

The impact of oppressive behaviours on female general surgical trainees' educational experience in Malaysia

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Dear Editor,

Although projected to attain high-income country status by 2028,¹ Malaysia is still critically short of specialist surgeons with 1.2 per 10,000 population² compared with the OECD average of 7.23 per 10,000. The majority (60%) of Malaysian medical students are women, but they form a minority of the general surgical workforce (10%). The proportion across Southeast Asia varies widely, from 3.5% (Indonesia) to 50% (Thailand).³ Worldwide, surgery is declining in popularity, particularly among women, with lifestyle factors identified as key deterrents.⁴⁻⁶

In addition, oppressive behaviours in the workplace negatively influence career decisions among prospective trainees, disproportionately affecting women.⁴⁻⁶ In Australasia, 49% of respondents to a survey commissioned by the Royal Australasian College of Surgeons (RACS) had experienced oppressive behaviours, and female trainees were more highly affected.⁷

Following a commission by the College of Surgeons, Academy of Medicine of Malaysia (CSAMM), we designed a structured questionnaire based on the RACS report,⁷ comprising 17 items on demographics and career plans, and 66 items on work-life balance, job satisfaction, quality of life support system

(WHOQOL-BREF)⁸ and oppressive behaviours in the workplace.⁷ Where rating was required, a 7-point Likert scale was used. Discrimination was defined as unjust or prejudicial treatment of different categories of people.⁹ Bullying was the use of superior strength or influence to intimidate a subordinate, forcing the person to conform to one's desire.¹⁰ Harassment was the use of aggressive pressure on, or intimidation of others⁷ while sexual harassment was any unwelcome/unwanted physical, verbal or visual sexual advances to another person.^{6,7}

All female general surgical trainees across all Malaysian training programmes were invited to participate with informed consent. Sixty-three out of 74 invited participants (85%) responded, with 62 completing the survey. The mean age was 32.5 ± 1.9 years. Ethnic distribution approximated national proportions (Malays 54%, Chinese 29%, Indians 14.5%). Nearly half (45.2%) were married with children and worked, on average, for 75 ± 19.59 hours a week. Work-family role conflict was experienced by 45.5% of the participants. A significant proportion (40.3%) were not satisfied with their health (Table 1).

Nearly half of the respondents had experienced at least 1 of the oppressive behaviours in the workplace (discrimination 43.5%; bullying 45.2%;

Table 1. Descriptive statistics of all study variables.

Variables	n	Minimum	Maximum	Mean	Standard deviation
Work-family role conflict	62	22.00	60.00	39.25	9.27
Social support	62	13.00	60.00	47.95	8.46
Intention to quit	62	4.00	18.00	7.90	3.74
Quality of life (overall)	62	6.00	18.00	13.00	3.02
Physical health	62	8.00	18.29	14.05	2.12
Psychological health	62	7.33	20.00	13.40	2.27
Social relationships	62	5.33	20.00	13.62	3.29
Environmental health	62	7.00	18.50	13.72	1.99

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sexual harassment 19.4%; harassment 27.4%). In 61.3% of cases, the perpetrator was male. Obstacles to seeking redress were worries about impact on career progression (27.4%), loss of reputation to self (22.6%), fear of being blamed (21%) and the stress of filing a complaint (16.1%). Fear of not being believed (12.9%) or being victimised (11.3%) were also of concern. Interestingly, a small proportion (4.3%) worried about loss of reputation for the perpetrator.

Actions taken included direct confrontation (27.4%), peer discussions (24.2%), legal consultations (14.5%), formal complaints (1.6%) and police reports (1.6%). Only 65.8% reported satisfactory resolution. For 8.1%, the behaviour has continued.

The suggested preventive measures included training of trainers, delivered by the hospitals (59.7%) or by CSAMM (40.3%); resources to support better communication (66.1%); better support mechanisms such as counselling services (66.1%) and greater leadership by surgical departments (69.4%). Nearly half (49.1%) coped through family support. While 67.7% were considering another job, only 35.5% were contemplating quitting the profession altogether. Undeterred, 75.8% were considering further training in a subspecialty.

Surgery is still appealing to medical graduates, but resilience is required to remain and practice in the field. Despite compelling evidence to the contrary,^{5,6} surgical culture has been built on the myth that oppressive behaviours in the workplace are necessary to train surgical excellence.

We have shown that oppressive behaviours in Malaysian surgical workplaces are more prevalent than global pooled figures,¹¹ negatively impacting female general surgical trainees.¹² Perpetrators are often highly respected members of the fraternity, and trainees may not know or feel that they can seek redress. Avenues for redress can result in punitive outcomes, for either party, so trainees may choose against lodging complaints.⁴

This experience is not unique to general surgery. Malaysian orthopaedic trainees report gender discrimination in career opportunities (28%) and daily work (60%) favouring men while women were more likely to experience verbal (32%) and physical (11%) sexual harassment.⁶ Female paediatric surgical trainees were more likely than men to face work-life conflicts.⁵ Even in internal medicine, female trainees were more likely to experience verbal bullying or sexual harassment, with a greater likelihood of negative personal consequences.¹³

Improving surgical working conditions for women would positively impact surgical culture as a whole,^{4,6} supporting sustainability of the surgical workforce. Nevertheless, changing ingrained surgical culture is

difficult. While a top-down approach (i.e. administrative directives) is helpful, only bottom-up implementation can ensure true and meaningful change. While policies supporting flexible working hours, maternity and breastfeeding leave exist, these depend on approval by administrative heads and may conflict with training requirements. However, as there are existing policies, in some respects, this is an easier battle, as trainees can be empowered to defend their rights.¹⁴

Changing oppressive behaviours in the workplace is much more challenging. There are few policies on dealing with complaints; there are none relating to prevention. Within some training programmes, trainers are explicitly briefed on their roles and responsibilities, including appropriate behaviour in the workplace, and trainees are informed of their rights and avenues for complaint. Nevertheless, this does not occur uniformly.¹⁴ While oppressive behaviours usually occur in the direction of the power distance (i.e. the powerful oppress the weak, trainers oppress trainees), this can be affected by gender (e.g. female trainer sexually harassed by male trainee). Therefore, measures must be in place to protect both trainees and trainers from fabricated allegations.¹⁵

Prior to 2022, only the amended Employment Act 2012 provided recourse for sexual harassment in the workplace in Malaysia. The Anti-Sexual Harassment Act 2022 was a step forward in providing legal foundation for action.¹⁴ Nevertheless, while some educational institutions have started to establish policies, implementation has been challenging, often relying on the efforts of individuals. We recommend that training institutions also focus on changing workplace culture, utilising implementation science strategies. Such organisational support is essential for empowering and sustaining young female would-be surgeons in the profession.

Ethics statement

Ethics approval was obtained from University Malaya Research Ethics Committee (UM.TNC2/RC/H&E/UMREC-114). Informed consent forms were signed by all participants as per approved guidelines.

Declaration

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