Policy Document

Sexual Harassment (2021)

Position Statement

AMSA believes sexual harassment is a significant issue for medical students, and also constitutes a broader public health issue. Sexual harassment disproportionately affects medical students due to their intersecting vulnerabilities both as students in tertiary settings, and as juniors within medical workplaces. AMSA also believes that certain demographics are disproportionately more likely to be a target of sexual harassment. Sexual harassment has significant acute and long term consequences including mental and physical health issues, and both direct and indirect negative career implications. Overarchingly, AMSA recommends change through leadership and governance, a shift in attitudes and behaviours within the medical workplace, as well as implementation of effective and actionable strategies by universities and other regulatory bodies.

AMSA recognises the extensive barriers to reporting sexual harassment. These barriers prevent individuals who have experienced sexual harassment from accessing support, and obfuscate its prevalence within society and the medical community, perpetuating a culture in which sexual harassment is tolerated. The appropriate management of sexual harassment needs to be substantiated in clear, accessible policies; its reduction and elimination necessitates sociocultural change, including clear repercussions for offenders. AMSA also believes that comprehensive and regular sexual harassment education is an essential component in the prevention, reduction and elimination of sexual harassment.

AMSA acknowledges that sexual harassment occurs on a spectrum of sexual and gender-based violence including, but not limited to, sexual assault and rape. AMSA also believes there is urgent need for significant further research into the prevalence, perpetuating factors and effects of sexual harassment within medical schools, the medical workplace and in the general public.

Policy

AMSA calls upon:

1. The Federal Government to:
    a. Fund and conduct comprehensive research into the prevalence, perpetuating factors, and impacts of sexual harassment in the general population, medical education and in healthcare settings, including demographic details where possible;
    b. Conduct a Royal Commission into Sexual Harassment in the Workforce;
    c. Provide immediate, short and long-term mental health support for those who have been affected by sexual harassment, including but not limited to access to:
        i. Psychologists and psychiatrists;
        ii. General practitioners and telehealth services;
        iii. Crisis centres;
        iv. Inpatient services;
        v. Support groups;

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d. Implement sexual harassment awareness campaigns in an effort to reduce stigma around talking about sexual harassment and sexual violence, and reduce the isolation and silencing of those affected; and
e. Promote cultural change on a national level through initiatives aimed at minimising discrimination against all people, particularly sexual harassment based on gender, sexual orientation, background, Aboriginal and Torres Strait Islander status or disability.

2. State and Territory Governments to:
    a. Fund and conduct comprehensive research into the prevalence, perpetuating factors, and impacts of sexual harassment in medical education and in the state public healthcare sector, including demographic details where possible;
    b. Provide immediate, short and long-term mental health support for those who have been affected by sexual harassment, including but not limited to:
        i. Access to psychologists and psychiatrists;
        ii. General practitioner and telehealth services;
        iii. Crisis centres;
        iv. Inpatient services;
        v. Support groups;
    c. Implement awareness campaigns in an effort to reduce stigma around talking about sexual harassment and sexual violence, and reduce the isolation and silencing of those affected;
    d. Provide clear and effective evidence-based policies and procedures for the reporting, documentation and follow-up of sexual harassment allegations in workplaces, including in universities and hospitals;
    e. Mandate that all clinical employees of the health system, especially any person in a medical student supervisory position undertake education regarding sexual harassment that includes:
        i. Clear definitions of behaviours that constitute sexual harassment and sexual violence, and recognition of such;
        ii. How to prevent and counter sexual harassment;
        iii. How to appropriately intervene when witnessing a situation of sexual harassment;
        iv. How to effectively use reporting pathways; and
        v. Trauma-sensitive training.
    f. Mandate university and hospital administrations to adopt, regularly review and promote clear sexual harassment reporting and documentation policies, with victim protection and offender repercussions at the core.

3. Specialty Training Colleges to:
    a. Regularly audit the prevalence, and incidence of sexual harassment in the workplace, including demographic details where possible whilst ensuring anonymity;
    b. Implement and regularly review evidence-based “zero tolerance” sexual harassment policies that quickly and appropriately respond to reports of sexual harassment without impacting upon the progression of trainees;
    c. Evaluate and acknowledge the impact of sexual harassment on medical student choice of specialty training; and
    d. Institute strategies to promote gender equity, including but not limited to ensuring flexibility of training programs through parental leave and part-time training alternatives.

4. Hospitals and other healthcare providers to:
    a. Regularly audit the prevalence and incidence of sexual harassment in the workplace, including demographic details where possible, and to include medical students in this analysis;
    b. Implement and enforce evidence based “zero tolerance” sexual harassment policies that quickly and appropriately respond to reports of sexual harassment without impacting upon the progression of trainees;
    c. Provide accessible, effective and, where appropriate, anonymous reporting systems for all staff and students;
    d. Provide accessibility services to allow those with a disability or from culturally and linguistically diverse communities to effectively and efficiently report sexual harassment;
    e. Provide support for those who have experienced sexual harassment and want to escalate their grievances to relevant external authorities, including the police;
    f. Undertake regular evaluations of current sexual harassment reporting structures and policies to:
        i. Determine the efficacy of implemented reporting structures and policies, identifying areas of weakness and barriers to reporting within the medical workplace;
        ii. Use this information to strengthen current reporting structures and policies to rectify areas of weakness identified in the evaluation process.
    g. Ensure the process for investigating sexual harassment complaints is made clear, and explain how appropriate disciplinary actions are decided and executed;
    h. Work with staff and students to understand their needs to feel safe and protected, and where necessary, facilitate changes and offer pastoral support;
    i. Introduce compulsory and regular training sessions for all staff and students, aimed at recognising, preventing and addressing sexual harassment in the workplace;
    j. Undertake regular evaluations on the effectiveness of these training sessions in facilitating behavioural change, including their effectiveness at lowering the incidence of sexual harassment and increasing reporting rates;
    k. Ensure university staff and students are trauma-informed and trained to sensitively and confidentially support those affected by sexual harassment;
    l. Institute strategies to promote gender equity, including but not limited to:
        i. Ensuring equal pay for equal roles;
        ii. Prioritising the inclusion of women and gender diverse individuals in managerial, teaching and leadership roles;
    m. Liaise with universities to establish continuous duty of care for students on clinical placements; and
    n. Ensure the contact details of Aboriginal and Torres Strait Islander Health Officers and other support services are publicised and made available to Aboriginal or Torres Strait Islander staff and students who have been targets of sexual harassment.

5. Universities and medical faculties to
    a. Conduct regular, comprehensive research into the prevalence, perpetuating factors, and impacts of sexual harassment within their institutions;
    b. Implement and enforce evidence based “zero tolerance” Sexual Harassment policies that quickly and appropriately respond to reports

of sexual harassment without impacting upon the progression of students;

c. Provide accessible, effective and anonymous reporting systems for all students and staff;
d. Provide accessibility services to allow those with a disability or from culturally and linguistically diverse communities to effectively and efficiently report sexual harassment;
e. Provide support for those who have experienced sexual harassment and want to escalate their grievances to relevant external authorities, including the police;
f. Undertake regular evaluations of current sexual harassment reporting structures and policies to:
    i. Determine the efficacy of implemented reporting structures and policies, identifying areas of weakness and barriers to reporting within the medical workplace;
    ii. Use this information to strengthen current reporting structures and policies to rectify areas of weakness identified in the evaluation process.
g. Actively involve students and staff in producing, reviewing and amending effective, targeted strategies and solutions to eliminate sexual harassment within universities;
h. Ensure transparent investigations into sexual harassment complaints; which include a detailed list of findings and explanation of how appropriate disciplinary actions are decided and executed;
i. Work with students affected by sexual harassment to understand their needs, and provide leniency in academic performance and attendance requirements, offer professional and pastoral support, and facilitate change of classes or placements as required;
j. Improve the culture around sexual harassment and sexual violence within residential colleges and university residences, with a particular focus on risk management;
k. Introduce regular compulsory training sessions for all staff and students, aimed at recognising and addressing sexual harassment in the workplace;
l. Undertake regular evaluations on the effectiveness of these training sessions in facilitating behavioural change, including their effectiveness at lowering the incidence of sexual harassment and increasing reporting rates;
m. Ensure university staff and students are trauma-informed and trained to sensitively and confidentially support those affected by sexual harassment;
n. Clearly define the policies relevant to medical students on placement and to make all reporting measures clear before beginning placement;
o. Liaise with hospitals and other clinical placement providers to ensure continuous duty of care for students; and
p. Ensure the contact details of Aboriginal and Torres Strait Islander Health Officers and other support services are publicised and made available to Aboriginal or Torres Strait Islander students who have been the target of sexual harassment.

6. Staff and students working in health settings to:
    a. Support those affected by sexual harassment;
    b. Attend and engage in training sessions with regards to recognising, preventing and responding to sexual harassment;
    c. Nurture a safe and responsive environment within the university and medical workplace where complaints of sexual harassment are handled confidentially, and are not met with poor outcomes for those who report it;

d. Educate themselves and share information regarding the behaviours that encompass sexual harassment, sexual harassment policies and procedures at their workplace and actions available including bystander action and reporting; and
e. Advocate for change to current policies and reporting structures if they feel they are inadequate, and work with institutions to create stronger policies and reporting structures.

7. Students and medical student societies to:
    a. Attend and engage in education sessions with regards to recognising and responding to sexual harassment, as well as current policies and procedures at their university and actions available, including bystander action and reporting;
    b. Actively work with faculties to:
        i. Identify weaknesses in and amend current sexual harassment policies;
        ii. Identify and publish sexual harassment reporting pathways, both for those who have been harassed and for bystanders or knowledgeable parties;
        iii. Identify barriers to accessing sexual harassment reporting pathways at their University and implement strategies specific to those identified;
    c. Implement awareness campaigns in an effort to reduce stigma around talking about sexual harassment and sexual violence, and reduce the isolation and silencing of those affected;
    d. Support their peers to prevent occurrences of sexual harassment, as well as advocating and supporting peers if they are a witness to or subject to sexual harassment;
    e. Ensure the contact details of Aboriginal and Torres Strait Islander Health Officers and other support services are publicised and made available to Aboriginal or Torres Strait Islander students who have been targets of sexual harassment;
    f. Support students in navigating reporting processes;
    g. Minimise sexual harassment within student society events by developing and using well-publicised policies and procedures to prevent and deal with such incidents.

8. The Australian Medical Association to:
    a. Lead the profession's efforts to eliminate sexual harassment in the medical workplace, particularly through hospitals and colleges;
    b. Advocate for the development of safe environments within the medical workforce where persons can lodge their complaints without fear of repercussion;
    c. Support and advocate for those doctors and medical students affected by sexual harassment; and
    d. Develop campaigns aimed at promoting knowledge and understanding of sexual harassment among medical staff and students.

9. The Australian Health Practitioner Regulation Agency (AHPRA), including the Medical Board of Australia, to:
    a. Investigate sexual harassment allegations against members registered with AHPRA, and ensure transparency of the standards members must meet in order to maintain their registration; and
    b. Ensure appropriate consequences for members that perpetrate sexual harassment in healthcare settings.

10. The Australian Medical Council to:
    a. To include sexual harassment and trauma sensitive training amongst its accreditation standards for medical schools & doctor-in-training frameworks;
    b. Support training colleges and universities in developing, maintaining, and promoting sexual harassment reporting structures;

Background

Introduction

The Australian Bureau of Statistics defines sexual harassment as “experiences or behaviours that an individual is subjected to which makes them feel uncomfortable and are offensive due to their sexual nature” [1]. Certain behaviours may constitute harassment even in situations where the individual did not intend for them to be offensive, but were nonetheless perceived as inappropriate by the target [2]. Such behaviours and actions can include, but are not limited to:

- Staring or leering
- Unwelcome physical contact
- Unwelcome sexual comments, jokes or insults
- Unwanted invitations to go out on dates or requests for sex
- Intrusive questions about a person's private life, body or sexual orientation
- Accessing sexually explicit pictures, screen savers or posters
- Accessing sexually explicit websites
- Behaviours considered an offence under criminal law, including, but not limited to stalking, indecent exposure, assault and sexual violence (see below) [3]

Sexual violence is defined as the occurrence, attempt or threat of sexual assault, and can be split into into the categories of sexual threats and sexual assault [1]. Sexual threats are the threat of acts of a sexual nature that the target believed were able and likely to be carried out. Sexual assault is an act of a sexual nature carried out against a person's will through the use of physical force, intimidation or coercion, including any attempts to do this. These acts are considered criminal offences under state and territory law. Examples of sexual assault include, but are not limited to:

- Rape
- Attempted rape
- Aggravated sexual assault (including assault with a weapon)
- Indecent assault
- Penetration by objects
- Forced sexual activity that did not end in penetration
- Attempts to force a person into sexual activity [1]

Sexual harassment occurs as part of a continuum of sexual violence, and both are closely associated with other forms of discrimination, particularly gender, sexuality, and racially based discrimination - all of which have similar social and cultural underpinnings [4,5]. Perpetrators may use sexual harassment as a means to assert power over their targets, as well as to degrade and humiliate them [1]. Targets of sexual harassment are often left with significant negative psychological impacts, which may severely affect their personal, social and working lives [5].

Prevalence

There is limited recent research regarding the prevalence of sexual harassment and sexual violence in the general population of Australia. The most recent sexual harassment data was published by the Australian Bureau of Statistics from the 2016 Personal Safety Survey [4]. It was found that 53% of women and 25% of men over the age of 15 had been sexually harassed at least once in their lives [4]. Over half the women surveyed stated their perpetrators to be men, whilst statistically men showed equal likelihood of their perpetrators being either men or women [4]. Women were also almost twice as likely as men to have experienced sexual harassment in the 12 months prior to the survey, with 1 in 6 women reporting an incident compared to 1 in 11 men [4]. In addition to sexual harassment, 18% of women and 4.7% of men reported at least one incident of sexual violence. In incidents of sexual violence, 98% of women reported their perpetrator to be a man, whilst 55% of men reported their perpetrator to be a woman [4].

There is limited research about the prevalence of sexual harassment in Australian medical schools. The majority of studies that have been published in this field are cross-sectional, and reported prevalence relies on a subjective interpretation of the term “sexual harassment”, often in the absence of clear definitions. Furthermore, few studies report solely on sexual harassment and many do not provide primary data [6].

Medical students are at risk of experiencing sexual harassment at all stages of their training, including in the pre-clinical academic setting. The most recent data on the prevalence of sexual harassment in Australian medical students reported that 37.9% from one university had experienced at least one incident [7]. However, due to limited research into the prevalence of sexual harassment in medical schools, this data is from 2000 and as a result may not accurately reflect current prevalence. Despite limited evidence in an Australian context, studies from countries such as Canada [8], the Netherlands [9], Japan [10] and the USA [7,11] show that sexual harassment is experienced widely by medical students across the globe.

More broadly, students enrolled in tertiary education report high prevalence of sexual harassment. The Australian Human Rights Commission (AHRC) reported that 51% of Australian university students were sexually harassed on at least one occasion in 2016, and have identified that young people, especially young women between the ages of 18 and 24, are at an increased risk of experiencing sexual harassment. Worryingly, 47% of students knew nothing or little about where to seek assistance and support [12]. Postgraduate students were identified as being almost twice as likely as undergraduate students to be sexually harassed by a lecturer or tutor at their university [13].

As medical students transition to the clinical setting, they are also at risk of experiencing sexual harassment in the workplace. However, there is a significant lack of data regarding the prevalence of sexual harassment of clinical year medical students. As such, it may be appropriate to extrapolate the experience of medical students in the clinical workplace from the experiences of doctors in training. Doctors in training are consistently more likely to have experienced sexual harassment in comparison to colleagues higher up the medical hierarchy [14]. A 2016 study of PGY1 and PGY2 doctors in the ACT and NSW reported that 16-19% had experienced sexual harassment in the clinical workplace [15]. Participants discussed the workplace normalisation of these behaviours, fear of reprisal and lack of knowledge and confidence in the reporting process. The authors suggested, however, that interventions targeted at the level of junior doctors to improve the culture are unlikely to be helpful due to the systemic nature of the problem.

Recent reports suggest that there are many instances of unwitnessed sexual harassment in the Australian medical workplace and that this behaviour is part of a broader cultural issue (16). A 2019 inquiry conducted by the Australian Salaried Medical Officers’ Federation (ASMOF) into sexual harassment found over 30% of all

doctors had experienced sexual harassment at least once in their careers [14]. Female doctors were consistently more likely to experience sexual harassment than their male colleagues, with 50% of female doctors stating to have experienced at least 1 incident, compared to 6% of male doctors [14]. Up to 90% of perpetrators were reported to be male, irrespective of the targets' gender, and 70% of perpetrators were reported to be fellow doctors - almost double the number stated as patients or other healthcare workers [14]. Despite patients and other hospital workers also being perpetrators of sexual harassment, colleague-related harassment may result in greater impacts on targets of sexual harassment, as they often hold positions of power [6].

Significant further research is required to develop a clearer understanding of the nature and scope of the problem, the adverse effects and the potential targets for change. Research into the prevalence of sexual harassment and sexual violence is needed in the broader context of the general public, as well as in the medical workplace and importantly in medical students - a group where there is very little Australian data on sexual harassment prevalence. Further research should also endeavour to record where possible the demographic details of sexual harassment targets, in order to better understand its prevalence, particularly amongst vulnerable demographics. Additionally, further research should also be conducted into the specific impacts of sexual harassment on medical students, as well as evaluating the efficacy of current strategies to structure the development of effective prevention and management strategies around.

Perpetuating Factors

The drivers that perpetuate sexual harassment are multifactorial and difficult to accurately identify. Although increased awareness of the prevalence of sexual assault has resulted in some culture changes over the past decade, sexual assault is still rampant in our society [1]. Compared to 2012, the 2016 Personal Safety Survey (PSS) indicated a 2-3% increase in people experiencing harassment in the 12 months prior to the survey [1]. It should be mentioned that this survey was conducted before the rise of the #MeToo movement and, as such, the results of the next PSS may show a different picture of harassment.

A 2018 report from the US National Academies of Science, Engineering and Medicine (USNASEM) assessing sexual harassment in Academia identified the most important predictor of sexual harassment in an organisation to be the perception that sexual harassment is tolerated [17]. Organisations that support and protect the targets of sexual harassment are those that fairly investigate and discipline harassers, and are transparent about their processes [17]. Sexual harassment specialist C. Brady Wilson states that companies tend to "close ranks and blame the victim" when dealing with a sexual harassment complaint and that companies are generally reluctant to participate in investigations of harassment [18]. Policies and procedures that protect the institution but do not prevent harassment are also common [18,19].

Most organisations now have policies against sexual harassment that meet legal requirements, but do not cover policy points that are needed to prevent sexual harassment. The USNASEM study has labelled this 'symbolic compliance' [17]. It is not enough for institutions to address legal requirements alone; workplace culture and climate also need to be addressed [17,18,19].

The #MeToo movement has highlighted the prevalence of sexual harassment, bringing it to the forefront of public awareness. The use of #MeTooMedicine further emphasises the prevalence of this issue in medical environments and the ways in which these spaces facilitate sexual harassment [17,20]. The structure of medical teaching both within medical schools and postgraduate training involves a number of circumstances that precipitate sexual harassment. These include:

- Environments with a hierarchical power structure or where power is concentrated to people who attract money or publicity: a structure common, but not unique to, all medical schools. As a result, students and staff are less likely to reveal harassment for fear of the negative impact on their lives [21].

- Medical training includes an accepted philosophy that some level of suffering is part of the learning process. This directly translates to sexual harassment, with many students feeling some level of harassment is expected, and even considered acceptable [17].

- Medicine is a meritocracy with academic reputation being important to future success, and career advancement is often dependent on recommendations from advisors and mentors. This leaves those who are the targets of harassment fearful of educational and career repercussions if they were to report superiors.

- The absence of female leadership amongst medical institutions. Organisations with few numbers of women, and men who dominate the leadership roles have more frequent incidents of harassment for women [17,19,21,22]. Women in Australia make up at least 50% of medical school cohorts, yet as of 2019 represent only 28% of Medical Deans,12.4% of hospital CEOs and 33% of state and federal chief medical officers or chief health officers [22].

Vulnerable Demographics

Sexual harassment is fundamentally reliant on an ingrained power imbalance. As a result, groups who face systemic discrimination are at higher risk. Women and gender diverse individuals, LGBTQ+ individuals, those from culturally and linguistically diverse backgrounds, Indigenous peoples and those with disability face disproportionate rates of sexual harassment and sexual violence in society. However, it should be acknowledged there is a shortage of current, high quality and relevant research, which complicates assessment of the full extent of this issue.

Gender Identity

Gender inequity has been clearly documented in all levels in society. In the medical profession specifically, the cause is multifactorial [23]:

- Female-identifying doctors are concentrated in lower earning/less prestigious specialties;
- Women earn less than their male counterparts in equivalent roles in the same specialty;
- Structural and cultural barriers to change exist; and
- Imbalances in gender distribution in managerial, teaching and leadership roles are perpetuated.

In practice, this has translated into significantly higher rates of sexual harassment for women than men, with women almost twice as likely to have been sexually harassed. In 2016, 63% of women were sexually harassed on at least one occasion, compared with 35% of men, while in a university setting, 32% of women and 17% of men experienced sexual harassment [12]. In the US, up to 88% of women experience gender-based discrimination in medical school, 88% during residency and 91% during practice [24]. These rates remain skewed according to gender, with a 2015 report by the Royal Australasian College of Surgeons identifying 30% of women within the College had experienced sexual harassment in stark contrast to only 2% of men [16].

The gender diverse community is also disproportionately affected, but there is far less relevant literature available. A 2017 systematic review found a high worldwide

prevalence of sexual violence motivated by perceived gender, with high rates amongst all gender minorities (up to 11%) but particularly transgender individuals (up to 49%) [25].

Sexual Orientation

Entrenched societal homophobic attitudes exist worldwide, and in the context of inadequate recognition of and protection against discrimination on the basis of sexual orientation, LGBTQ+ individuals are frequently exposed to sexual harassment and sexual violence [26].

Students who identified as bisexual, gay, lesbian or homosexual were more likely than students who identified as heterosexual to have been sexually harassed [12]. In 2016, 44% of those who identified as bisexual and 38% of those who identified as gay, lesbian or homosexual were sexually harassed at university, compared with 23% of those who identified as heterosexual.

Culturally and Linguistically Diverse Background

Australia is culturally and linguistically diverse, home to many individuals born overseas or with non-English speaking backgrounds, as well as to refugees with a distinct (and often traumatic) experience of migration [27]. Racial and ethnic minorities are more likely to face poverty, violence and racism, contributing to alienation and discrimination they may suffer in society. This perpetuated imbalance increases the risk of sexual harassment and sexual violence.

A 2017 survey found that overall there was little significant difference in the prevalence of sexual harassment based on home language. It was identified that men who spoke a language other than English at home were 6% more likely than those who spoke primarily English to have experienced recent sexual harassment [12]. However, it is important to note that these surveys were conducted in English, and may therefore be less accessible to those from non-English speaking backgrounds and provide only a superficial representation of the issue.

Aboriginal and Torres Strait Islander Communities

Aboriginal and Torres Strait Islander (hereafter respectfully referred to as 'Indigenous') doctors make up a tiny fraction (0.3%) of Australia's medical workforce, well below population parity of around 3% [28]. Indigenous Australians are often faced with pervasive and multifactorial discrimination in society and in the workforce. Since colonisation, genocide, disposession, subjugation, segregation, as well as interpersonal and institutional racism have and continue to occur. This has created and amplified a power imbalance that facilitates and perpetuates higher rates of sexual harassment and violence against Indigenous people [29].

Students who identified as Indigenous are more likely to have been sexually harassed. In 2016, over 60% of students who identified as Indigenous were sexually harassed, compared with 51% of non-Indigenous students [12]. AHPRA's Medical Training Survey found over two thirds of Indigenous trainees to have experienced or witnessed bullying, harassment, or discrimination (including that of sexual nature), double the number of all trainees [27].

Disability

People with disabilities face higher rates of exploitation and violence than able-bodied people, with between 30-50% of those who experience abuse having a disability [30]. Sexual violence rates are likewise far higher in the disabled population (16%) compared to those without a disability (9%) [31]. The risk increases according to the degree of disability, with up to 24% of those with severe or profound disability having experienced sexual violence.

Impacts of Sexual Harassment

People who have experienced sexual harassment and sexual violence experience a plethora of immediate, short-term and long-term physical, psychological and social impacts, which may lead to academic and career-related consequences.

Immediately following an incident of sexual harassment or violence, targets have been found to suffer from depression and anxiety related disorders, including but not limited to: psychological trauma [32] post-traumatic stress disorder (PTSD), major depressive disorder, suicidal ideation, social withdrawal, internalised stigma, guilt and shame, and report feeling intimidated, isolated and silenced [33,34]. The mental wellbeing/health of individuals who have experienced sexual harassment can be damaged/impacted/compromised for as long as 20 years following an assault [32], and women who have been sexually assaulted have higher than average rates of use of medical care even years after the event [35]. Targets reported more difficulty forming interpersonal relationships, citing difficulties engaging and communicating with romantic partners and emotional intimacy, fear and mistrust of others, higher levels of sexual dissatisfaction and higher levels of anxiety during sexual activity [32].

Sexual violence can lead to sexual and reproductive health problems; globally, women subject to sexual violence suffer from physical impacts including, but not limited to physical pain during subsequent intercourse [32], chronic headaches, weight fluctuation, adolescent/unintended pregnancy, intrauterine haemorrhage, abdominal pain, chronic pain, and head/neck/face, musculoskeletal and genital injuries [35]. The combination of these psychosocial impacts has further consequences for victims, being 2.6 times more likely to engage in alcohol-related substance abuse [32,35] than those who have not experienced sexual assault.

Medical students who have been sexually harassed can subsequently disengage from the academic environment, for a variety of reasons. These include bullying and inappropriate advances from perpetrators, a sense of helplessness, limited financial and career flexibility, lowered sense of safety in, and distrust of, the institution, and a general loss of job/academic satisfaction [34]. In many cases, these factors result in a decline in academic performance, difficulty concentrating, poorer class attendance, and decreased quality and quantity of work - all of which can be exacerbated by the effects of substance abuse[32]. Targets of sexual violence also have lower rates of graduation [32], increased likelihood to quit their jobs or to be made redundant [34] as a result of these performance and productivity problems.

Often, juniors in the medical hierarchy such as students, interns and residents are reluctant to report harassment, fearing that it could have adverse impacts on their medical careers such as job loss, retaliation from seniors or being labelled as too sensitive and a ‘complainer’. [36] Doctors in training lower down the medical hierarchy may experience a number of career impacts as a result of sexual harassment. Doctors in training who have experienced sexual harassment report decreased job satisfaction and sense of safety in the workplace [33], leading to increased attrition rate. This, in addition to increased absenteeism and job burnout [37], is associated with performance decline, which can result in reduced quality of care and increased risk for patient safety and wellbeing. There is the potential for empathy decline [33] which can affect a physician’s capability of accurate diagnosis and patient care. The ordinary demands of being part of the medical workforce can be stressful, and workplace cultures that permit and excuse sexual harassment can serve to further exacerbate these stressors [37].

Female medical students have been found to be less likely to pursue specialties where they had experienced or observed high rates of discrimination or harassment, reinforcing the idea that programs with unequal gendered experiences and a lack of trusted female mentors are marginalising to female medical students [33]. Students can experience self-doubt, question whether what they experienced was sexual assault at all, or feel that the harassing behaviour is an inherent and normalised part

of the workplace power imbalances. They often also experience self-blame and shame for being targeted [34].

Support for individuals who have experienced sexual harassment can be targeted at various levels: immediate, short and long-term individualised support, as well as contributing to a cultural and systemic shift towards intolerance of sexual harassment, assault or violence of any kind. Access to comprehensive post-assault care is essential – consisting of psychological support, emergency contraception, prophylaxis and treatment for HIV and other STIs [35]. In the short-term, individuals who have experienced sexual harassment should be offered the analysis of forensic evidence if they choose to pursue legal avenues of punishment, as well as mental health support and support from their institution to instate punitive measures against the perpetrator, and put into place safety measures and allowances for the individual [35].

Cultural Reform

As sexual harassment is fostered by a culture that accepts disrespectful and discriminatory attitudes, instituting cultural change to eliminate these attitudes has become the cornerstone of sexual harassment policies. To communicate this, all universities with medical schools have instituted advisory bodies on sexual assault and sexual harassment, 16% of which are led by the Vice Chancellor or CEO of that university [13].

Universities should adopt a clear, succinct, and broadened approach in their reporting pathways in order for the issues associated with sexual harassment to be tackled. Of particular note, many of the essential features necessary to encompass a good reporting pathway is elucidated in Macquarie University's website. Their sexual harassment and assault reporting model is user friendly and forms a good basis in which other universities should adopt to make the reporting system more effective [38]. Some of these elements include;

- Allowing an anonymous submission for those who do not to desire to reveal their identity, to flag an individual for their inappropriate behaviour;
- An option to let the team know if the student is experiencing any disruption to study or work because of the situation they are reporting and hence be eligible for special consideration;
- Making the evaluating panel as transparent as possible so students are aware of who exactly will be viewing the sensitive and confidential information provided;
- The option for students to voice their opinion on what they believe the most appropriate outcome should be;

All but one have standalone policies addressing sexual assault and sexual harassment. However only three universities have policies solely addressing sexual harassment [13], as recommended by Universities Australia [39] and the Australian Human Rights Commission [12]. Barring one, all medical schools offer seminars for student leaders and staff, and have web pages offering educational resources and access to services [13], such as appropriate contact information, campus security services, and in some cases, incidence data [40]. Of all Australian universities (including those without medical schools) that offer online training, 10% consider this mandatory [13].

Students however, feel that actions currently taken by universities are ineffective at addressing sexual harassment. Only 6% of students believed their university was adequately providing and promoting clear, accessible information on sexual harassment procedures, policies and support services. Only 4% of students said they believed this was the case in relation to sexual assault [12]. Students who did go on to make a formal report or complaint about sexual assault or sexual harassment stated they were often dissatisfied with the response of their university [12].

Additionally, despite gender stereotyping, sexism and underrepresentation of women in leadership roles contributing to the perception of a workplace more tolerant of sexual harassment, these gender parity objectives remain largely absent from university and hospital harassment policies.

Barriers to Reporting

Reporting in the Workplace

Despite the high prevalence of sexual harassment in Australia, the issue continues to be under-reported, with only 17% of people who have experienced sexual harassment making a formal complaint [43]. Of those who made a formal report about sexual harassment, 43% experienced negative consequences such as being labelled as a 'trouble-maker' or being ostracised by colleagues [43]. Perpetrators were not disciplined in 19% of cases, and where action was taken, the most common outcomes were a warning or an apology [43]. Of those who reported sexual harassment, 45% indicated that there was no change in the workplace as a result of the complaint [43].

Several reasons were identified as barriers to reporting sexual harassment in the workplace. Many people who experienced harassment thought that others would regard the report as an overreaction, whereas other targets of harassment thought it was easier to stay silent [43]. Some believed that the reporting process would be too difficult or embarrassing, and would not lead to any meaningful change [43]. Additionally, some workers did not feel that the harassment behaviour was severe enough to constitute a formal report, as these behaviours were perceived as a normal occurrence in the workplace [43].

Work environment has also been cited as a major factor against reporting, with a lack of trust and confidence in the organisation's processes discouraging employees from voicing their concerns [43]. The ways in which employees view conduct that may be considered harassment is also a significant factor in determining reporting rates [44]. Individuals tend to use their own thresholds to judge what is worth reporting, which often exceeds the legal definition of what constitutes sexual harassment [44]. In other words, conduct will only be reported if it exceeds what is tolerated within a particular organisation [45]. Current organisational policies and procedures are in place such that every complaint must be processed through a formal complaint process [46]. This results in the individualisation of workplace harassment, which focuses on policing the behaviour of individuals rather than addressing the practices, systems and work culture that allow such behaviours to occur [47].

Workplace training can thus be optimised to promote a dialogue between employees and for collective discussion of the causes and possible solutions. Equity in other aspects of the workplace have also been identified as protective factors for sexual harassment and can help in reducing sexual harassment [48]. This could include having an equal number of women and men in leadership positions, providing clear expectations of each employee and open dialogue between co-workers and leaders about the culture of the workplace [48].

Reporting in Medical Schools

Barriers to reporting sexual harassment is a similarly large issue within universities and medical schools. A characteristic feature of medical school is the inclusion of a large practicum component that necessitates students to spend significant periods in settings other than their university. When instances of sexual harassment occur in these settings, there can be confusion or limitations to reporting sexual harassment, and this may represent a large barrier to reporting [16,49]. Confusion regarding which policies medical students fall under when learning off-campus results in difficulty

when attempting to enforce these policies. Without resolution, universities and hosting practicum organisations do not uphold their duty of care to students.

Whilst many of the barriers to reporting in the workplace remain the same in medical schools, there are several factors that become exacerbated. The most evident of these is the vulnerability of students, with many students determining that the risk of poor evaluations, shame and embarrassment outweighed any benefits of reporting [34]. Anonymity was also highlighted as an important aspect of reporting [50,51,52]. Absence of the ability to report anonymously may discourage victims from reporting their experience. Organisations should therefore offer avenues through which sexual harassment may be reported anonymously.

The accessibility and ease of reporting may also pose a barrier to reporting. Those who are disabled or from a culturally and linguistally diverse community may find it difficult to navigate the complicated report process, and, as such, may prevent them from completing a sexual harassment report [53,54]. Consequently, university and organisational services should also require expert input from specialist disability services to ensure accessibility for victims with a disability. Additionally, information about accessing help should be readily available in multiple languages, with translator services provided for in-person or telephone appointments.

Whilst sexual harassment cannot be completely eliminated without widescale social change, many students identified education as a meritable interim measure [34]. Medical schools should promote discussions between students and the faculty with regards to sexual harassment, and involve them in the process of reform. Teaching supervisors and physicians to intervene and acknowledge unacceptable behaviours may also begin to change the culture of the medical profession. Many universities and organisations offer training to staff involved with handling complaints of sexual harassment [13,55]. This should include a survivor-centered approach, which provides strategies to staff receiving complaints to treat victims with dignity and respect, to reduce victim-blaming and promote agency [56].

Education

Alongside robust organisational policies, appropriate education and training is recognised as an important part in the chain of prevention against sexual harassment and sexual violence. Education plays a significant role in increasing public knowledge, reforming culture and ultimately changing behaviour within workplaces, including hospitals and universities [57].
At an individual level, empowering workforce employees, doctors and medical students with easily accessible information on sexual harassment is of extreme relevance. This encompasses education on what constitutes harassment, handling sexual harassment situations, and clear pathways for escalation and reporting [58]. A National Survey conducted by the Australian Human Rights Commission (AHRC) found that within universities, the majority of students who witnessed incidences of sexual assault or harassment reported taking no action in response [12]. Alongside other previously mentioned barriers, a lack of transparent escalation pathways and confidence in the system were contributing factors to this bystander inaction. Similarly in hospitals, doctors and nurses outlined the need for accessible reporting procedures that were made universally known within the organisation [58]. Training within organisations is therefore vital to increase knowledge of acceptable behaviours, improve bystander responses, reduce victim blaming, and openly reinforce a ‘zero tolerance’ attitude towards sexual harassment where action is taken immediately without use of a warning system [59].

Education and training of staff is also required to facilitate greater cultural and behavioural change within workplaces. In highly hierarchical organisations such as hospitals, educating senior staff is particularly important to ensure their active involvement in providing role modelling behaviour and support to their team of doctors

and medical students [57,58]. Ongoing reinforcement of key messages on sexual harassment, rather than one-off education sessions, is important to maximise cultural change [12].

Education on sexual harassment and assault has been present in some form within many organisations for years; however, these sessions are often brief, with little consistency between programs [59]. While National Sexual Assault Prevention Education Standards have been developed, current evidence regarding the most effective ways to implement education is sparse and disparate [60,61,62]. This is partly due to the wide variance of programs delivered and the diverse cultural settings in which they are implemented [60]. Programs can range from computer-based to live sessions, role play or team discussions. Developing programs according to a robust evidence base is essential to ensuring that resources are well-directed, and that the implemented solutions are indeed effective [12]. For example, increasing evidence suggests that without behavioural change, simply raising awareness and changing people's attitudes to sexual assault and violence is insufficient to decrease actual rates of occurrence [62]. Proper evaluation of workplace and university education programs is therefore vital, in order to gather evidence on strategies that are most likely to actuate greater cultural and behavioural change.

Within the general community, education regarding sexual harassment and sexual violence is generally targeted towards young people. This is achieved by addressing criteria in the high school curriculum, which is overseen by state governments. Focus of the high school curriculum centres around healthy and respectful relationships, with some states explicitly including knowledge of consent in their learning outcomes [63,64,65]. While resources are usually made available to schools, decisions on how teaching is implemented are made at the school level, so that students' level of exposure to consent education can vary.

In addition to education aimed at preventing and reducing sexual harassment, there is also a need for training in managing patients who have experienced sexual violence. Many doctors, particularly inexperienced junior doctors, feel they lack the training needed to support and manage patients who have experienced sexual violence [66,67]. Many doctors expressed a sense of unpreparedness when managing patients who had experienced sexual violence, despite wanting to provide trauma-sensitive support. Others expressed a lack of understanding of these patients, dismissing their reactions to sexual violence as "overexaggerated", or disbelieving patients' accounts of sexual violence [67]. Some professionals also expressed a belief that avoiding the topic may be more beneficial for the patient's health, so as not to "open old wounds" [67]. Generally, health professionals who lack experience and training in this area are more likely to be disrespectful or inconsiderate of patients who have experienced sexual violence [67].

A major factor contributing to these poor clinical outcomes originates from medical training predominantly being structured around biomedical models of care [67]. The biomedical model focuses on treating psychological symptoms in response to traumatic events such as sexual violence as pathological, rather than adaptive behaviours [67].This model of treatment often does not address the impacts trauma can have on a patients' life, resulting in training programs failing to prepare doctors adequately to respond to a patients' disclosure of having experienced sexual violence.

Medical schools and specialty colleges should therefore incorporate the trauma-informed care model in their training programs, as this facilitates greater understanding, respect and trust between doctors and patients who have experienced traumatic situations. This model differs from the biomedical model by approaching patient care in a more holistic manner, particularly by understanding the impacts of traumatic experiences on patients' lives and incorporating this into their care [67]. Training should involve development of clinical skills in sensitively identifying patients who have experienced sexual violence, and discussing and responding to the

disclosure of that information. Ideally, these programs should also be tailored to the knowledge and experience of individual doctors to maximise the clinical benefits [67]. In instances where further education and training programs have been actioned, the general attitudes of doctors regarding the care of patients who had experienced sexual violence were noted to have been improved [67].

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Policy Details

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Alisha Tang, Hannah Rubinstein, Sivasaaini Sivakumaran, Sapumal Gunaruwan, Jing Hsu, Laura Kelly, Aahana Dudani, Fergus Stafford (National Policy Officer)
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