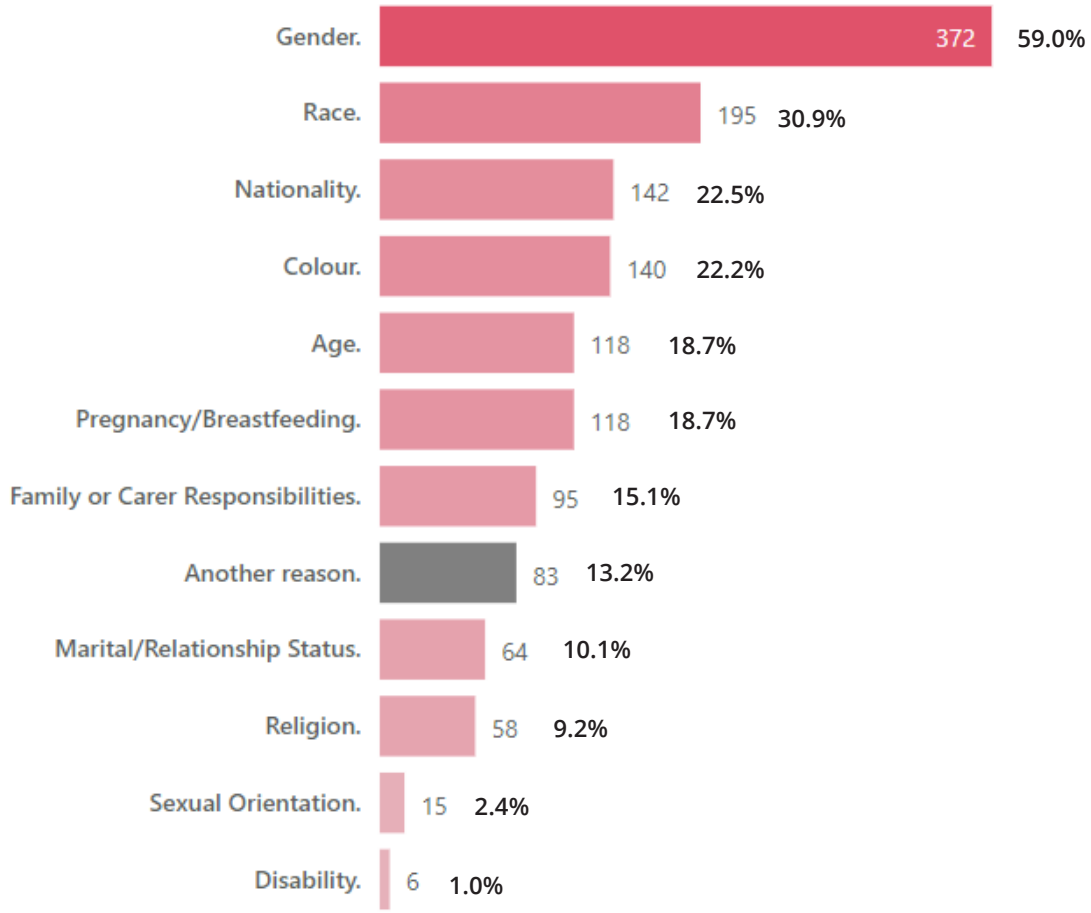
Q15: 'On what basis do you think you have experienced discrimination?'

In addition to telling their personal story, respondents were given a list of 11 commonly cited reasons for Discrimination and asked to select the options they believe as to why they may have experienced discrimination. Respondents were able to select as many as apply.

The top 4 of Gender, Race, Nationality and Colour are the stand outs.

When I experienced Discrimination, I believe it was because of my...

Figure 21: Respondents perceived reason for Discrimination (n=631)



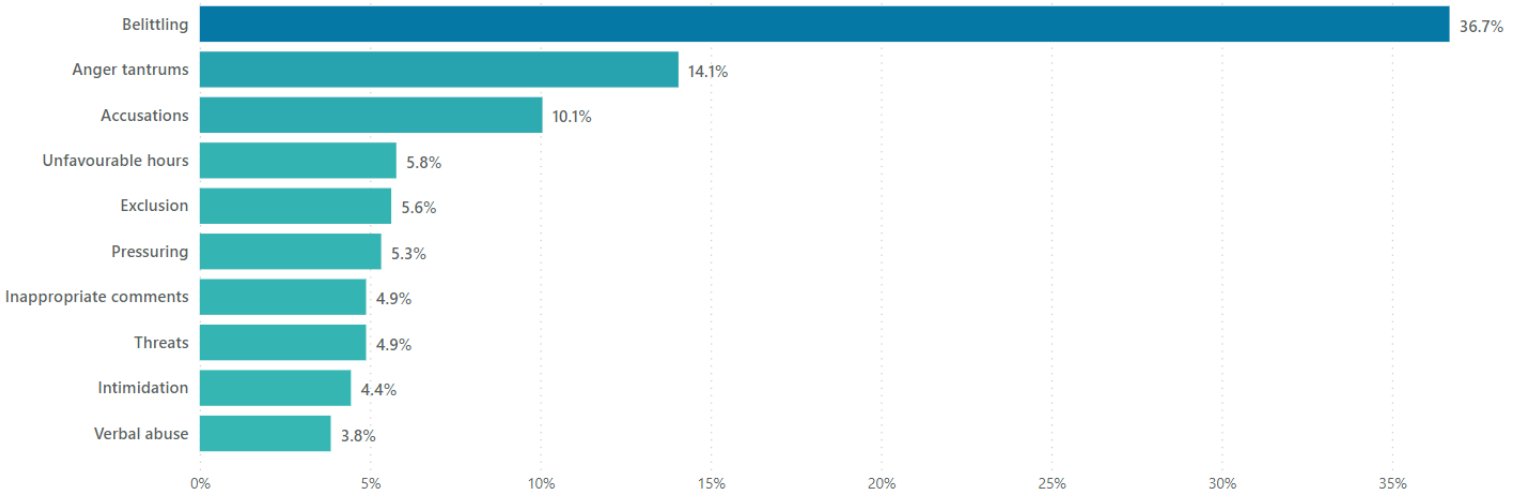
RESPONDENTS' EXPERIENCES OF BULLYING

676 personal stories from respondents produced the following 10 coding categories.

The prevalence statistic for **Bullying** is:

44.3%

Figure 22: Episode of Bullying - Description of Behaviour (n=696)



NB: The percentages on the bar chart are the % of respondents who triggered each category (needs a minimum of 4 respondents to trigger a category). The percentages will not tally to 100% because individual responses can be coded to multiple categories.

Definitions: Episodes of Bullying - Description of the Behaviours experienced

> **Belittling** | Belittling, putting people down in front of others, humiliating others, name-calling, being derogatory, condescending, ridiculing, insulting or degrading.
>
> **Anger tantrums** | Outbursts of anger tantrums, including yelling, shouting or screaming.
>
> **Accusations** | Inappropriate or false accusations, allegations, criticism, blame or reprimand. May also include victimisation, targeting, scapegoating or vilification.
>
> **Unfavourable hours** | Unfavourable decisions about working hours, shifts or rosters.
>
> **Exclusion** | Being excluded, ignored, isolated, overlooked, dismissed, denied access, marginalised, left out, sidelined or ostracized.
>
> **Pressuring** | Feeling pressured or forced to do something. May include being physically punched or shoved.
>
> **Inappropriate comments** | Comments or 'jokes' that are inappropriate - including comments that are negative, derogatory, belittling, sexist, racist, sarcastic, demeaning or containing sexual references.
>
> **Threats** | Threats or threatening behaviour.
>
> Intimidation | Intimidation, standover tactics, overbearing manner, horizontal violence, coercion or stalking.
>
> Verbal abuse | Verbal abusive behaviour - may include verbal aggression and verbal harassment.

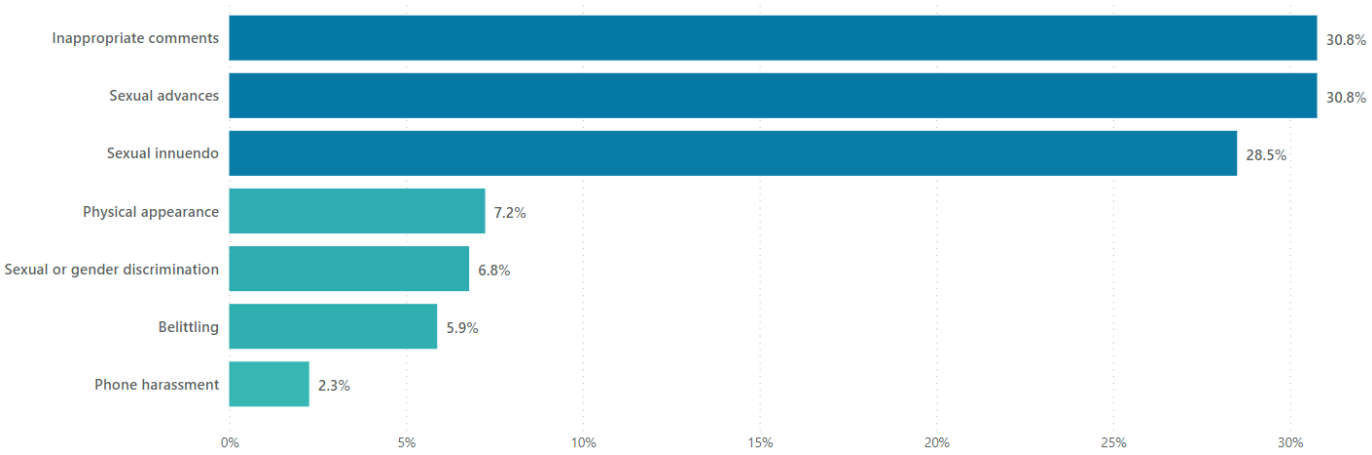
RESPONDENTS' EXPERIENCES OF SEXUAL HARASSMENT

221 personal stories from respondents produced the following 7 coding categories.

The prevalence statistic for **Sexual Harassment** is:

13.5%

Figure 23: Episode of Sexual Harassment - Description of Behaviour (n=224)



NB: The percentages on the bar chart are the % of respondents who triggered each category (needs a minimum of 4 respondents to trigger a category). The percentages will not tally to 100% because individual responses can be coded to multiple categories.

Definitions: Episodes of Sexual Harassment - Description of the Behaviours experienced

Inappropriate comments | Comments or 'jokes' that are inappropriate - including comments that are negative, derogatory, belittling, sexist, racist, sarcastic, demeaning or containing sexual references.

Sexual advances | Unwanted sexual advances, touching, kissing, flirting or requests for sex.

Sexual innuendo | Sexual innuendo or comments of a sexual nature. Includes general references to sexual harassment that do not refer specifically to sexual advances.

Physical appearance | Being treated differently because of physical appearance or weight.

Sexual or gender discrimination | Discrimination based on gender or sexual orientation.

Belittling | Belittling, putting people down in front of others, humiliating others, name-calling, being derogatory, condescending, ridiculing, insulting or degrading.

Phone harassment | Inappropriate use of phone communication, including to abuse or intimidate.

RESPONDENTS' EXPERIENCES OF SEXUAL HARASSMENT

Respondents were asked:

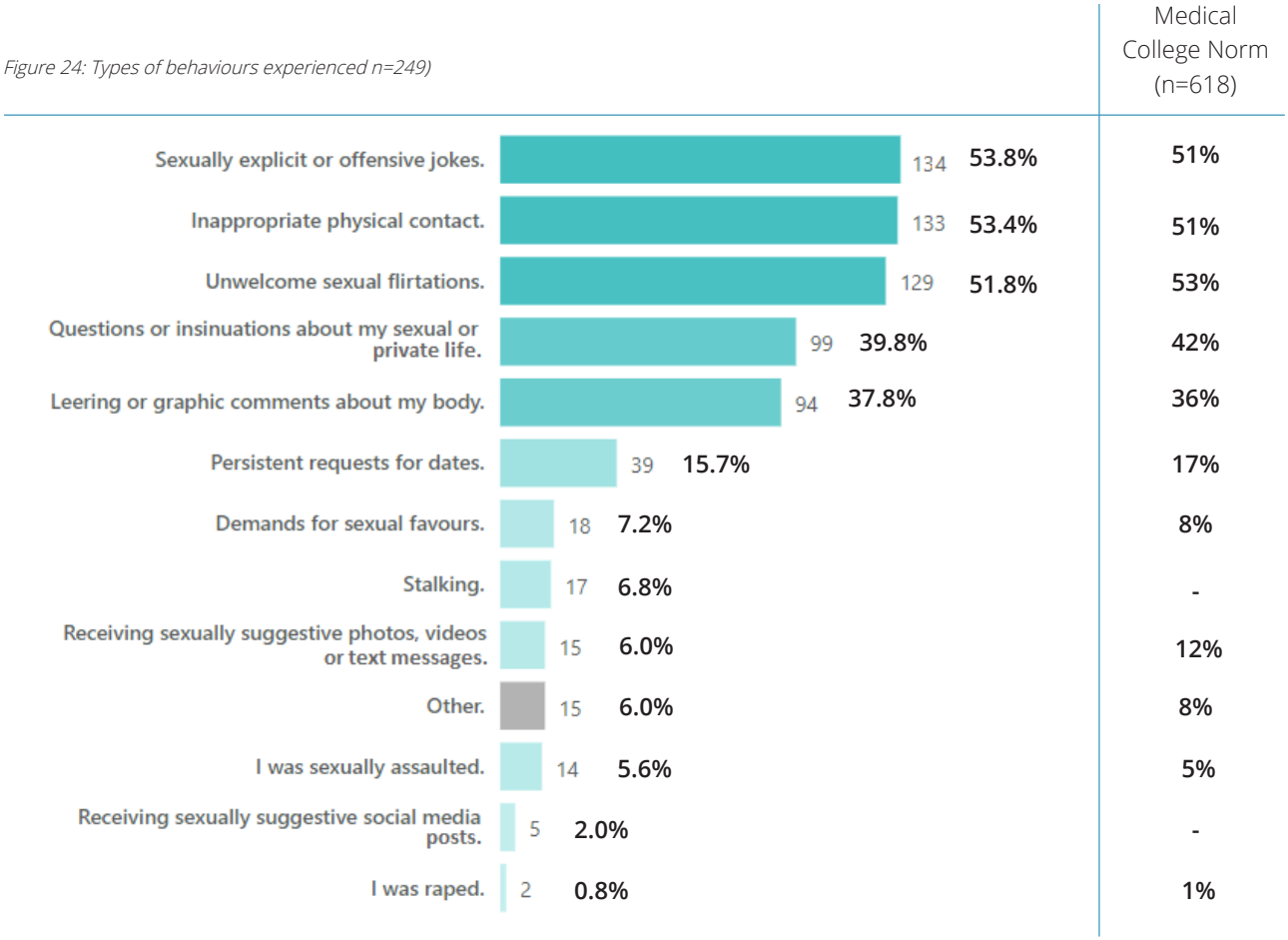
Q16: 'Have you ever been the recipient of any of these behaviours in the workplace by a professional colleague?'

In addition to telling their personal story, respondents were given a list of 12 commonly cited Sexual Harassment behaviours and asked to select the options they may have been the recipient of. Respondents were able to select as many as apply.

The top 3, each very close in their frequency of selection, are 'Sexually explicit or offensive jokes', 'Inappropriate physical contact', and 'Unwelcome sexual flirtations'.

The Medical Colleges norm for these behaviours is included. RANZCOG's ratings are similar to the norms with the exception of 'Receiving sexually suggestive photos, videos, emails or text messages' which is half the norm.

Figure 24: Types of behaviours experienced n=249)



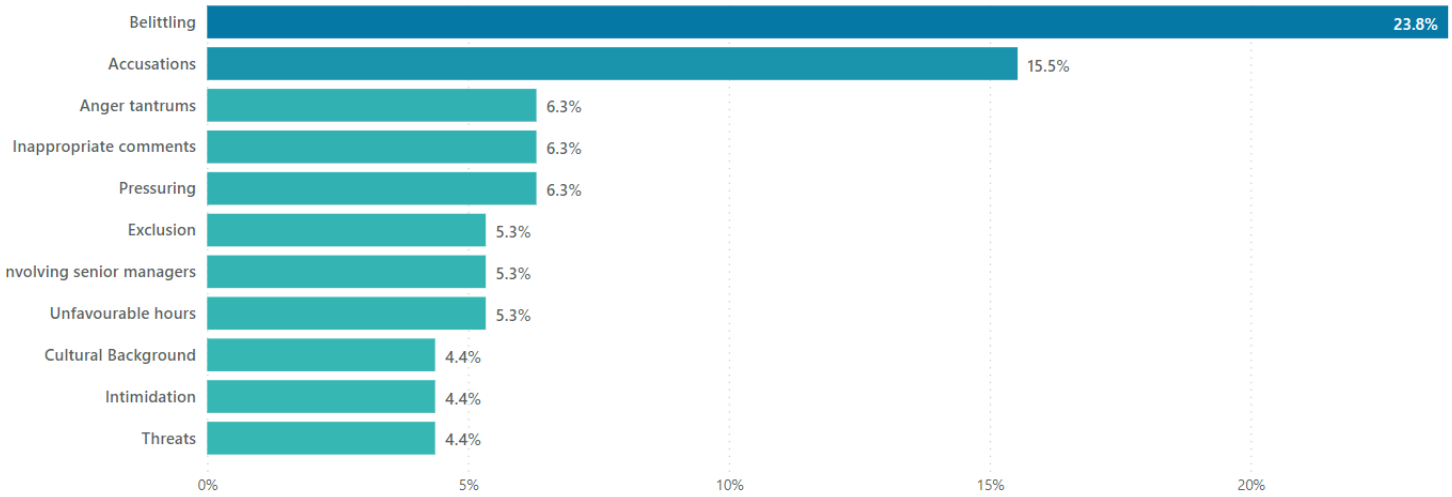
RESPONDENTS' EXPERIENCES OF HARASSMENT

206 personal stories from respondents produced the following 11 coding categories.

The prevalence statistic for **Harassment** is:

15.5%

Figure 25: Episode of Harassment - Description of Behaviour (n=218)



NB: The percentages on the bar chart are the % of respondents who triggered each category (needs a minimum of 4 respondents to trigger a category). The percentages will not tally to 100% because individual responses can be coded to multiple categories.

Definitions: Episodes of Harassment - Description of the Behaviours experienced

Belittling | Belittling, putting people down in front of others, humiliating others, name-calling, being derogatory, condescending, ridiculing, insulting or degrading.

Accusations | Inappropriate or false accusations, allegations, criticism, blame or reprimand. May also include victimisation, targeting, scapegoating or vilification.

Anger tantrums | Outbursts of anger tantrums, including yelling, shouting or screaming.

Inappropriate comments | Comments or 'jokes' that are inappropriate - including comments that are negative, derogatory, belittling, sexist, racist, sarcastic, demeaning or containing sexual references.

Pressuring | Feeling pressured or forced to do something. May include being physically punched or shoved.

Exclusion | Being excluded, ignored, isolated, overlooked, dismissed, denied access, marginalised, left out, sidelined or ostracized.

Involving senior managers | Involving the behaviour of senior managers or executive management.

Unfavourable hours | Unfavourable decisions about working hours, shifts or rosters.

Cultural Background | Being treated differently related to their cultural or ethnic background.

Intimidation | Intimidation, standover tactics, overbearing manner, horizontal violence, coercion or stalking.

Threats | Threats or threatening behaviour.

SCOPE OF THE BEHAVIOUR

In addition to the description of the behaviour experienced, the respondent was asked a series of quantitative questions to unpack the scope of the behaviour. Some of these questions include:

- The role of the person who displayed the behaviour against the respondent;
- The respondent's RANZCOG status when the behaviour occurred;
- The gender of the person who displayed the behaviour;
- Where the incident usually occurred (in the operating theatre, outpatient clinic, on the wards, etc.);
- The frequency of the behaviour during the respondent's career.

The following pages of this Summary drill-down into each of these issues.

SCOPE OF THE BEHAVIOUR – ROLE OF THE PERPETRATOR

Respondents were asked:

Q17: 'Which of the following persons have displayed this behaviour against you?'

Respondents were provided with a list of 12 positions/roles as to potential persons who displayed the DBSH behaviour against them.

Overwhelmingly, respondents implicate a Senior O&G Consultant as the primary perpetrator of any of the 4 DBSH behaviours, in 57% to 73% of responses.

This was followed by (but at a much lower frequency):

- Junior O&G Consultant - 15% to 29%
- Midwifery Staff - 4.3% to 27.5%
- Other Medical Consultant - 14.5% to 19.7%

On the following page is the full list of roles of the perpetrators and the percentage frequency of the role nominated by the respondent to this survey.

Respondents could select more than one option as perpetrators.

Senior O&G Consultants are nominated as being the primary perpetrator ...

- ... of Discrimination at 73.1% (n=463) - the highest prevalence rating of all 4 behaviours. The next highest prevalence is 44.2% lower, for Junior O&G Consultants at 28.9%.
- ... of Bullying at 63.3% (n=534), followed by Junior O&G Consultant (26.9%) and Midwifery Staff (20.4%) ;
- ... of Sexual Harassment at 57.4% (n=147), followed by Other Medical Consultant at 28.9% (n=74). The ratings then drop away to 15.2% for Junior O&G Consultants (n=39) as perpetrators and O&G Trainees at 10.9%.
- ... of Harassment at 62.5% (n=177), followed by Junior O&G Consultants at 20.8% (n=59) and Midwifery Staff at 15.9% (n=45). This follows the same pattern as Discrimination and Bullying.

Some exceptions to the most frequently occurring roles include:

- Junior O&G Consultant ranked 2nd as a person/s nominated for displaying 3 out of 4 of the DBSH behaviours, with Sexual Harassment being the exception.
- Midwifery staff rank 3rd as a person/s nominated for displaying 3 out of 4 of the DBSH behaviours, with Sexual Harassment being the exception, in which they ranked 8th.

SCOPE OF THE BEHAVIOUR – ROLE OF THE PERPETRATOR

Respondents were asked:

Q17: 'Which of the following persons have displayed this behaviour against you?'

Respondents were given the option to nominate the role of the perpetrator for each DBSH behaviour:

Table 21: Which of the following persons displayed this behaviour against you?

Person who displayed this behaviour	Discrimination (n= 633)	Bullying (n=844)	2016 Survey (n=505)	Sexual Harassment (n=256)	2016 Survey (n=99)	Harassment (n=283)
Senior O&G Consultant	73.1% [463]	63.3% [534]	69.5%	57.4% [147]	76.8%	62.5% [177]
Junior O&G Consultant	28.9% [183]	26.9% [227]	27.7%	15.2% [39]	17.2%	20.8% [59]
Other Medical Consultant	19.7% [125]	16.7% [141]	9.9%	28.9% [74]	7.1%	14.5% [41]
O&G Trainee	21.5% [136]	18.7% [158]	12.1%	10.9% [28]	7.1%	12.4% [35]
Other Trainee	5.1% [32]	4.7% [40]		8.6% [22]		4.2% [12]
Junior Medical Officer	3.9% [25]	1.9% [16]		6.3% [16]		3.2% [9]
Nursing Staff	16.9% [107]	10.9% [92]	5.9%	3.1% [8]	0%	8.1% [23]
Midwifery Staff	27.5% [174]	20.4% [172]	28.1%	4.3% [11]	3.0%	15.9% [45]
Allied Health Professional	2.4% [15]	1.2% [10]		1.2% [3]		1.1% [3]
Medical Administration Staff *(includes medical or nursing admin)*	21.8% [138]	13.6% [115]	18.2%	2.3% [6]	2.0%	11.7% [33]
Hospital Administration Staff	18.5% [117]	10.1% [85]		1.2% [3]		7.8% [22]
Other	6.3% [40]	6.6% [56]	7.5%	8.2% [21]	5.0%	6.7% [19]

SCOPE OF THE BEHAVIOUR – STATUS OF THE RESPONDENT WHEN THE BEHAVIOUR TOOK PLACE

Respondents were asked:

Q18: 'What was your status with RANZCOG at the time this behaviour took place?'

Tellingly, for all 4 DBSH behaviours, the incident occurs most frequently for FRANZCOG Trainees and Fellows.

Table 22: What was your status with RANZCOG at the time this behaviour took place?

Membership Status	Discrimination (n=627)	Bullying (n=838)	Sexual Harassment (n=254)	Harassment (n=273)
DRANZCOG Trainee	13.4% [84]	13.4% [112]	8.7% [22]	9.9% [27]
FRANZCOG Trainee	46.3% [290]	45.0% [377]	52.4% [133]	38.1% [104]
Diplomate	9.3% [58]	8.5% [71]	7.1% [18]	6.6% [18]
Fellow	33.3% [207]	31.5% [264]	17.7% [45]	41.0% [112]
SIMG	6.2% [39]	4.8% [40]	1.6% [4]	7.3% [20]
Other Specialist	2.2% [14]	1.7% [14]	1.2% [3]	2.2% [6]
Other Status	14.8% [93]	13.5% [113]	31.5% [80]	8.8% [24]

NB: The percentages will not tally to 100% because the respondents could select all that apply.

Some of the 'Other Statuses' nominated by the respondent by way of narrative comments include:

- Medical student
- Intern / resident / RMO / junior doctor
- Pre-training / pre-vocational

In the 2016 Survey **71.5%** [n=361] were a FRANZCOG Trainee at the time the incident took place

SCOPE OF THE BEHAVIOUR - GENDER OF THE PERPETRATOR

Respondents were asked:

Q19: 'What was the gender of the person/s who displayed this behaviour against you?'

Respondents were given five options to nominate the gender of the person who displayed any of the DBSH behaviours against them:

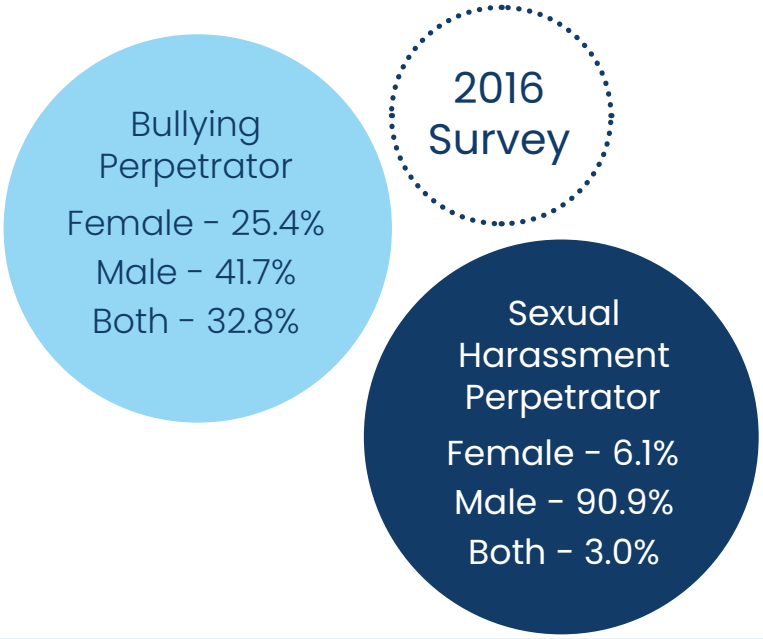
- Always male
- Always female
- Most of the time male
- Most of the time female
- Equal frequency of male and female

Always male or mostly male accounts for 89.8% of cases of sexual harassment, and more than 44% of the other behaviours.

The worst rating behaviour for female perpetrators is bullying, at 35.7% being always female or mostly female.

Table 23: What was the gender of the person/s who displayed this behaviour against you?

Person who displayed this behaviour	Discrimination (n= 628)	Bullying (n=845)	Sexual Harassment (n=257)	Harassment (n=276)
Always male	24.8% [156]	28.9% [244]	87.9% [226]	35.5% [98]
Always female	13.5% [85]	21.5% [186]	7.8% [20]	24.3% [67]
Most of the time male	22.8% [143]	15.1% [128]	1.9% [5]	12.3% [34]
Most of the time female	14.6% [92]	14.2% [120]	1.2% [3]	10.1% [28]
Equal frequency of male and female	24.2% [152]	20.2% [171]	1.2% [3]	17.8% [49]



SCOPE OF THE BEHAVIOUR – WHERE THE INCIDENT OCCURRED

Respondents were asked:

Q20: 'Where did this behaviour usually occur?'

Respondents were given seven options to nominate where the DBSH incident took place. They could select as many as applied.

Table 24: Where did the behaviour usually occur?

Location	Discrimination (n=623)	Bullying (n=833)	Sexual Harassment (n=254)	Harassment (n=270)
In the operating theatre	47.4% [295]	49.5% [412]	57.1% [145]	40.7% [110]
In the outpatient clinic	31.1% [194]	30.4% [253]	29.9% [76]	34.1% [92]
In the birth suite	43.0% [268]	46.3% [386]	24.8% [63]	39.3% [106]
On the wards	41.3% [257]	43.3% [361]	44.1% [112]	43.3% [117]
During teaching/training sessions	30.0% [187]	23.6% [197]	28.0% [71]	24.4% [66]
In private practice	7.7% [48]	8.4% [70]	8.3% [21]	9.3% [25]
Other setting	34.0% [212]	23.9% [199]	24.4% [62]	31.9% [86]

NB: The percentages will not tally to 100% because the respondents could select all that apply.

Figure 23: Top 5 locations for highest incidence of DBSH behaviours.

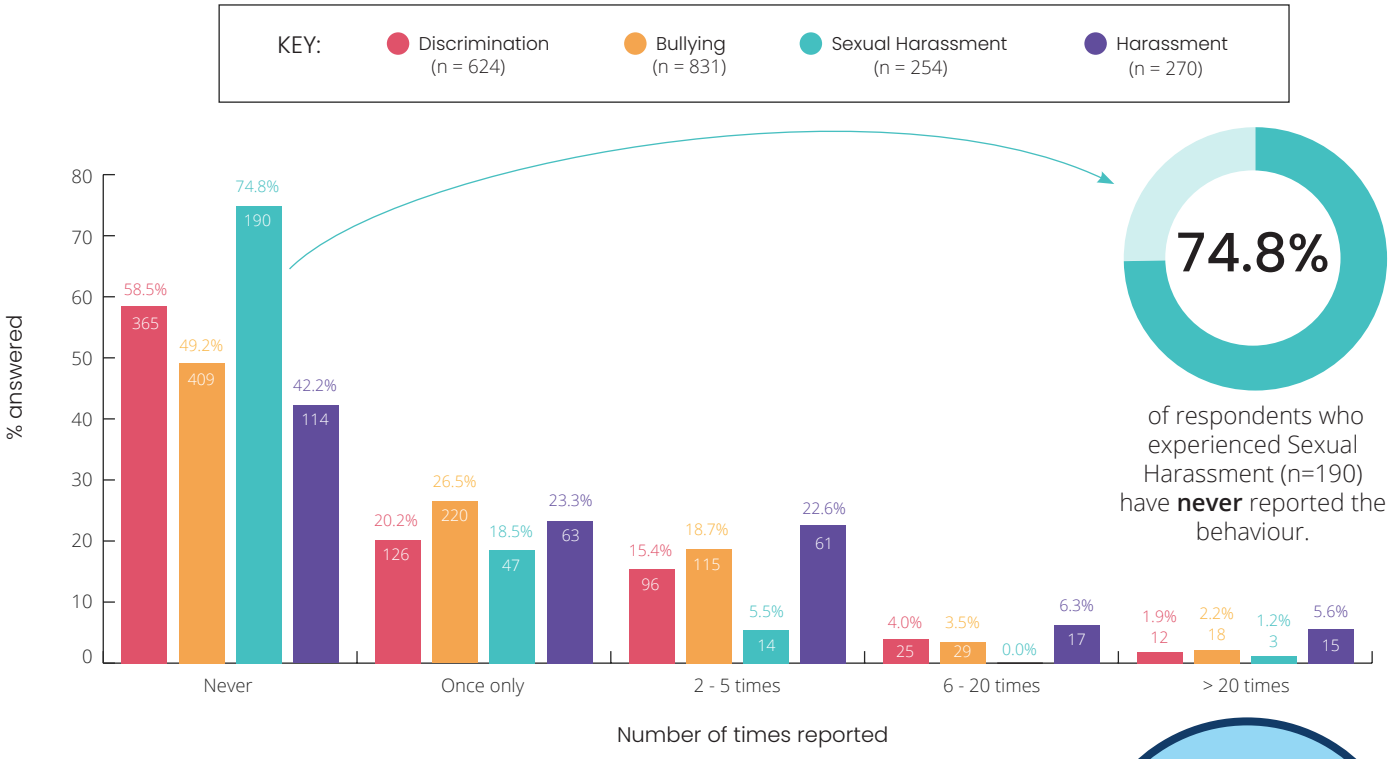
REPORTING DBSH

Respondents were asked:

Q21: 'How many times throughout your career have you reported this behaviour?'

More than 40% of respondents have never reported DBSH, and almost 75% of respondents who experienced Sexual Harassment have never reported it.

Figure 24: How many times throughout your career have you reported this behaviour?



When broken down by membership status, the rates of reporting are generally higher for Fellows >10 years than they are for FRANZCOG Trainees and Fellows <10 years, with the exception of the behaviour of Sexual Harassment. The table below reflects the percentage of respondents who have **never** reported DBSH.

In the 2016 Survey
24.1%
[n=200]
answered 'Yes' to reporting B&SH

Table 25: Membership status of respondents who have never reported DBSH throughout their career.

Membership Status	Discrimination	Bullying	Sexual Harassment	Harassment
FRANZCOG Trainee	57.3% [51]	41.8% [59]	74.5% [38]	27.0% [10]
Fellow <10 years	54.0% [94]	44.1% [93]	76.3% [45]	42.6% [23]
Fellow >10 years	62.1% [118]	54.4% [135]	66.7% [56]	49.1% [53]

TAKING ACTION

Respondents were asked:

Q22: 'Did you seek to address this behaviour in any of the following ways?'

Respondents were given a list of 18 options to choose from, including three options of no action:

- No I didn't want to;
- No, I wasn't able to at the time;
- No, I didn't feel I needed to.

For the 3 'no' options, a constructed demographic was built which is represented in the graph below.

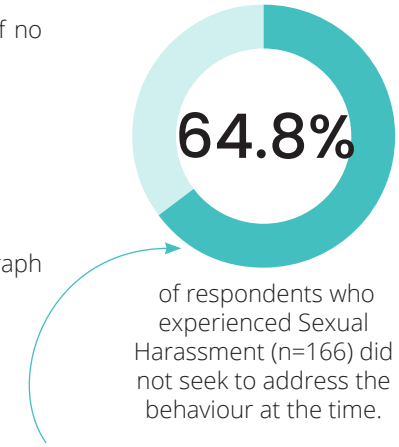
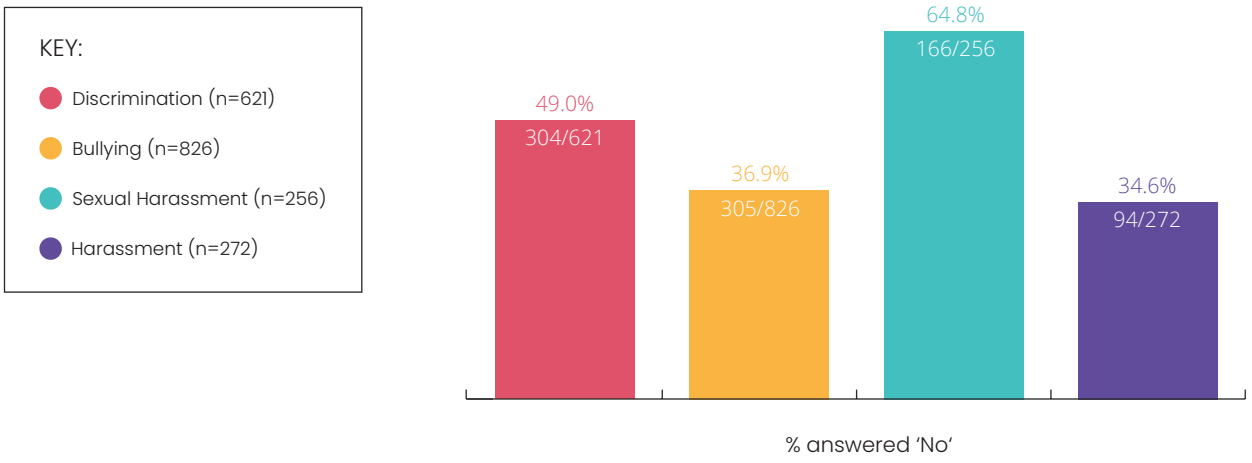


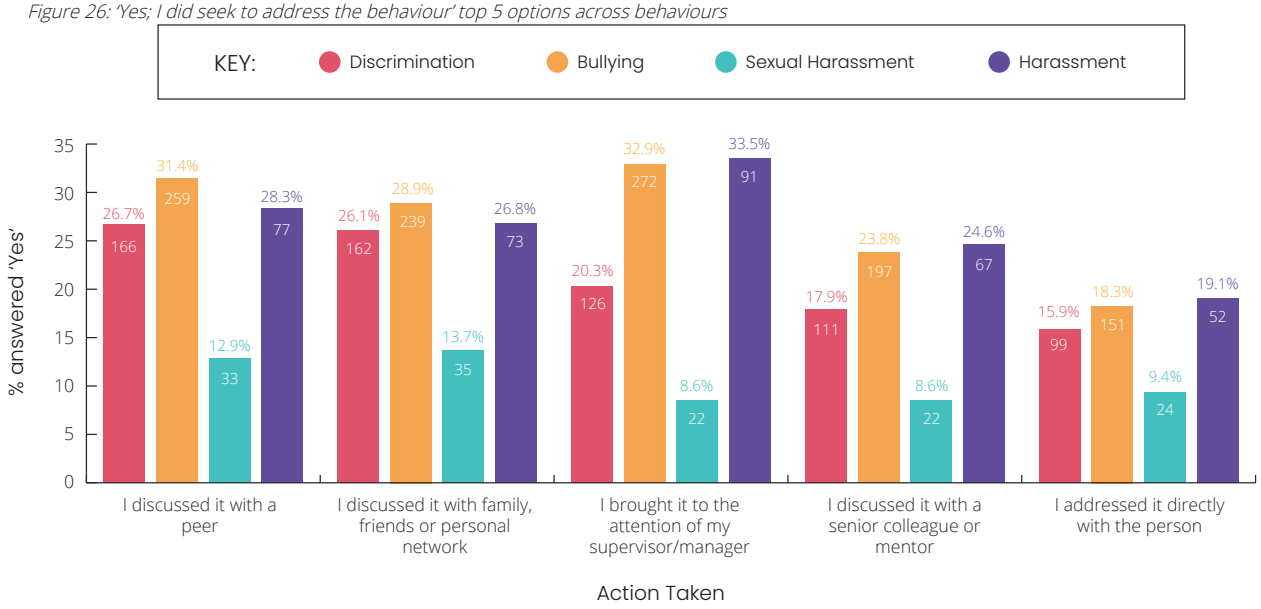
Figure 25: Did you seek to address this behaviour in any of the following ways? Percent who answered 'No'



TAKING ACTION

For the respondents who answered 'Yes, I did seek to address the behaviour', they were give a list of 15 options and could select as many as applied to them. The top 5 options with most commonality between the behaviours is illustrated in the graph below.

Figure 26: 'Yes; I did seek to address the behaviour' top 5 options across behaviours



For respondents who experienced Sexual Harassment, their top action in 18.4% of cases (n=47) was avoiding being on their own with the person. 1/5 did the same for Harassment.

Making an informal or formal complaint to Human Resources or another office in the workplace, or to RANZCOG rated low in terms of take-up rate, particularly in the case of Sexual Harassment.

Table 26: Percentage frequency of complaints to HR or RANZCOG

Unreasonable Behaviour	I made an informal or formal complaint to Human Resources or another office in the workplace (hospital, etc.)	I made a complaint to RANZCOG
Discrimination (n=621)	12.9% [80]	6.4% [40]
Bullying (n=826)	16.7% [138]	4.8% [40]
Sexual Harassment (n=256)	6.3% [16]	0%
Harassment (n=272)	18.4% [50]	6.6% [18]

Respondents speaking to their employer's or RANZCOG's counselling service rated even lower.

Table 27: Percentage frequency of complaints to their employer's or RANZCOG's counselling service

Unreasonable Behaviour	I spoke to my employer's counselling service	I spoke to RANZCOG's counselling service
Discrimination (n=621)	2.4% [15]	2.6% [16]
Bullying (n=826)	3.4% [28]	3.3% [27]
Sexual Harassment (n=256)	0.8% [2]	0%
Harassment (n=272)	2.9% [8]	3.3% [9]

RESULT OF ACTION TAKEN

Respondents were asked:

Q23: 'What was the result of the action/s you took?'

Respondents were provided with a list of 18 options including an 'other' category where they could type in a response.

Significant results with commonality across all 4 DBSH Behaviours are identified in the table below.

Table 28: Result of Action taken

Result of Action Taken	Discrimination (n=313)	Bullying (n=515)	Sexual Harassment (n=85)	Harassment (n=177)
Not applicable as I did not take action.	9.9% [31]	7.4% [38]	28.2% [24]	7.3% [13]
I did not expect action to be taken	24.9% [78]	19.2% [99]	12.9% [11]	14.7% [26]
The unreasonable behaviour continued	29.1% [91]	28.7% [148]	7.1% [6]	36.7% [65]
I was victimised for making a complaint	23.0% [72]	18.4% [95]	12.9% [11]	23.2% [41]
I moved to another location *(state/town/country)*	20.1% [63]	21.6% [111]	17.6% [15]	19.8% [35]
Complaint not progressed by receiving body	16.6% [52]	11.5% [59]	8.2% [7]	14.7% [26]
The unreasonable behaviour stopped	7.3% [23]	9.3% [48]	20.0% [17]	9.6% [17]
Other	17.6% [55]	21.2% [109]	22.4% [19]	21.5% [38]

NB: Not all options are reflected in the table above - only the top 8 with commonality. The percentages will not tally to 100% because the respondents could select all that apply.

As with other sections in this report, the ratings for Sexual Harassment have a few notable differences to the other three behaviours (also noting the smaller respondent pool).

- 28.2% (24 respondents) did not take action, compared to a range of 7.3% to 9.9% across the other three behaviours.
- 20% (17 respondents) selected 'the unreasonable behaviour stopped', compared to a much lower range of 7.3% to 9.6% across the other three behaviours.
- 7.1% (6 respondents) selected 'the unreasonable behaviour continued', compared to the much higher range of 28.7% to 36.7% across the other three behaviours.

RESOLUTION

Respondents were asked:

Q24: 'How many of the instances of this behaviour have been resolved to your satisfaction?'

The options were:

- All of them
- Most of them
- A majority of them
- Less than half of them
- Only some of them
- None of them

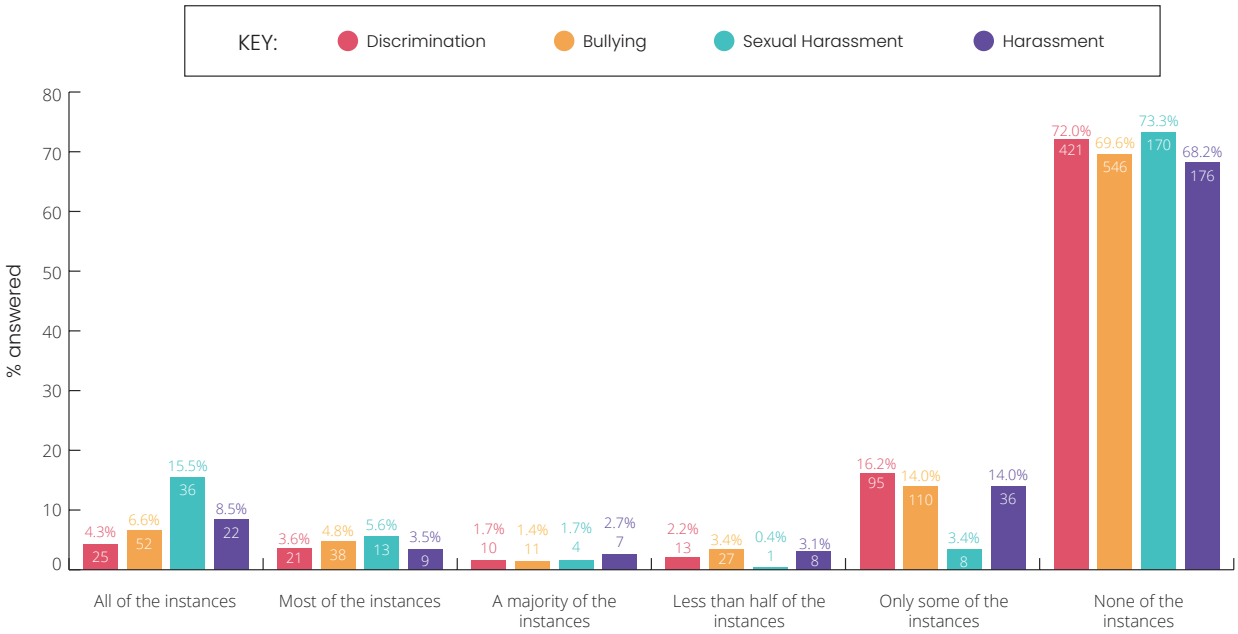
Overwhelmingly as evidenced in the graph below, in the vast majority of cases, none of the instances have been resolved to the respondent's satisfaction.

The pattern of non-resolution is similar across all membership statuses.

Table 29: How many instances of this behaviour have been resolved to your satisfaction?

Resolution	Discrimination (n= 585)	Bullying (n=784)	Sexual Harassment (n=232)	Harassment (n=258)
All instances resolved	4.3%	6.6%	15.5%	8.5%
Most instances resolved	3.6%	4.8%	5.6%	3.5%
A majority of instances resolved	1.7%	1.4%	1.7%	2.7%
Less than half of instances resolved	2.2%	3.4%	0.4%	3.1%
Only some instances resolved	16.2%	14.0%	3.4%	14.0%
No instances resolved	72.0%	69.6%	73.3%	68.2%

Figure 27: How many instances of this behaviour have been resolved to your satisfaction?



POTENTIAL BARRIERS TO ACTION TAKEN

Respondents were asked

Q25: 'Did you experience any of the following potential barriers in your decision about whether to take action or not?'

Respondents were provided with a list of 17 options including 'Other (please specify)'.

The number 1 barrier to taking action is the effect on future career options. It ranks highest across all four behaviours.

The percentages are low when it comes to respondents not being aware of how to make a formal complaint. There are other factors at play that are preventing respondents from taking action.

The top 10 barriers in common across all 4 DBSH Behaviours are identified in the table below.

Table 30: The barrier to me taking action to address this behaviour was ...

Barriers to taking action	Discrimination [n=619]	Bullying [n=819]	Sexual Harassment [n=250]	Harassment [n=268]
Effect on future career options	64.1% [397]	55.7% [456]	54.0% [135]	44.4% [119]
The stress associated with filing a complaint and enduring an investigation	41.8% [259]	43.3% [355]	40.4% [101]	38.8% [104]
Potential for victimisation	42.0% [260]	41.9% [343]	35.2% [88]	41.0% [110]
Effect on assessments	40.9% [253]	39.3% [322]	41.2% [103]	35.8% [96]
Loss of reputation for self	35.4% [219]	35.9% [294]	37.2% [93]	35.8% [96]
Uncertainty about whether the behaviour would be judged as serious enough	33.8% [209]	32.4% [265]	44.8% [112]	29.1% [78]
Impact on my daily practice	33.6% [208]	38.6% [316]	29.2% [73]	38.4% [103]
Loss of support from supervisors, colleagues, friends, partner, family.	36.7% [227]	29.7% [243]	30.8% [77]	32.8% [88]
Fear of being blamed	21.6% [134]	22.1% [181]	28.8% [72]	25.7% [69]
I was not aware how to make a formal complaint	13.2% [82]	12.3% [101]	15.2% [38]	11.6% [31]

In the cases of Sexual Harassment, there were two questions that rated notably different to the other three behaviours:

- 44.8% (112 respondents) selected 'uncertainty about whether the behaviour would be judged as serious enough', compared to a lower range of 29.1% to 33.8% across the other behaviours. This was felt by the <34 years age group where 49.5% (n=-50) agreed - a statistically significant outcome.
- 29.2% (73 respondents) selected 'impact on my daily practice' compared to a higher range of 33.6% to 38.6% across the other behaviours.

RESPONDENTS' EXPERIENCES OF REPERCUSSIONS

Respondents were asked:

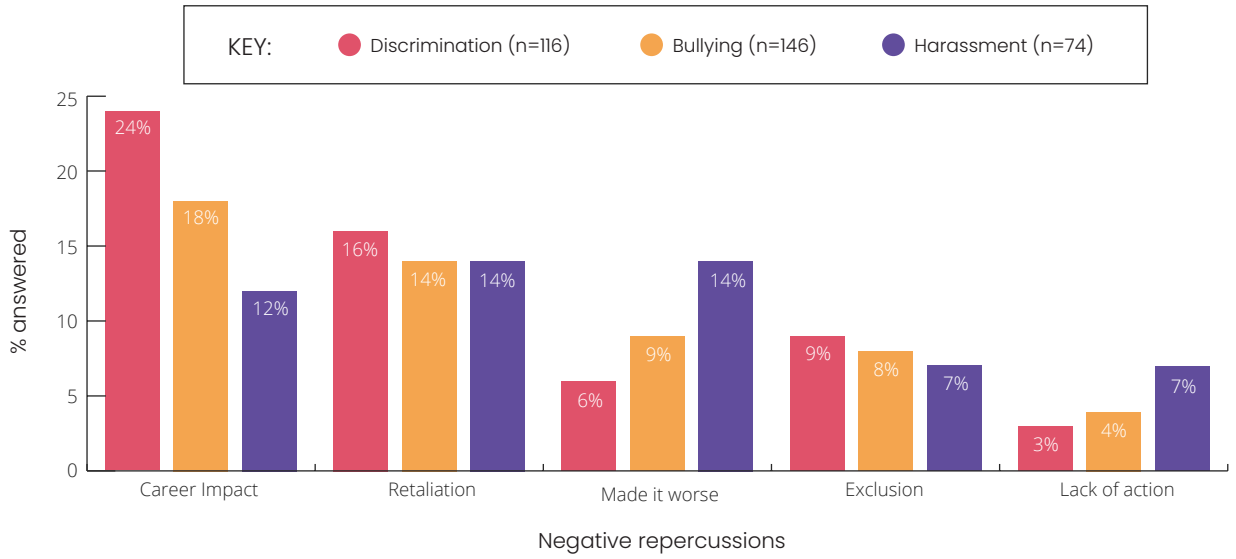
Q26: 'Have you ever experienced negative repercussions from reporting your experiences?'

The results reflected below exclude any respondents who stated in Q22 that they did not take any action.

Table 31: Negative repercussions from reporting experiences.

Experience of negative repercussions	Discrimination (n=242)	Bullying (n=415)	Sexual Harassment (n=51)	Harassment (n=161)
Yes, I experienced negative repercussions	50.0%	39.5%	31.4%	51.6%
No, I did not experience negative repercussions	20.7%	33.3%	54.9%	20.5%
Not sure, or not applicable	29.3%	27.2%	13.7%	28.0%

Where respondents answered 'yes', they were asked to provide a description of the negative repercussions they experienced. Of the respondents who provided a narrative comment, the following graph reflects the four most common concepts across the three behaviours of Discrimination, Bullying and Harassment. Sexual Harassment did not receive enough responses for linguistic analysis to be performed.



Each behaviour had some differences in the most common themes, some of which were:

...for Harassment, Psychological impact at 11% of mentions

...for Discrimination, Power imbalance and Victim blaming both at 9% of mentions

...for Bullying, Victim blaming at 8% and Power imbalance at 7% of mentions

RESPONDENTS' EXPERIENCES OF REPERCUSSIONS

Respondents were asked:

Q27: 'Did you experience any of the following as a result of this behaviour?' (i.e. reporting your experiences).

Respondents were provided with a list of 8 options including an 'other' category where they could type in a narrative response.

For all four behaviours, experiencing 'hurtful and humiliating comments' made about them or to them was the most common negative repercussion experienced.

Table 32: Did you experience any of the following as a result of this behaviour?

Negative repercussion	Discrimination (n= 497)	Bullying (n=579)	Sexual Harassment (n=83)	Harassment (n=205)
Being denied operating lists	27.8% [138]	22.3% [129]	12.0% [10]	22.4% [46]
Being excluded from meetings directly related to my role	19.9% [99]	21.6% [125]	14.5% [12]	22.4% [46]
Being assigned meaningless tasks unrelated to my role	25.6% [127]	25.4% [147]	18.1% [15]	23.9% [49]
Being excluded from social events where other colleagues have been invited	20.3% [101]	18.0% [104]	21.7% [18]	18.0% [37]
Being denied a promotion/job	29.8% [148]	18.8% [109]	27.7% [23]	28.8% [59]
Being denied training opportunities	40.4% [201]	31.6% [183]	20.5% [17]	27.8% [57]
Hurtful and humiliating comments made about or towards me	57.7% [287]	65.8% [381]	44.6% [37]	62.0% [127]
Another detriment	19.7% [98]	24.5% [142]	37.3% [31]	23.9% [49]

NB: The percentages will not tally to 100% because the respondents could select all that apply.

REFLECTION ON THE EXPERIENCE

Respondents were then asked:

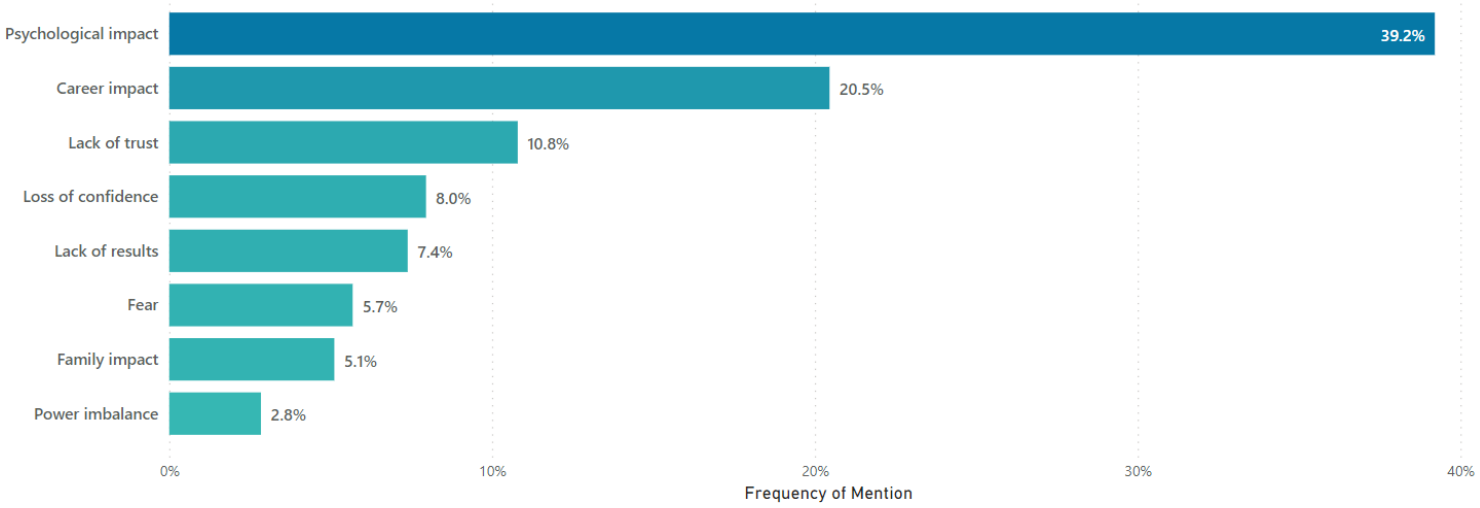
Q28: 'Do your experience/s of this behaviour still have negative repercussions for you today?'

Table 33: Current experience of negative repercussions

I still experience negative repercussions today from this experience	Discrimination (n=615)	Bullying (n=820)	Sexual Harassment (n=248)	Harassment (n=270)
Yes	45.4% [279]	44.3% [363]	20.6% [51]	51.1% [138]
No	31.5% [194]	36.7% [301]	61.7% [153]	29.6% [80]
Not sure	23.1% [142]	19.0% [156]	17.7% [44]	19.3% [52]

Where respondents answered 'yes', they were asked to provide a description of the negative repercussions they are still experiencing. Discrimination was the only behaviour where enough responses were received for linguistic analysis to be performed.

Figure 28: Description of ongoing repercussion (n=176)



REFLECTION ON TAKING ACTION ON DBSH

Respondents were asked:

Q29: 'In hindsight, what is one thing that could have been done differently that would have made it safer or easier for you to take action on this behaviour?'

1,150 narrative text responses were received across all four behaviours:

- 356 comments from being discriminated against;
- 500 comments from being bullied;
- 138 comments from being sexually harassed;
- 156 comments from being harassed.

BPA applied its Linguistic Analysis Methodology to each of the narrative text comments and coded the verbatim text using the same dictionary across all four behaviours.

Across all 4 DBSH behaviours, there is overlap in the areas respondents felt could be improved to make it easier or safer to take action. The top 5 areas in common were:

Support, defined as support, especially for those pursuing a complaint.

Avenues for reporting, defined as existence, awareness, or availability of systems and pathways for reporting.

Action, defined as reports being acted upon, taken seriously, listened to, or followed up.

Cultural change, defined as changing the culture so the behaviour is no longer endemic or accepted.

Speaking out, defined as speaking out, standing up, or calling out bad behaviour.

Whilst there is overlap in the coding of each behaviour, there are also noticeable differences. Some of the concepts that were unique to each behaviour are listed below.

Discrimination - 'Discussing it' was the 6th highest mention and is defined as 'discussing, raising, or talking about DBSH issues, with superiors or peers'. Inclusion was another notable (and logical) difference, with this being defined as 'inclusion, acceptance, and workplace diversity'.

Bullying - Empowerment was the 7th highest mention and is defined as 'empowerment of victims to complain, or mitigating power imbalances'. Third party involvement was also featured, representing respondents' desire for the 'involvement of, or access to, an independent third party' when taking action.

Sexual Harassment - Education came in with the highest mention, notable as this is the only DBSH behaviour in which it featured in the top 10, as with 'Policies' at number 3. The dominance of these two concepts reflects a desire for more formalised training and procedures to address this behaviour.

Harassment - The most notable differences in this behaviour was the inclusion of 'Changing jobs' and 'Departure of perpetrator' at number 5 and 7 respectively. There is an implication here that recipients of this behaviour feel that the best course of action is being removed from the situation - through either the perpetrator or themselves leaving their job.

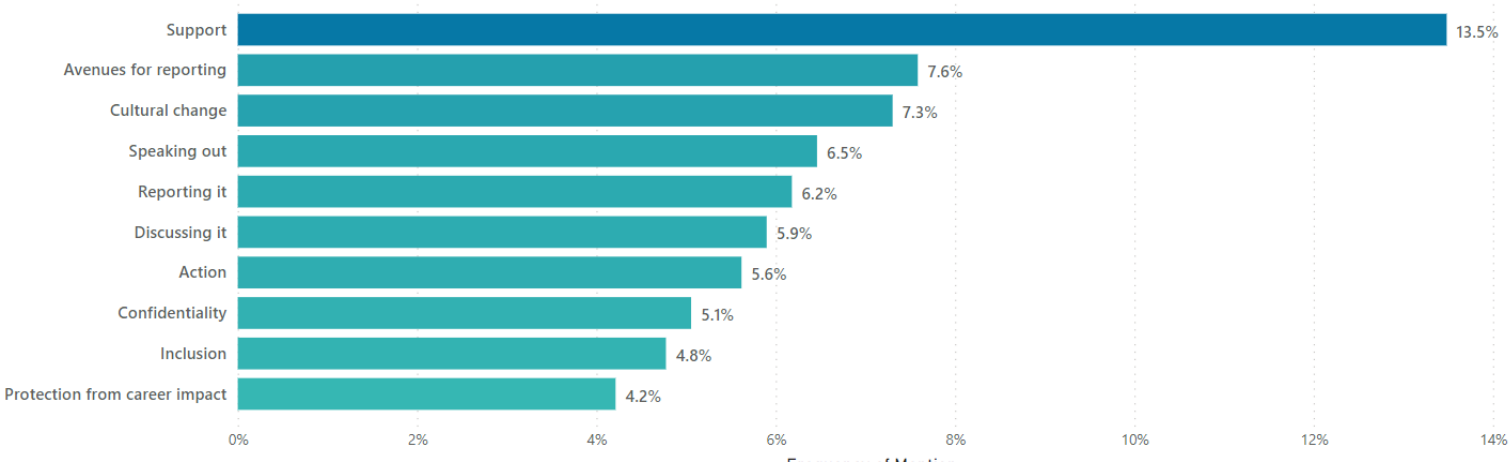
The next 4 pages of this summary include a graph of the coding categories for each of the DBSH behaviours.

Included with each graph is BPA's definition of each coding concept – the words that make-up the coding category.

REFLECTION ON TAKING ACTION ON DISCRIMINATION

356 narrative comments from respondents produced the following 10 coding categories.

Figure 29: Barriers to addressing Discrimination



NB: The percentages on the bar chart are the % of respondents who triggered each category (needs a minimum of 4 respondents to trigger a category). The percentages will not tally to 100% because individual responses can be coded to multiple categories.

Definitions: Barriers to Addressing Discrimination - Better Ways Forward

Support | Support, especially for those pursuing a complaint.

Avenues for reporting | Existence, awareness, or availability of systems and pathways for reporting.

Cultural change | Changing the culture so the behaviour is no longer endemic or accepted.

Speaking out | Speaking out, standing up, or calling out bad behaviour.

Reporting it | Reporting it, escalating it, or making a formal complaint.

Discussing it | Discussing, raising, or talking about DBSH issues, with superiors or peers.

Action | Reports acted upon, taken seriously, listened to, or followed up.

Confidentiality | Confidentiality or anonymity in the reporting process.

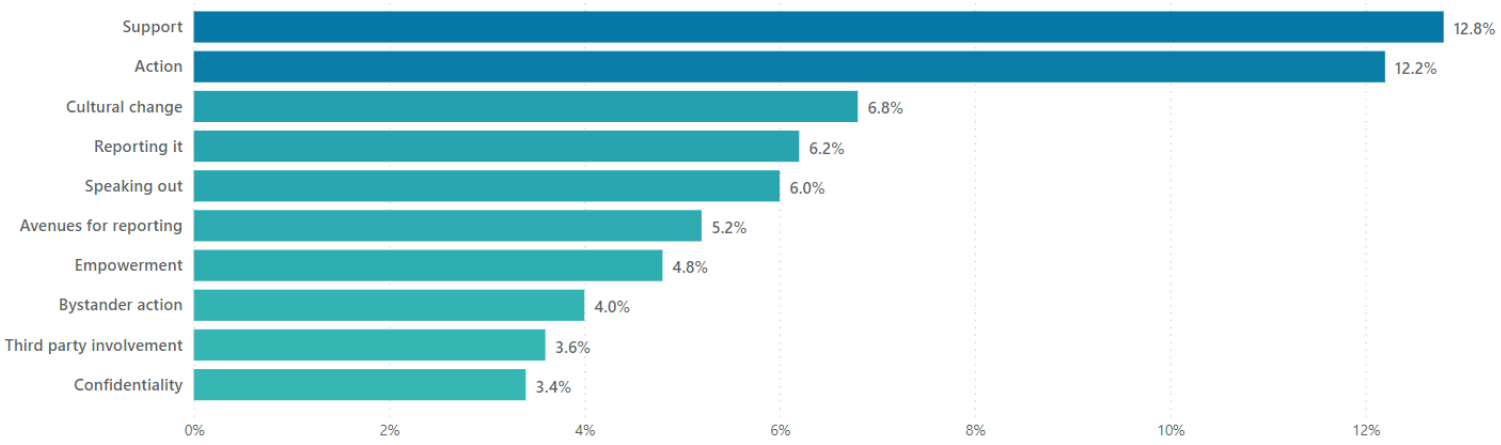
Inclusion | Inclusion, acceptance, and workplace diversity.

Protection from career impact | Protection from loss, limitation, or withdrawal of career or training opportunities.

REFLECTION ON TAKING ACTION ON BULLYING

500 narrative comments from respondents produced the following 10 coding categories.

Figure 30: Barriers to addressing Bullying



NB: The percentages on the bar chart are the % of respondents who triggered each category (needs a minimum of 4 respondents to trigger a category). The percentages will not tally to 100% because individual responses can be coded to multiple categories.

Definitions: Barriers to Addressing Bullying - Better Ways Forward

Support | Support, especially for those pursuing a complaint.

Action | Reports acted upon, taken seriously, listened to, or followed up.

Cultural change | Changing the culture so the behaviour is no longer endemic or accepted.

Reporting it | Reporting it, escalating it, or making a formal complaint.

Speaking out | Speaking out, standing up, or calling out bad behaviour.

Avenues for reporting | Existence, awareness, or availability of systems and pathways for reporting.

Empowerment | Empowerment of victims to complain, or mitigating power imbalances.

Bystander action | Bystanders and witnesses stepping in, reporting it, or taking action.

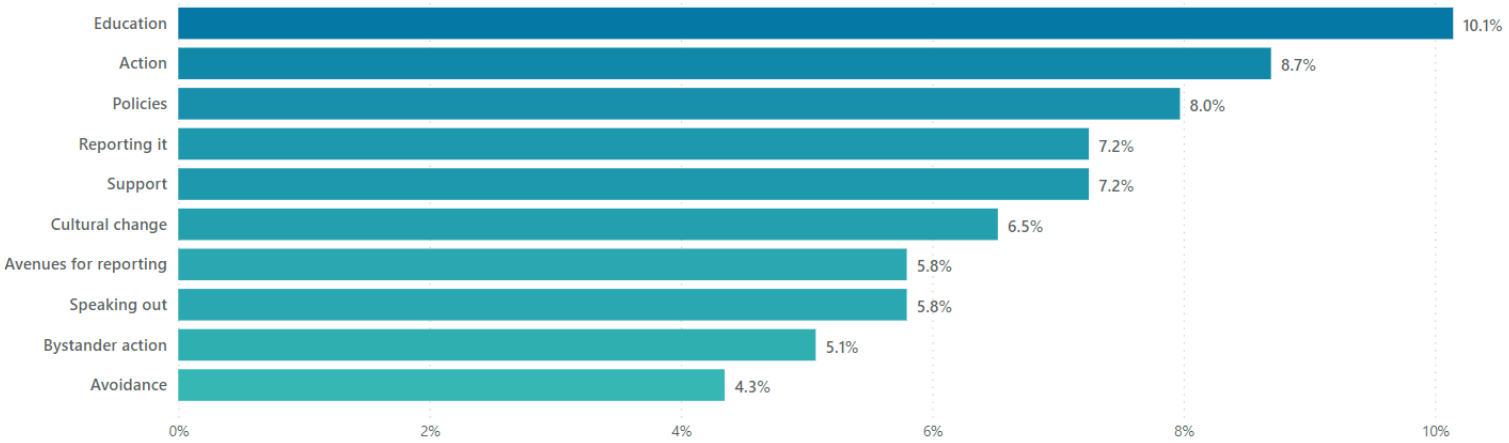
Third party involvement | The involvement of, or access to, an independent third party.

Confidentiality | Confidentiality or anonymity in the reporting process.

REFLECTION ON TAKING ACTION ON SEXUAL HARASSMENT

138 narrative comments from respondents produced the following 10 coding categories.

Figure 31: Barriers to addressing Sexual Harassment



NB: The percentages on the bar chart are the % of respondents who triggered each category (needs a minimum of 4 respondents to trigger a category). The percentages will not tally to 100% because individual responses can be coded to multiple categories.

Definitions: Barriers to Addressing Sexual Harassment - Better Ways Forward

Education | Education on DBSH issues, including identifying and managing behaviour.

Action | Reports acted upon, taken seriously, listened to, or followed up.

Policies | Policies, protocols, guidelines, or a code of conduct.

Reporting it | Reporting it, escalating it, or making a formal complaint.

Support | Support, especially for those pursuing a complaint.

Cultural change | Changing the culture so the behaviour is no longer endemic or accepted.

Avenues for reporting | Existence, awareness, or availability of systems and pathways for reporting.

Speaking out | Speaking out, standing up, or calling out bad behaviour.

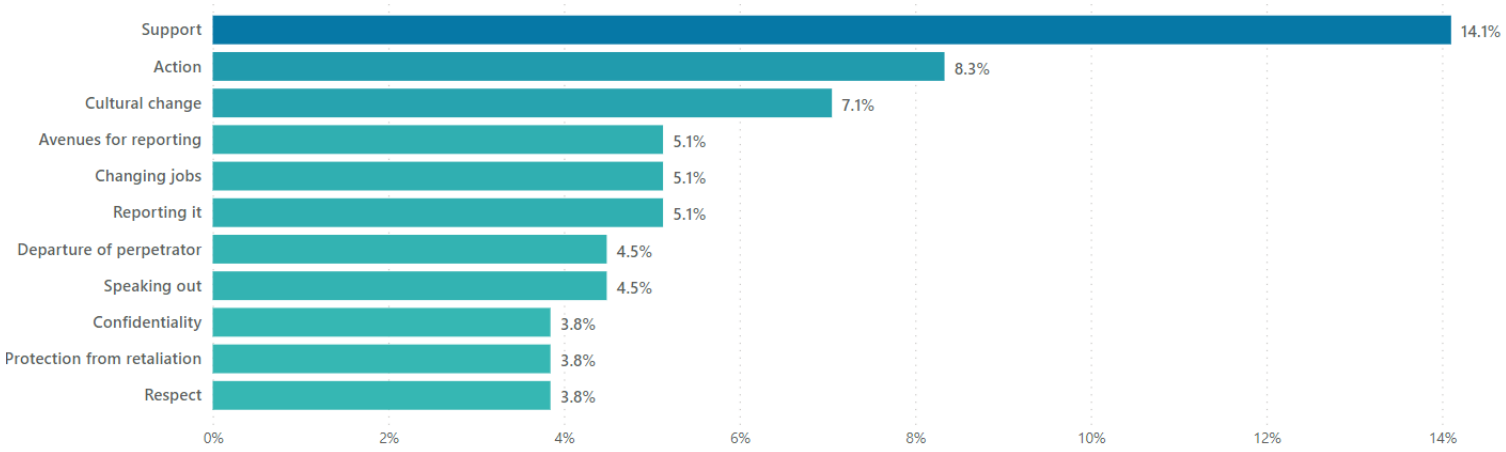
Bystander action | Bystanders and witnesses stepping in, reporting it, or taking action.

Avoidance | Avoidance of the perpetrator or workplace, or not getting into that situation in the first place.

REFLECTION ON TAKING ACTION ON HARASSMENT

156 narrative comments from respondents produced the following 11 coding categories.

Figure 32: Barriers to addressing Harassment



NB: The percentages on the bar chart are the % of respondents who triggered each category (needs a minimum of 4 respondents to trigger a category). The percentages will not tally to 100% because individual responses can be coded to multiple categories.

Definitions: Barriers to Addressing Harassment - Better Ways Forward

Support | Support, especially for those pursuing a complaint.

Action | Reports acted upon, taken seriously, listened to, or followed up.

Cultural change | Changing the culture so the behaviour is no longer endemic or accepted.

Avenues for reporting | Existence, awareness, or availability of systems and pathways for reporting.

Changing jobs | The decision or need to move to a new workplace, job, or career.

Reporting it | Reporting it, escalating it, or making a formal complaint.

Departure of perpetrator | Perpetrator leaving or being terminated, removed, suspended, or obligated to resign.

Speaking out | Speaking out, standing up, or calling out bad behaviour.

Confidentiality | Confidentiality or anonymity in the reporting process.

Protection from retaliation | Protection from retaliation, retribution, backlash, or other targeted adverse reactions.

Respect | Treating others with respect, fairness, or kindness.

BYSTANDER OBSERVATIONS OF DBSH

Respondents were asked:

Q30: 'In the past 5 years, have you observed a colleague experiencing DBSH behaviours in the workplace?'

904 answered 'Yes' which equates to 50.2% of respondents.

A number of respondents have witnessed more than one type of behaviour, with bullying in the workplace ranking highest in terms of frequency of mentions by respondents at 37.0%.

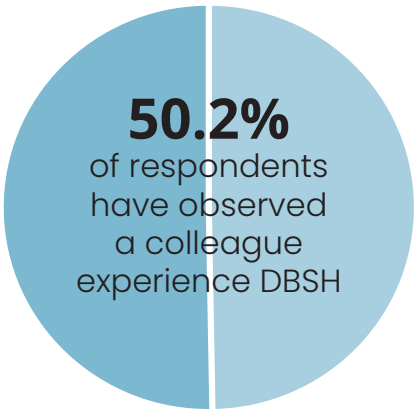
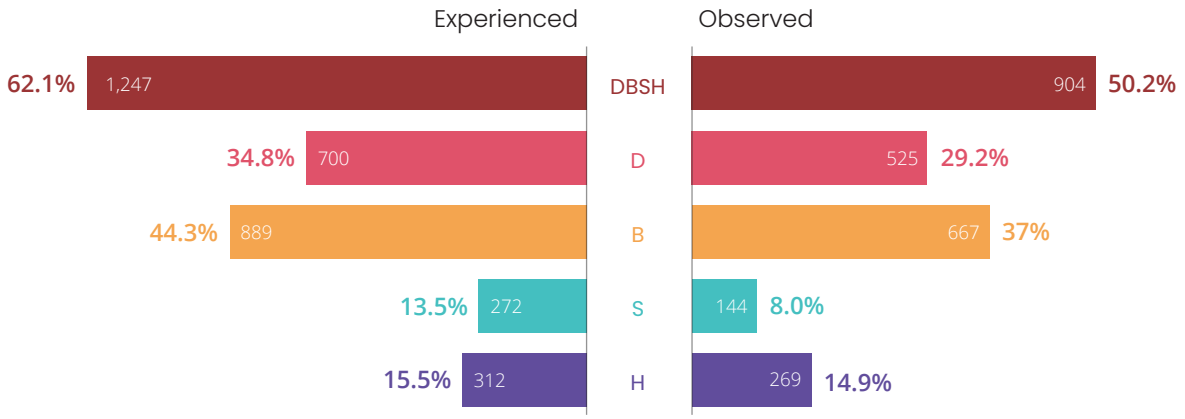


Table 34: Have you observed a colleague experiencing DBSH in the workplace?

Observed unreasonable behaviour (by a professional colleague)	No. of respondents	No of respondents who answered 'Yes'	% answered 'Yes' - observed behaviour
DBSH	1,801	904	50.2%
Discrimination	1,801	525	29.2%
Bullying	1,801	667	37.0%
Sexual Harassment	1,801	144	8.0%
Harassment	1,801	269	14.9%

A comparison between experienced and observed behaviour produces the following results:

Figure 32: Comparison of experienced vs observed DBSH behaviours



BYSTANDER OBSERVATIONS OF DBSH

Respondents were asked:

Q32: 'Reflecting on the most recent instance when you observed this behaviour, did you report it?'

Table 35: Did you report the most recent instance of observing a DBSH behaviour?

Unreasonable behaviour observed	No. of respondents	No. of respondents who reported the behaviour	% who answered 'Yes'	% who answered 'No'
Discrimination	439	107	24.4%	75.6%
Bullying	609	207	34.0%	66.0%
Sexual Harassment	129	30	23.3%	76.7%
Harassment	248	90	36.3%	63.7%

Where respondents answered 'no', they were asked what prevented them from reporting the behaviour.

616 respondents provided a narrative comment across all four behaviours:

BPA applied its Linguistic Analysis Methodology to each of the narrative text comments and coded the verbatim text using the same dictionary across all four behaviours. The top 7 reasons (and their definitions) in common across all 4 behaviours have been provided below.

1) **Power Imbalance**: Perpetrators holding a more senior or powerful position, or victims feeling powerless.

2) **Fear**: Fear, intimidation, or being too scared to complain or act.

3) **Retaliation**: Retaliation, retribution, backlash, or other targeted adverse reactions.

4) **Not my place**: Not my place to act, or the victim asked me not to.

5) **Career impact**: Loss, limitation, or withdrawal of career or training opportunities.

6) **No action required**: No action was necessary, or the victim handled it themselves.

7) **Informal resolution**: Handling problems informally, in person, or without immediate escalation.

Three of the top four reasons that observers did not report the incident are telling, indicating that there is a common feeling of fear around repercussions and implications on career prospects.

Aside from the order of dominance, there is very little difference between the responses given across the four behaviours. Some of the exceptions are listed below.

- **Part of the culture**: The behaviour is part of the culture, part of the job, endemic, or widely accepted (featured under Discrimination, Bullying).
- **No point reporting**: Reporting is pointless, a waste of time, not worthwhile, couldn't be bothered (Discrimination, Harassment).
- **Not being believed:** Not being believed, not having evidence, or behaviour too subtle to prove (Discrimination, Harassment).
- **Unsure if it was DBSH**: The behaviour is part of the culture, part of the job, endemic, or widely accepted (Bullying).

BYSTANDER TAKING ACTION

75-86% agree they would speak with the victim of DBSH, but <25% agree they would speak with the perpetrator

Respondents were asked:

Q33: 'Did you speak to the recipient about this observed behaviour?'

Table 36: Did you speak to the recipient of DBSH about the experience?

Unreasonable behaviour	No. of respondents	No. of respondents who spoke to the recipient	% who answered 'Yes'	% who answered 'No'
Discrimination	478	362	75.7%	24.3%
Bullying	653	557	85.3%	14.7%
Sexual Harassment	136	106	77.9%	22.1%
Harassment	263	227	86.3%	13.7%

Respondents were asked:

Q34: 'Did you speak to the person responsible about their behaviour?'

Table 37: Did you speak to the person responsible about their behaviour?

Unreasonable behaviour	No. of respondents	No of respondents who spoke to the perpetrator	% who answered 'Yes'	% who answered 'No'
Discrimination	476	115	24.2%	75.8%
Bullying	650	156	24.0%	76.0%
Sexual Harassment	136	30	22.1%	77.9%
Harassment	262	66	25.2%	74.8%

As evident above, there is very little difference in the level of agreement that the observer would speak to the perpetrator. The percentage who agree is low.

Age and length of time as a Fellow (>10 years) had the most impact on whether the respondent would speak with the perpetrator. A comparison between the two cohorts is outlined below.

Table 38: Did you speak to the person responsible about their behaviour?

Unreasonable behaviour	% of Fellows <10 years who spoke to the perpetrator	% of Fellows >10 years who spoke to the perpetrator
Discrimination	20.9% [n=27]	41.6% [n=52]
Bullying	17.1% [n=27]	44.7% [n=71]
Sexual Harassment	11.4% [n=4]	35.3% [n=12]
Harassment	13.1% [n=8]	48.8% [n=39]

REPORTING DBSH IN THE FUTURE

Respondents were asked:

Q35: 'In the future, if you were to be the subject of DBSH in your primary workplace, to whom would you report the behaviour?'

Respondents were given a list of 10 options represented in the table below.

Whilst 42% - 75% of respondents indicated that they have never reported their personal experience of any one of the DBSH behaviours in the past, only 8.3% responded that they would **not report** DBSH in the future.

Table 39: Where would you report DBSH in the future?

In the future, I would report the behaviour to...	No. of respondents who would report to this party n=1,783	% of respondents
Employer (formal complaint)	866	48.6%
Employer (informal complaint)	640	35.9%
RANZCOG	385	21.6%
Union, medical association or representative	362	20.3%
Other	240	13.5%
Lawyer or legal service	224	12.6%
Other medical college	159	8.9%
No one	148	8.3%
Police	68	3.8%
External agency (human rights commission, etc.)	67	3.8%

Where respondents selected 'other' they were given the opportunity to specify who they would report to. Some of the most common examples provided were:

- Supervisor, training supervisor, direct manager or department head (40 mentions)
- Trusted colleagues (29 mentions)
- Friends or family (15 mentions)
- AHPRA (10 mentions)
- Medical Board / Medical Council / Medical Indemnity (6 mentions)

There were also an additional 21 mentions of the respondent stating that they would address it directly with the perpetrator.

THE IMPACT OF ORGANISATIONAL CULTURE

Respondents were asked:

Q36: 'Please rate your level of agreement with the following statements'

Respondents were given 4 Organisational Culture questions on the topic of dealing effectively with any person/s who display unreasonable behaviours in the workplace.

Using a 1 to 6 rating scale (where 1 = Strongly Agree and 6 = Strongly Disagree) respondents were asked to rate their level of agreement (or disagreement) with the following statement...

Table 40: Impact of Organisational Culture

At my primary work place...	% who Strongly Agree or Agree (rated a 1 or 2)	% who Strongly Disagree or Strongly Disagree (rated a 5 or 6)	Norms for Medical Colleges
The Hospital Executive deal effectively with people who display DBSH.	26.3% [n=431]	28.7% [n=471]	33% [n=6,699]
The department heads and supervisors deal effectively with people who display DBSH.	31.9% [n=524]	27.5% [n=452]	41% [n=5,050]
RANZCOG Fellows and Diplomates understand the difference between reasonable performance management/feedback measures and DBSH.	45.7% [n=750]	12.4% [n=204]	55% [n=6,916]
FRANZCOG/DRANZCOG Trainees understand the difference between reasonable performance management/feedback measures and DBSH.	46.6% [n=759]	10.6% [n=173]	n/a

The question relating to Hospital Executive dealing effectively with people who display DBSH rates with the lowest level of agreement at 26.3% and is statistically lower by respondents...

...who are FRANZCOG Trainees - 21.5% agree

...did their specialist training in New Zealand - 20.1% agree

Statistically higher ratings for this question were observed by...

...Fellow >10 years - 34.4% agree

...Primary workplace = private practice - 34.5% agree

IMPACT OF A FORMAL COMPLAINT

Respondents were asked

Q37: 'Would you advise a colleague (at your primary workplace) who has been subjected to DBSH by a professional colleague to file a formal complaint?'

- 53.6% answered 'Yes' (921 respondents)
- 41.4% answered 'Maybe, if they had strong evidence (709 respondents)
- 5.0% answered 'No' (87 respondents)

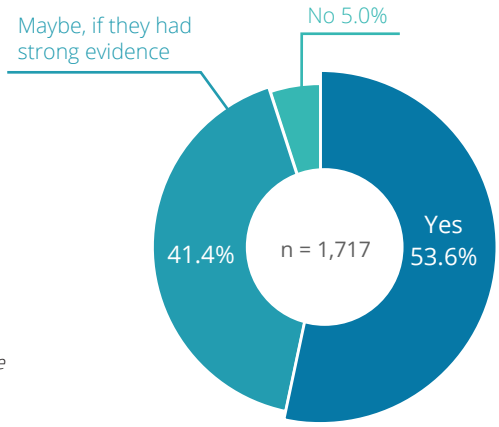
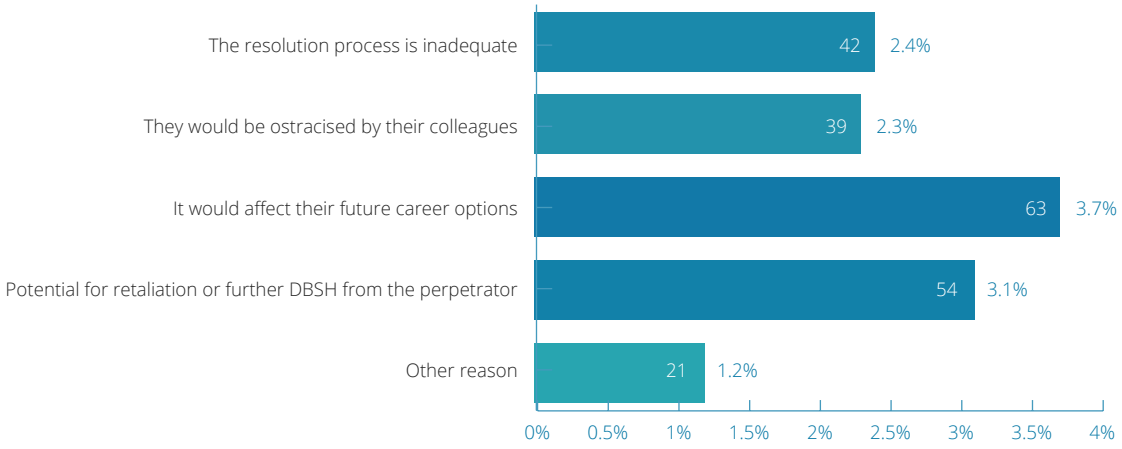


Figure 33: Would you advise a colleague who has been subject to DBSH to file a formal complaint?

The 5% of respondents answered 'no' were given 5 options to select the reason why they would not recommend filing a formal complaint, as represented in the graph below.

Figure 34: Reasons for not advising a colleague to file a formal complaint of an experience of DBSH.



NB: The percentages will not tally to 100% because this graph is only the percentage who answered 'no'.

GENDER EQUITY – LEVEL OF SUPPORT

Respondents were asked:

Q38: 'Please rate your level of agreement with the following (Gender Equity) statements'

Respondents were asked to rate the level of agreement (or disagreement) that the College is supportive of Gender Equity:

- **69.0%** of respondents [1,152] agree that the College is supportive of **female O&G Specialists** - only 6.5% disagree.
    - 59.5% of women agree (statistically lower score)
    - 84.0% of men agree (statistically higher score)
    - 60.8% of FRANZCOG Trainees agree (statistically lower score)
    - 61.9% of Fellows <10 years agree (statistically lower score)

      ...whereas 74.9% of Fellows >10 years agree (statistically higher score)
- **66.9%** of respondents [1,099] agree that the College is supportive of **female Diplomates** - 5.4% disagree.
    - 58.4% of women agree (statistically lower score)
    - 80.5% of men agree (statistically higher score)
    - 60.3% of FRANZCOG Trainees agree (statistically lower score)
    - 58.3% of Fellows <10 years agree (statistically lower score)

      ...whereas 72.4% of Fellows >10 years agree (statistically higher score)
- **66.7%** of respondents [1,107] agree that the College is supportive of **female Trainees** - 8.1% disagree.
    - 56.5% of women agree (statistically lower score)
    - 82.7% of men agree (statistically higher score)
    - 55.1% of FRANZCOG Trainees agree (statistically lower score)
    - 58.8% of Fellows <10 years agree (statistically lower score)

      ...whereas 76.3% of Fellows >10 years agree (statistically higher score)
- **71.9%** of respondents [1,187] agree that the College is supportive of **male Trainees** - 6.2% disagree.
    - 78.1% of women agree (statistically higher score)
    - 62.9% of men agree (statistically lower score)
    - 82.6% of FRANZCOG Trainees agree - the highest level of agreement (statistically higher score)

GENDER EQUITY – EMPLOYER PRACTICES

Respondents were asked

Q39: 'Have you ever made a request for your primary employer to accommodate your responsibilities as a parent or carer?'

Out of 1,706 respondents...

524 answered 'Yes' (30.7%)

1,182 answered 'No' (69.3%)

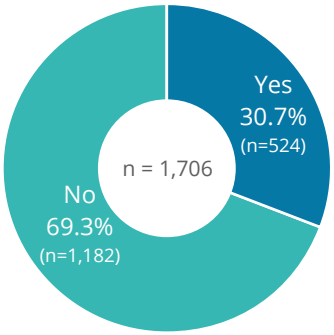


Figure 35: Have you ever requested your employer to accommodate your responsibilities as a parent or carer?

Where respondents answered 'yes', they were given 5 options to evaluate the outcome of their request. This is represented in the table below.

Table 41: What was the outcome of your request?

Outcome of the request	No. of respondents who selected this option (n=520)	Percentage represented
My request was approved	301	57.9%
My request was partially approved	98	18.8%
My request was considered but not approved	28	5.4%
My request was refused	66	12.7%
Other outcome	27	5.2%

Of the respondents who answered that their request was approved, a drilldown by Membership Status reveals that the only statistically significant differences were for...

- Retired Fellows, with the highest rate of approval at 83.3% (n=10)
- FRANZCOG Trainees, with the lowest rate of approval at 35.9% (n=23)
- Diplomates, who were the only other cohort with a statistically higher score at 71.3% (n=92)

GENDER EQUITY – RANZCOG PRACTICES

Respondents were asked:

Q40: 'Have you ever made a request for RANZCOG to accommodate your responsibilities as a parent or carer?'

From 1,706 respondents...

171 answered 'Yes' (10.0%)

1,535 answered 'No' (90.0%)

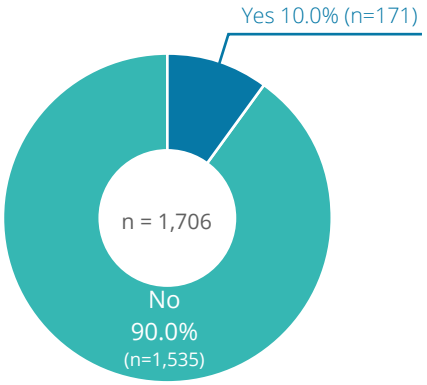


Figure 36: Have you ever requested RANZCOG to accommodate your responsibilities as a parent or carer?

Where respondents answered 'yes', they were given 5 options to evaluate the outcome of their request. This is represented in the table below.

Table 42: What was the outcome of your request?

Outcome of the request	No. of respondents who selected this option (n=171)	Percentage represented
My request was approved	100	58.5%
My request was partially approved	26	15.2%
My request was considered but not approved	8	4.7%
My request was refused	25	14.6%
Other outcome	12	7.0%

TRAINING IN THE WORKPLACE

Respondents were asked:

Q41: 'In the last 5 years have you attended training on how to deal with DBSH in the workplace?'

43.2% (n=798) answered 'Yes' they have attended training, and of these 65.4% attended training on DBSH provided by their employer.

56.8% have NOT attended training on how to deal with DBSH in the workplace.

Figure 37: Have you attended training on DBSH in the last 5 years?

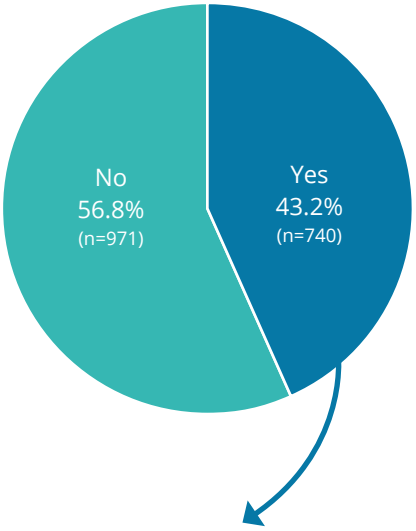


Figure 38: Training on DBSH in the workplace

NB: The percentages will not tally to 100% because the graph represents only those who answered 'yes'.

RESPONDING TO DBSH IN THE WORKPLACE

Respondents were asked:

Q42: 'Do you believe that you are equipped with the skills to effectively respond to DBSH?'

...If you are subjected to DBSH

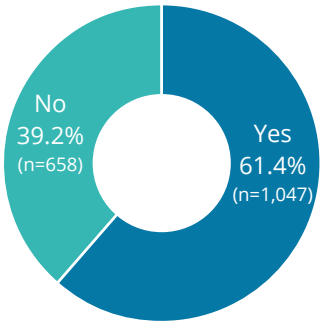
- 61.4% answered 'Yes'
- 38.6% answered 'No'

The norm in Medical Colleges is **68%**

Of those who answered yes:

- 70.1% Fellows >10 years (statistically higher)
- 54.6% Fellows <10 years (statistically lower)
- 47.7% FRANZCOG Trainees (statistically lower)
- 45.1% DRANZCOG Trainees (statistically lower)
- 39.8% Trainees 3-5 years in program (statistically lower)
- 75.4% Men (statistically higher)
- 53.0% Women (statistically lower)

Figure 39: Are you equipped with the skills to respond to DBSH if you were subjected to the behaviour?



...If others are subjected to DBSH

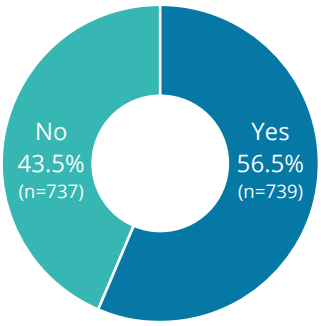
- 56.5% answered 'Yes'
- 43.5% answered 'No'

The norm in Medical Colleges is **60%**

Of those who answered yes:

- 64.1% Fellows >10 years (statistically higher)
- 50.4% Fellows <10 years (statistically lower)
- 39.7% FRANZCOG Trainees (statistically lower)
- 43.6% DRANZCOG Trainees (statistically lower)
- 68.7% Men (statistically higher)
- 48.9% Women (statistically lower)

Figure 40: Are you equipped with the skills to respond to DBSH if others were subjected to the behaviour?



FUTURE ACTION/PREVENTION

Respondents were asked:

Q43: 'What action do you think is required to assist in the prevention of DBSH in your primary workplace?'

Respondents were provided with 6 options, the ranking of which is outlined in the table below.

Table 43: Future action to prevent DBSH in the workplace

Future Action in the Workplace for the Prevention of Discrimination, Bullying, Sexual Harassment, and Harassment		No. of respondents who selected this option (n=1,657)	Percentage represented
1st	Greater leadership by executives, directors and/or supervisors is required to assist in the prevention of DBSH.	1,231	74.3%
2nd	Resources to support more effective complaint resolution procedures in the workplace.	980	59.1%
3rd	Better support mechanisms (e.g. counselling services) are required to assist in the prevention of DBSH.	655	39.5%
4th	Further training from my employer is required to assist in the prevention of DBSH.	565	34.1%
5th	Further training from RANZCOG is required to assist in the prevention of DBSH.	542	32.7%
6th	Another action (other than the preceding options) is required to assist in the prevention of DBSH in my current workplace.	203	12.3%

NB: The percentages will not tally to 100% because the respondents could select all that apply.

FUTURE SUPPORT FROM RANZCOG

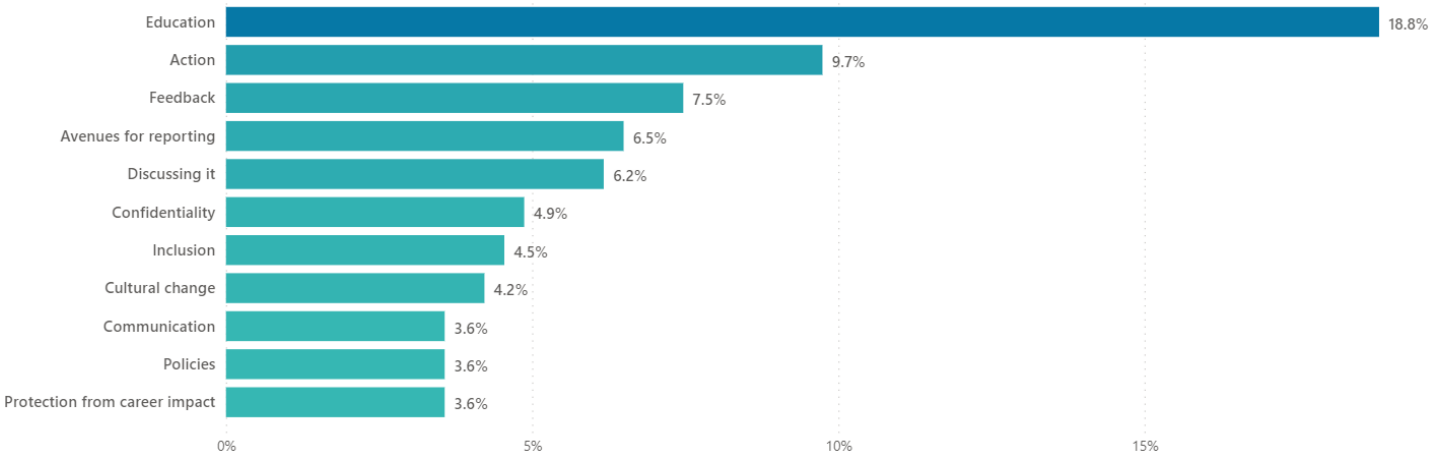
Respondents were asked:

Q44: 'Do you have any suggestions for other ways in which RANZCOG could better support Fellows, Diplomates, Trainees, and SIMGs in being equipped to personally address DBSH?'

308 respondents provided a suggestion(s) via a narrative text field in the survey. BPA applied its Linguistic Analysis Methodology to these responses and coded the verbatim text as reflected in the graph below.

Their comments are included in the narrative report which accompanies this Summary.

Figure 41: Suggestions for improved support from RANZCOG



NB: The percentages on the bar chart are the % of respondents who triggered each category (needs a minimum of 4 respondents to trigger a category). The percentages will not tally to 100% because individual responses can be coded to multiple categories.

Definitions: Suggestions for Improved Support from the College

Education | Education on DBSH issues, including identifying and managing behaviours.

Action | Reports acted upon, taken seriously, listened to, or followed up.

Feedback | Gathering, facilitating, or providing feedback.

Avenues for reporting | Existence, awareness, or availability of systems and pathways for reporting.

Discussing it | Discussing, raising, or talking about DBSH issues, with superiors or peers.

Confidentiality | Confidentiality or anonymity in the reporting process.

Inclusion | Inclusion, acceptance, and workplace diversity.

Cultural change | Changing the culture so the behaviour is no longer endemic or accepted.

Communication | Good or clear communication.

Policies | Policies, protocols, guidelines, or a code of conduct.

Protection from career impact | Protection from loss, limitation, or withdrawal of career or training opportunities.

FUTURE SUPPORT FROM RANZCOG

Of the 308 comments that were coded using BPA's Linguistic Analysis, the top 5 themes were:

1. **Education**
2. **Action**
3. **Feedback**
4. **Avenues for reporting**
5. **Discussing it**

There were a number of thoughtful and constructive comments, a selection of which are...

"More education so that people who are responsible for the behaviour may have a light bulb moment. I don't want to address DBSH - I want the people responsible for that behaviour to stop."

"More information about what supports are available through the college. Found to be helpful in supporting trainees but wasn't aware this was available until we needed it."

"Continuing to discuss DBSH and provide education and resources for members. Encouraging a culture that acknowledges DBSH exists and taking steps to create safe spaces to share experiences."

> "Incorporate proactive questions (anonymous surveys, information about pathways of escalation, formal reporting processes) into the 3 and 6 month trainee assessments."

> "Create a more empowering and supportive training process via its feedback mechanisms and supervisor responsibilities."

"Trainees always have regular formal feedback from consultants but there is no opportunity for trainees to give feedback to their supervisors / consultants about what is working and what is not working."

"RANZCOG needs to be able to find ways to formally intervene on behalf of trainees and fellows who experience DBSH."

"Education about definitions and examples of appropriate and inappropriate behaviours to help to 'draw the line' more clearly on the grey zone of interactions."

"Complaints should generate personal face to face consultation and a plan for resolution. (prevent avoidance of the problem and/or buck-passing)."

> "Raise cultural awareness and encourage open minded discussion with supervisors."

RANZCOG SUPPORT AND EDUCATION SERVICES

Respondents were provided with a list of 10 support and education services that RANZCOG introduced as a result of their 2016 Bullying and Sexual Harassment Survey.

Respondents were asked:

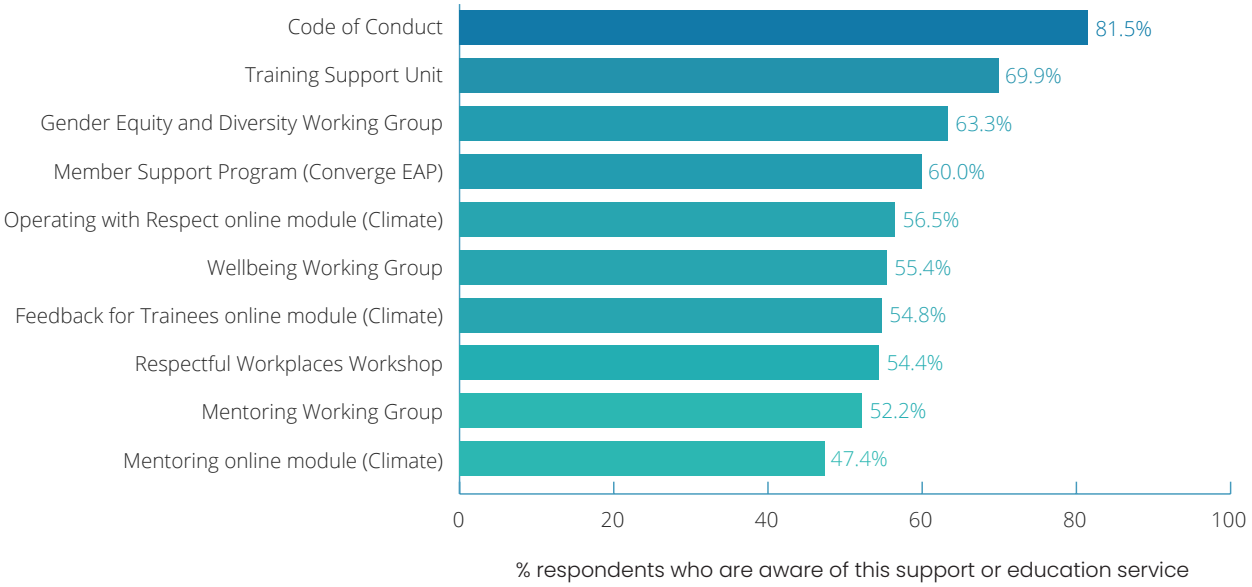
Q45: Please rate your level of awareness of the support and education services, and how well RANZCOG was performing on each'.

The ratings scales were:

- Are they aware of the initiative at all?
- RANZCOG is making good progress on this.
- RANZCOG is giving attention to this, but there is still a lot of room for improvement.
- RANZCOG is nowhere near getting traction on this.

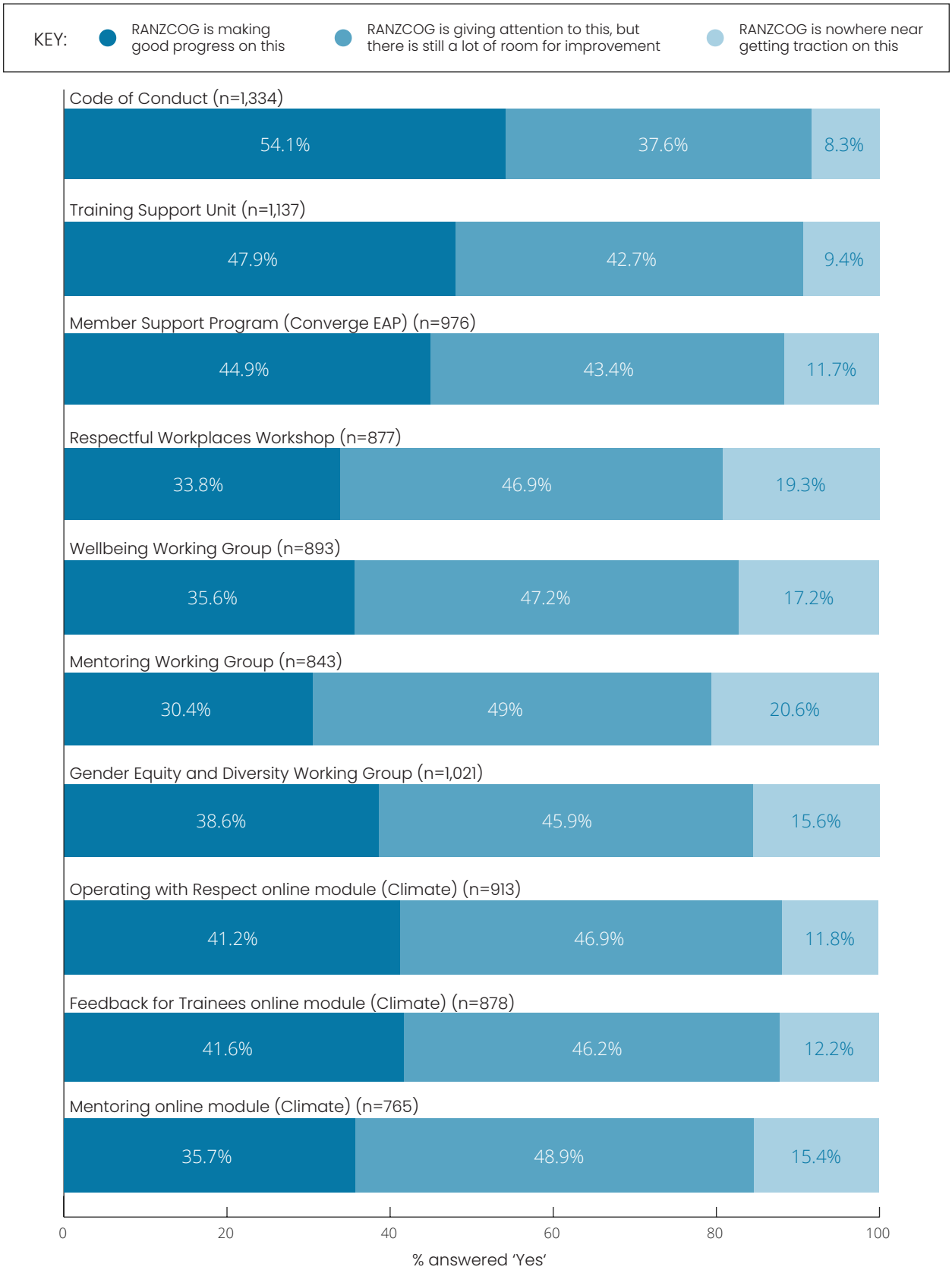
The graph below reflects the percentage of respondents who are aware of each initiative.

Figure 42: Awareness of RANZCOG support and education service.



A breakdown of how well respondents think RANZCOG is performing on each initiative is provided over the page.

RANZCOG SUPPORT AND EDUCATION SERVICES CONT...



32% response rate to the survey (2,105 respondents)

62.1% of respondents have experienced a form of DBSH.

73.5%
of **Fellows <10 years** have experienced any one of the 4 DBSH behaviours.

71.5%
of **FRANZCOG Trainees** have experienced any one of the 4 DBSH behaviours.

43.5%
are **<44 years** of age.

64.4%
of respondents identify as a **woman**.

68.6%
of FRANZCOG Trainees who responded have been in the training program **>3 years**.

26.1% obtained their primary medical degree in a country other than Australia or New Zealand.
49 other countries were nominated.

17.3% did their specialist training in a country other than Australia or New Zealand.
34 other countries were nominated.

60.2% of respondents' primary workplace is a Public Hospital (Metropolitan or Regional).

43.2% have attended DBSH training in the past 5 years.

81.5% are aware of RANZCOG's Code of Conduct.

53.6% of respondents would advise a colleague to file a formal complaint if they were subject to DBSH.

61.4% of respondents believe they are equipped to effectively respond to DBSH.

DBSH Results **Snapshot**