Equal Opportunity Tasmania

Inquiry into Tasmanian experiences of gendered bias in healthcare

Submission by the Anti-Discrimination Commissioner (Tas)

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Introduction

Thank you for the opportunity to make a submission on the **Inquiry into Tasmanian experiences of gendered bias in healthcare** (the 'Inquiry').

As Anti-Discrimination Commissioner, I am responsible for administering the *Anti-Discrimination Act 1998* (Tas) (the Act). The Act prohibits both direct[1] and indirect[2] discrimination on the basis of gender[3], offensive, humiliating, intimidating, insulting or ridiculing conduct[4] on the basis of gender[5], as well as other types of conduct and in relation to other protected attributes.

Gendered bias in healthcare is widely known to exist. There have been many anecdotal experiences shared across traditional and social media, amongst communities and with service providers, where individuals (in particular, women) express they have had their concerns dismissed, ignored and undermined, leading to poorer health outcomes.

An additional barrier presented by gendered bias in healthcare, is the identification of the experience as one of discrimination. Vulnerability is inherent in the seeking of healthcare and for individuals who experience bias in such service delivery, it may not be until a significant period of time has passed that such bias is identified.

While Equal Opportunity Tasmania has limited complaint examples to provide, **confidential** examples provided to the Committee demonstrate the existence of bias in healthcare which is evident in relation to both gender and gender identity.

Gendered bias impacts both health outcomes and access to healthcare. It is essential that those administering medical services do not compromise care with biases, disadvantaging both individuals and social groups, and increasing risk for specific demographics.

Sarah Bolt
Anti-Discrimination Commissioner

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1 As defined in section 14 of the *Anti-Discrimination Act 1998* (Tas).

2 As defined in section 15 of the *Anti-Discrimination Act 1998* (Tas).

3 *Anti-Discrimination Act 1998* (Tas) s 16(e).

4 *Anti-Discrimination Act 1998* (Tas) s 17(1).

5 See note 3.

Considerations under the *Anti-Discrimination Act 1998* (Tas)

Gendered bias can result in discrimination, which is unlawful under the *Anti-Discrimination Act 1998* (Tas) (the Act).

The Act provides protections on a number of grounds (called 'protected attributes'). For the purposes of the Inquiry, the attributes most relevant to experiences of gendered bias in healthcare have been identified as:

- gender
- sexual orientation
- lawful sexual activity
- gender identity
- intersex variations of sex characteristics
- marital status
- relationship status
- pregnancy
- breastfeeding
- parental status
- family responsibilities

There are a number of other protected attributes under the Act, however it is clear from enquiries and complaints made to Equal Opportunity Tasmania that these attributes are often the basis for discriminatory treatment for the scope of the Inquiry. It is crucial to be aware that gendered bias can sometimes constitute discrimination on the grounds attributes other than gender, such as lawful sexual activity, or pregnancy, for example.

Further, these attributes have been identified as most relevant owing to the fact that treatment on the basis of these is more likely to be intertwined with experiences of gendered bias. An intersectional lens is important to understand the differing experiences of gendered bias for varied social demographics. A patient may experience discriminatory treatment because of an

intersection of their gender and that they are:

- culturally and linguistically diverse
- Aboriginal or Torres Strait Islander
- LGBTIQA+
- of a particular age

Actual and anecdotal evidence suggests that developing a comprehensive understanding of the experience of women, in particular, who have encountered gendered bias in a healthcare setting requires consideration of the many interacting elements.

Intersectionality is demonstrated by the difference of experiences resultant from 'intersecting' attributes (such as gender and race, or gender and age), for example:

- a young woman may have a vastly different experience to an older woman, and a young Afghan woman may have a vastly different experience to a young Caucasian Australian woman
- a man in his twenties may be treated quite differently to an older man, where stereotypes about how receptive older men are to receiving and listening to medical advice may impact the provision of such services

Attributes are not always determinative of experience, but can significantly impact how individuals, including those who administer health services, come to decisions. There is a risk that decision-making is driven by bias, rather than evidence, or that the perception of evidence is impacted by bias. Positively and negatively held prejudices influence individuals to behave in particular ways, often without consideration given to their biases and how those biases may reinforce and underpin confidence in flawed decision-making.

Behaviours arising from gendered bias in healthcare may be against the law. The Act makes the following types of conduct unlawful:

- direct discrimination
- indirect discrimination
- offensive, humiliating, intimidating, insulting or ridiculing conduct
- sexual harassment
- victimisation
- publishing or displaying, or permitting the publish or display, of content which is discriminatory, offensive etc. sexually harassing etc.
- aiding a contravention of the Act

Direct discrimination

Direct discrimination may be the most commonly identified type of discrimination for individuals impacted by health services which have been compromised due to gendered bias.

Direct discrimination occurs when a person treats a person less favourably on the basis of a protected attribute, an imputed protected attribute, or a characteristic imputed to a protected attribute, compared to another person.

For example:

- offensive comments towards a male patient with suspected HIV[6]
- refusing to refer a patient for abortion services
- pressuring a young woman to go on the contraceptive pill after she discloses she is sexually active

Direct discrimination is more easily identified by individuals as unfair and unequal treatment. This is because of the nature of the conduct, being 'directed' at an individual. It is generally overt, observable and can be compared to how another (who does not possess the attribute which forms the basis for the conduct) is treated.

Indirect discrimination

Indirect discrimination is more difficult to identify and occurs when there is a condition, requirement or practice which disadvantages a member of a group of people who share, or are believed to share a prescribed attribute (or characteristic imputed to that attribute), more than a person who is not a member of that group. The condition, requirement or practice must also be considered unreasonable in the circumstances for it to be indirect discrimination.

For example, refusal by a medical facility to allow children into treating rooms which may impact women more than men as women are more likely to have caring duties may be indirect discrimination.

Equal Opportunity Tasmania received a report of this in recent years (the requirement was implemented due to COVID-19). As it was an enquiry and not a complaint, there was no opportunity to explore whether or not the requirement was reasonable, however the argument it may impact women more than men is strong.

Additionally, indirect discrimination is often used to describe how larger-scale systemic and institutional disadvantage has formed. The disadvantage is structural, embedded within systems of power and high-level decision making, but impacts individuals. At present, there is a heightened awareness regarding this type of disadvantage and surrounding discussions tend to focus on achieving more positive outcomes, i.e. through decision-making about the funding of

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6 This conduct could also constitute offensive, humiliating, intimidating, insulting or ridiculing conduct under section 17(1) of the *Anti-Discrimination Act 1998* (Tas).

health initiatives where disadvantage is identified for particular social demographics.

Prohibited conduct

Other types of conduct covered under the Act are referred to as 'prohibited conduct'. It is observed that allegations of offensive, humiliating, intimidating, insulting or ridiculing conduct are often made alongside those of discrimination.

The test of offensive etc. conduct involves an objective assessment as to whether or not the offence etc. took place in circumstances in which a reasonable person, having regard to all the circumstances would have anticipated that the other person would be offended etc. I note however, that individuals working within a healthcare setting and providing medical treatment to vulnerable individuals should be aware of the potential for their behaviours to be offensive, humiliating, intimidating, insulting or ridiculing of individuals if conduct arises out of gendered bias in the provision of medical treatment.

The importance of training to prevent such conduct is explored further in this submission.

Further considerations for the Commissioner

If a person considers a breach of the Act has been committed against them, they can lodge a complaint under the Act. The Commissioner will investigate if a possible breach is disclosed.

Regarding health complaints, the Commissioner considers whether the Act is the appropriate jurisdiction for the complaint to be dealt with, as she has the option to reject the complaint if in her opinion, the subject matter of the complaint may be more effectively or conveniently dealt with by a State authority or a Commonwealth statutory authority.[7]

Whether a complaint made under the Act is more effectively or conveniently dealt with by the Health Complaints Commissioner is a relevant consideration for the Commissioner in her assessment of a complaint involving allegations about healthcare services. There is no direct referral mechanism available under the Act, so if the decision is made to reject the complaint, it remains up to the Complainant to then lodge a separate and additional complaint to the Health Complaints Commissioner. This may prove a barrier to complainants, and is not a process which allows for a trauma-informed approach, easy access to justice, nor alleviates individuals from complex bureaucratic requirements.

Additionally, there may be instances where the alleged treatment may have been impacted by bias, however there is not sufficient information to show a nexus[8] between the conduct and a particular protected attribute, and the Commissioner is therefore to reject the complaint.

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7 Anti-Discrimination Act 1998 (Tas) s 64(1)(g).

8 *Shayne Arkley v CatholicCare Tasmania & Andrea Witt* [2017] TASADT 3.

Issues within complaint-based jurisdictions

The option to make a complaint is vital as a way to access justice, however it is important to understand the barriers and limitations that are inherent to a complaint-based system. These barriers may act as a deterrent to complaining, in particular when an individual already feels disempowered due to their experience.

As stated above, seeking healthcare places an individual in a situation where they are vulnerable. A person who thinks they have been treated in a way that is biased as a result of gender may be influenced whether or not to make a complaint addressing such bias based on:

- the severity of the situation (i.e. a passing remark compared to medical malpractice)
- fear of the individual who administered the health service (particularly if there is ongoing treatment)
- whether they perceive they are able to go somewhere else (i.e. limited availability of medical services in particular areas)
- available support systems (advocates, families, workplaces)
- access to representation
- sociodemographic factors (financial status, levels of literacy)
- understanding of the complaint system and how to navigate it
- possibility of the complaint becoming public and their subsequent identification
- fear of being centred as the problem (including risk of victimisation)
- emotional capacity to engage with the process

A further consideration is the selection of the appropriate jurisdiction in which to lodge a complaint. Individuals have the option of different types of complaints, depending on context and preference. If a person thinks they have experienced gendered bias in the provision of healthcare, they may choose to lodge a complaint to Equal Opportunity Tasmania, the Health Complaints Commissioner, the Australian Health Practitioner Regulation Agency, or they may consider a medical negligence claim by obtaining private representation.

Complaints made under the Act are able to be resolved by conciliation in some circumstances. If, following investigation, a complaint is unable to be dismissed or resolved, the complaint will be referred to the Tasmanian Civil and Administrative Tribunal for inquiry.

The availability of conciliation is an element of the complaints process which affords individuals a level of control over the outcome of their complaint, however it can be incredibly dependent on the level of engagement of respondents. A respondent organisation (as distinct from an individual) often has a level of power and authority that a complainant does not. An organisation has access to legal representation and resources which make defending a complaint and participating in a

complaints process less onerous (in some circumstances).

The behaviour of a complainant is also a significant factor in the outcome of a complaint, however for the purposes of this submission, the focus is on the barriers and issues which are more likely to affect a complainant and impact remedies sought as a result of an experience of gendered bias in healthcare.

To that end, noting the vast many health facilities which are managed by the Tasmanian Health Service in Tasmania, I would encourage the adoption of model litigant obligations. While such obligations cannot be imposed on private health facilities, where there is the opportunity for the adoption of a consistent standard that government entities are obligated to uphold in their responses to complaints, this should be adopted.

Examples of Tasmanian experiences of gendered bias in healthcare

Equal Opportunity Tasmania does not receive many complaints relating to the provision of healthcare (even where such healthcare has involved gendered bias). As I understand it, most complaints of this nature are made to the Health Complaints Commissioner.

Equal Opportunity Tasmania received a complaint in 2022 containing allegations which demonstrated possible disability discrimination however included a gendered element. The alleged conduct disclosed allegations about the treatment by a female general practitioner of their female patient which resulted in high levels of distress for the patient.

Another complaint was received less recently, which set out possible discrimination on the basis of marital status. The alleged conduct can be taken to be more likely to affect women and appeared to arise from the lack of appropriate policy being implemented to ensure the safety of women in that particular facility.

Detailed examples have been provided to the Committee on a confidential basis.

Examples of Tasmanian experiences of gendered bias in the healthcare profession

It is more common for Equal Opportunity Tasmania to receive complaints disclosing discrimination on the basis of gender experienced by employees working in the healthcare profession.

Detailed examples have been provided to the Committee on a confidential basis.

I make the observation that the existence of discriminatory attitudes directed at employees may extend to patients who experience medical consultation or treatment by the individuals with biased views.

While highlighting gendered bias in the course of employment in healthcare settings may seem outside the scope of the Inquiry, it is essential that there is an understanding of the industry and the experiences of female staff who have encountered gender discrimination while working within it.

Medicine has historically been a male-dominated profession. Research has been usually undertaken by male medical practitioners, the gender pay gap and experiences of sexual harassment within the profession have been widely reported, and women who do progress to senior levels continue to experience discrimination on the basis of attributes such as family responsibilities, pregnancy and breastfeeding.

In order to combat gendered bias in the administration of healthcare, female staff must be able to be retained through ensuring safety in the workplace. The industry must be attractive to women choosing to study STEM and progress careers in the medical profession.

Lived experience of gender bias is helpful in the performance of duties, however more important is having adequate female staffing at more senior levels, which will assist to provide better care to female patients. Women's careers must be supported as their careers are arguably linked with the provision of care where gender is a relevant factor in the treatment. Workplaces which are safe for women will be better able to provide women with appropriate healthcare.

Examples of Tasmanian experiences of bias in the healthcare profession relating to transgender clients

The treatment of transgender people in the community is of increasing concern.

Equal Opportunity Tasmania has received a number of complaints relating to the provision of healthcare to transgender patients.

Detailed examples have been provided to the Committee on a confidential basis.

In *S. v H* [2017] TASADT 4[9] the Respondent operated a hospital. The Complainant, a transgender woman, who was a patient at the hospital, relevantly alleged that staff of the Respondent referred to her in the masculine, despite repeated requests by her that they stop doing so and refer to her by her preferred name and pronoun.

The Tribunal made a finding of discrimination and offensive, humiliating, intimidating, insulting or ridiculing conduct:

> 80. The evidence establishes that the Complainant was discriminated against in the treatment which she received by the Respondent's staff at the Hospital by references to her in the masculine gender and after staff were corrected by the Complainant that conduct continued.
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> 81. I accept that there was no motivation by any of the respondent's staff to intentionally cause any distress, insult or offence to the Complainant and that in most occasions it may have been merely a mistake on their part. However, given that the context of this conduct is a hospital where patients are being treated for mental health conditions, there should have been an enhanced awareness of these issues.
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> 82. The evidence was that neither Nurse D nor Nurse C had received any specific training in relation to transgender or gender issues.
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> ...
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> 84. I find that the Respondent's staff treated the Complainant less favourably on the basis of her sexual orientation and gender when referring to her as a male when she clearly identified and was described in the Hospital records as female. I find this complaint proved.
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> ...
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> 88. The conduct of the Respondent's staff in referring to the Complainant in the masculine gender did offend, humiliate and insult the Complainant on the basis of her gender, namely her being female.

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9 *S. v H* [2017] TASADT 4.

I note that the provision of healthcare to transgender people is a complex issue and subject to high levels of disinformation. Transgender people are continuously discussed without consultation, where statements are made in a flippant way, rendering harm to an already vulnerable community.

While Equal Opportunity Tasmania has not received reports of young transgender people and their experiences of transition in a healthcare setting, in particular how that experience has been impacted by gendered biases, I encourage the development of an understanding of this area. Discussions in the community will continue to be had and it is important that policy responses are informed following meaningful and targeted consultation with the community, including specific demographics of that community.

Training of employees providing health services

Ensuring staff are educated and informed is critical to preventing and responding to gendered bias (or potential bias) which may impact the delivery of health services.

For staff of a health facility, a knowledge of the concept of discrimination and harassment is not sufficient. Training should deal with specific attributes and provide more detail than generalised content. The nature of the health facility is also relevant.

The case of *S. v H* [2017] TASADT 4 (referred to previously in this submission) highlights the importance of comprehensive staff training. In that case it was submitted that employees of the Respondent received training in discrimination and harassment, however particular nursing staff had not received training on transgender or gender issues.

The Tribunal said:

> 100. I find that whilst the Respondent did make its employees aware of the meaning of discrimination and harassment, it failed to provide training to staff in respect of gender, sexual orientation and issues relating to transgender. This is particularly important for staff who are treating patients for mental health issues which may arise from such attributes. Further, it is clear that the Respondent has failed to ensure that its employees do not engage in discrimination or prohibited conduct as set out above.

The case also set out that there should be a higher awareness of such issues in a mental health facility due to the nature of the medical services being delivered:

> 104. The evidence was that this conduct was not on one isolated occasion, but occurred with several staff on at least several occasions. The context of where the conduct occurred, namely at the Hospital where the Complainant had sought treatment for mental health issues is also relevant. In such an environment, there should be an increased awareness of these issues.

The above observations can be applied in a wider range of health facilities, including those targeted towards men and women and the particular health issues that facility seeks to provide medical advice and treatment on.

Observations and concluding remarks

Gendered bias is inherent in medical systems, structures and methods of diagnosis due to the historical clinical development of the understanding of disease and illness as measured according to male bodies, overwhelmingly by male medical researchers. Shame, stigma and dismissal impact the accessibility of appropriate treatment for women, transgender and gender diverse patients.

A much referenced example of this is the differing heart attack symptoms experienced by men and women and the recent identification and wider promotion of this difference.

Discrimination can be addressed in a myriad of ways, such as:

- recruitment, retention and promotion of women, transgender and gender diverse individuals in the healthcare field (which also requires addressing the gender pay gap and ensuring those workplaces are safe)
- promotion of initiatives to combat gendered bias and discrimination in health settings
- continued and appropriate funding for women's health services specifically, including the delivery of such services and targeted research into health conditions which are more likely to impact individuals on the basis of gender

Endometriosis is a distinct example of how gendered bias in healthcare and lack of funding into research for conditions experienced by women, transgender and gender diverse people has been neglected over time to the detriment of those seeking medical care. The length of time to receive a diagnosis is abysmal, with many individuals reporting debilitating symptoms which have gone unaddressed despite increasing severity. Overall delays in diagnosing many medical conditions is a current issue of increasing concern.

Recently, there has been a significant rise in the awareness of this condition. This has had a number of benefits. More individuals are identifying their symptoms as possible endometriosis and seeking medical treatment as a result, individuals are being empowered to speak up about such symptoms, additional government funding specifically related to the condition is being implemented, significant media coverage of the condition and changes to government policy directly impacting accessibility of care is also occurring. Further, and most importantly, knowledge of the condition within the medical profession is rapidly increasing.

In relation to gendered bias in healthcare, men face ongoing barriers in relation to the access of mental health supports. Reductive attitudes relating to masculinity lead to isolation and reluctance to access medical care for mental health issues. The rate of suicide for men has been identified as a widespread social issue, requiring a strategic approach which destigmatises the accessibility of mental health services for males and creates accessible, safe and responsive services (such as MensLine Australia and Men's Sheds).

The above examples demonstrate the importance of a multifaceted approach to combating gendered bias in the provision of healthcare. Men, women, transgender and gender diverse individuals may encounter stigma and sexism, impacting their ability to speak openly and in detail about their health issues. Women are disproportionately affected due to social taboos related to

speaking about health issues which affect them, i.e. discussions of menstruation across all cultures is generally discouraged and/or considered shameful or embarrassing, however for some women of culturally and linguistically diverse backgrounds, it is wholly unacceptable to openly discuss period symptoms. Campaigns to decrease shame and stigma are important, as well as culturally appropriate service delivery in healthcare, taking into account different perceptions of medical issues which may arise as a result of a patient's cultural background.

The stereotypical perception of women as being dramatic, sensitive and emotional may impact the seriousness with which their reported symptoms are considered and addressed. With increasing awareness, these stereotypes are being challenged, however there is still substantial work needed to change existing views.

Overarching cultural attitudes in relation to women, men, transgender and gender diverse people continue to be a major determinant in health outcomes for these individuals. Existing stereotypes and perceptions influence factors which include, but are not limited to:

- the acceptance of reported symptoms
- the likelihood of referral and where a patient is referred
- whether further questioning is undertaken
- whether informed consent is ensured
- whether the individual is centred as the problem
- correct diagnosis being achieved
- the promptness in addressing conditions

While gendered stereotypes and biases will continue to develop and change over the progression of time, it is essential to be cognisant of their ability to influence health outcomes for patients. It is the responsibility of individuals working in healthcare to attempt to unravel and address their own gendered biases, and it is the responsibility of their employer to facilitate this and to create safe workplaces. However, ultimately it is only government which can motivate and support widespread societal change to achieve the vision of the provision of healthcare unaffected by gendered bias.

The examination of gendered bias in healthcare through this Inquiry allows for the development of a wide-ranging understanding of the complex systems and social norms directly and indirectly influencing health outcomes. This understanding will enable the informed creation of policy tailored to address identified priority issues and seek to deconstruct and dismantle structures which result in harm of particular demographics and improve health outcomes for all individuals and social groups.

I thank the Committee for the opportunity to participate by providing a submission as part of the Inquiry.