



# Systematic audit of Australian specialty colleges' policies on bullying, discrimination, and harassment

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## ABSTRACT

**Objective.** To support policy makers and healthcare workers to reduce high rates of bullying, discrimination, and harassment (BDH) that affect doctors in Australian specialty training sites. **Methods.** This audit assessed the quality of policies regarding BDH and associated complaints of the Australian Medical Council-accredited Australasian specialty training Colleges (Colleges). Policies were systematically identified and scored against a national standard BDH policy checklist. **Results.** Fourteen of the 16 Colleges have each written and curated their own BDH policies for their members, with wide variation between Colleges regarding content and processes. This impairs the efficacy of BDH handling in specialty training sites. **Conclusions.** Key areas for improvement were identified. A checklist is proposed that is specific to College BDH policies and processes involving specialty training sites.

**Keywords:** bullying, complaints, discrimination, harassment, occupational health and safety, policy, psychosocial hazards, work health and safety.

## Introduction

Improved, coordinated regulatory processes are required to address bullying, discrimination, and harassment (BDH) that are entrenched in the Australian health-care system.<sup>1</sup> Each year at specialty training sites, BDH directly impacts over one-third of doctors in specialist training (trainees) and risks patient safety and public health.<sup>1–4</sup>

Australian Medical Council (AMC)-accredited Australasian specialty training Colleges (Colleges) have chosen to address BDH through policy and/or position statements and frequently direct their members (specialists and trainees) to report BDH to their workplace or external agencies. However, contrary to a collaborative strategy recommended by the Australian Senate Inquiry's 2016 review of medical complaints processes, most Colleges have each designed and curated their own policies.<sup>1</sup>

High BDH rates may reflect the College policies' quality and/or consistency as well as the Colleges' compliance in applying these policies. Silos in healthcare have created differing expectations among doctors who work in the same clinical environment but are members of different Colleges. The resultant ambiguities and thinly spread accountability may advantage BDH perpetrators.<sup>1,5</sup> Australia introduced new work health and safety (WHS) regulations for psychological safety in April 2023, and Colleges appear to have WHS duties in relation to their oversight and accreditation of specialty training sites.<sup>6–9</sup>

This audit assesses the quality of Colleges' policies regarding BDH and associated complaints processes. The discussion offers suggestions to support policy upgrades and seeks to identify the potential benefits of a significantly revised, overarching policy to improve BDH outcomes and limit its widespread impacts. Insights from the audit are relevant to all healthcare professionals and offer practical ways to address Australia's BDH epidemic in specialty training sites.

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## Methods

### Inclusion criteria

The scope of this BDH policy audit was limited to the 16 Colleges (Box 1).<sup>10</sup>

A definition of College BDH and complaints 'policy' was established prior to conducting the audit search. Documents were deemed eligible if they included:

- the keywords 'bullying' or 'discrimination' or 'harassment' or 'grievance' or 'complaint(s)',
- the title 'Policy' or 'Rules and Regulations',
- evidence of promulgation, such as a document number and release date, and
- the name or role of authorised College signatories.

If a College policy stated that it was to be applied in conjunction with an accompanying complaints or grievance policy, then these were retrieved and incorporated into the audit. However, if yet further policy documents were referenced, then these were not audited because functional BDH complaints policies would ideally contain sufficient information regarding relevant processes within a maximum of two documents.

### Search strategy

The audit search was conducted by the first author between May and September 2022. Each College website was searched to obtain BDH policies, which were downloaded if publicly accessible. For Colleges where the BDH policy was inaccessible, an email was sent to that College requesting an electronic copy for research audit purposes. On 16 April 2023, the process was repeated to identify revised policies, and the most recent policy versions are reported in this paper.

### Scoring system

The Victorian Auditor-General's report on *Bullying and Harassment in the Health Sector* criticised medical complaints processes for lacking outcome rationale, using inappropriate investigators, and for not committing to an acceptable timeframe.<sup>5</sup> To identify whether those factors persist, Colleges' BDH policies were audited against a set standard, the Australian Government's Comcare audit tool for workplace BDH policies.<sup>11</sup> Comcare is the national authority for WHS and for workers' compensation, and it is recognised as such by the Australian Medical Association.<sup>12</sup>

Both authors performed the audit using the Comcare checklist, which has 32 criteria. These were allocated item numbers sequentially from 1 to 32, of which two (items 19 and 25) could not be assessed in this audit and so were allocated zero marks. For each College, any composite policy documents were treated as one policy overall. Policies were assessed and scored independently by each author, who allocated either one mark, if the policy was deemed to have met the criterion, or zero. Marks by the two authors were then compared and differences were discussed. For any marking difference that could not be resolved, the mark given by the first author was final. For each College, the final marks were totalled and then converted to a percentage score.

### Investigative standards benchmark

The *Council of Australian Tribunals (COAT) Practice Manual for Tribunals* is a publicly accessible resource that describes investigative standards and methods for minimising bias, and emphasises the importance of explicitly committing to uphold these standards.<sup>13</sup> It sets out the principles of natural justice and procedural fairness (Chapter 3); how tribunals reach decisions (Chapter 6), including how relevant evidence is identified and evaluated (Chapter 6.2.6–6.2.12);

#### Box 1 List of the Australian Medical Council-accredited Australasian specialty training Colleges<sup>10</sup>

- Australasian College for Emergency Medicine (ACEM)
- Australasian College of Dermatologists (ACD)
- Australasian College of Sport and Exercise Physicians (ACSEP)
- Australian and New Zealand College of Anaesthetists (ANZCA)
- Australian College of Rural and Remote Medicine (ACRRM)
- College of Intensive Care Medicine of Australia and New Zealand (CICM)
- Royal Australasian College of Dental Surgeons (RACDS)
- Royal Australasian College of Medical Administrators (RACMA)
- Royal Australasian College of Physicians (RACP)
- Royal Australasian College of Surgeons (RACS)
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
- Royal Australian and New Zealand College of Ophthalmologists (RANZCO)
- Royal Australian and New Zealand College of Psychiatrists (RANZCP)
- Royal Australian and New Zealand College of Radiologists (RANZCR)
- Royal Australian College of General Practitioners (RACGP)
- Royal College of Pathologists of Australasia (RCPA)

and how decisions are communicated (Chapter 6.3).<sup>13</sup> Therefore, the COAT manual was identified as a standard to assist the analysis of the policies.

Colleges and their members (specialists and trainees) traverse Australia's complex legislative landscapes. Their BDH investigative processes function as non-statutory tribunals. Even though the COAT manual explicitly applies to statutory tribunals, it applies a broad definition of a 'tribunal' (Box 2) – which encompasses College BDH handling processes – and thereby provides aspirational standards and a valuable conceptual framework that is directly relevant.

## Ethics

Due to the subject and scope, and because these audited policies are documents in the public domain, ethics approval was not required. It was neither appropriate nor possible to involve patients or the public in the design, conduct, or reporting of this research.

## Results

### Policy retrieval

Of the 16 Colleges, 12 had BDH policies that were directly accessible from public websites.<sup>14–25</sup> Access to the RANZCP policies required membership for access and were supplied upon email request.<sup>26,27</sup> The RACS policy did not include the search terms in its title but their *Equal Opportunity and Acceptable Workplace Behaviour* policy was supplied upon email request and was audited.<sup>28</sup> Additionally, 10 related policy documents were identified for assessment.<sup>29–38</sup>

The policy section of the RACP website contains a document, *Respectful Behaviour in College Training Programs*, that broadly mentions BDH but specifies no internal pathways to act on BDH affecting RACP members and redirects members with BDH concerns to report these to hospital training sites or external organisations.<sup>39</sup> This document did not meet inclusion criteria for the audit because, in essence, it is a position statement without evidence of promulgation. Of note, its format is very different to the RACP's formal policy documents.

The RACGP website did not yield an eligible policy, and a response was not received following two email requests sent to the RACGP. The document *RACGP Employee Handbook, Incorporating Human Resources Policies 2017* does contain

BDH policy, but it applies to RACGP employees rather than members, and therefore, it was not included in the audit.<sup>40</sup>

Results of the policy search process are summarised in Fig. 1.<sup>41</sup>

### Assessment of policies

Overall, the audit revealed that 14 of the 16 Colleges have BDH policies. In terms of accessibility, most were easily accessible on the relevant College website (12/14 policies) and were generally written in plain English. The RCPA was the first College to implement a BDH policy in 2000, with other Colleges gradually following suit over the following 21 years (Fig. 2).

Of the 14 Colleges with BDH policies, the scores ranged from 14 to 29 (out of 32), indicating that although some policies are reasonable, there is scope for significant improvement. The co-authors' scores generally aligned, and any variation in total score was less than two marks. The audit scoring should be interpreted as a guide and should not be interpreted as rejection or overt criticism of College policies (Table 1).

Many policies include formal and informal complaints processes, and almost all acknowledged that confidentiality is a priority. However, the BDH policies refer only vaguely to principles of natural justice, and most do not expressly mandate that experienced, qualified investigators will conduct timely and transparent investigations.

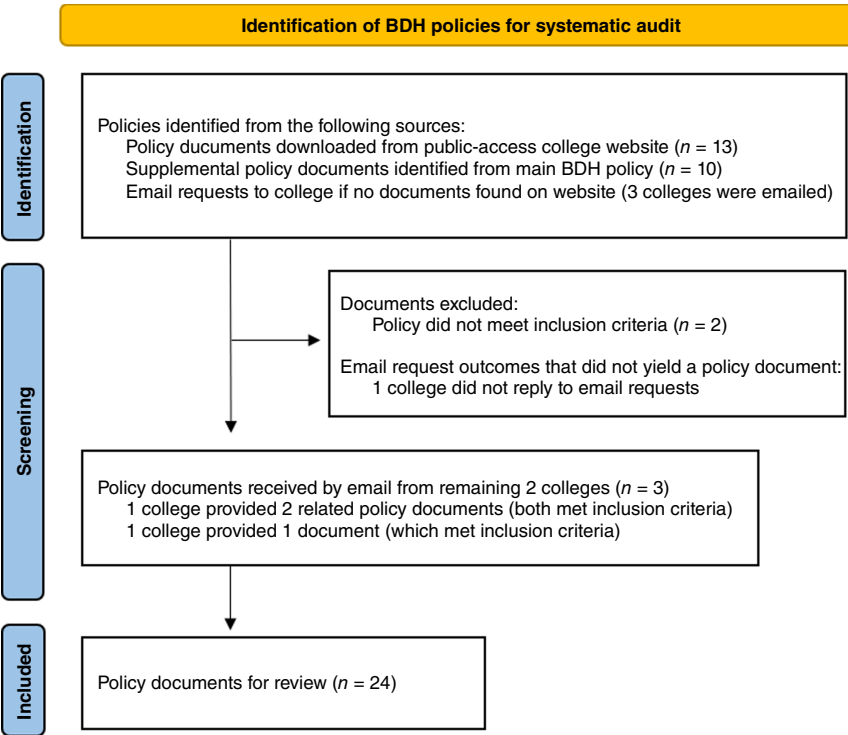
Most policies do not contain adequate mechanisms to mitigate the risk of investigator bias, none commit to recognised investigative standards, and only one identified the required standard of proof. Collectively, this analysis demonstrates key flaws in the Colleges' BDH policies and investigative procedures. Not all of these concepts were items on the Comcare checklist, but were identified by the COAT manual as important features of the complaints handling processes.

College policies varied widely regarding the areas of having processes for reporting BDH complaints, specifying timelines for investigation, mechanisms to ensure impartiality, specifying consequences for people who perpetrate BDH, articulating commitment to positive working relationships, and encouraging College members affected by BDH to take action.

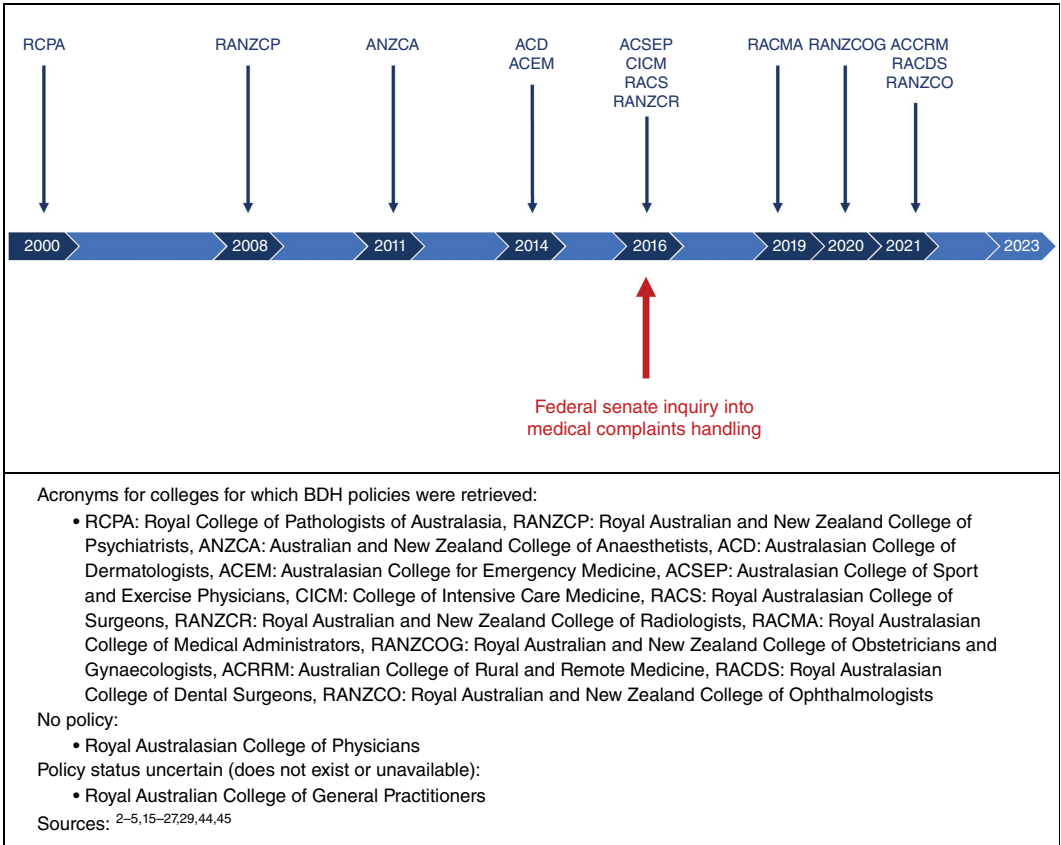
Most College BDH policies appear to be based upon the generic Australian Human Rights discrimination and harassment policy template.<sup>42</sup> The RANZCR policy was the most comprehensive; however, the RANZCOG and ACSEP

### Box 2 Broad definitions of tribunals are applicable in the context of College bullying, discrimination, and harassment handling<sup>13</sup>

Not all tribunals are established by government or will exhibit all of these features [of statutory tribunals]. Many tribunals arise in the private 'for profit' and the 'not-for-profit' sectors. Private sector tribunals may arise in various areas of endeavour. For example, sporting, religious, professional, industrial and cultural associations often establish tribunals to deal with complaints and disputes arising under their particular rules. These are often referred to as 'domestic tribunals'. They differ from statutory tribunals in that they derive their powers from contract, rather than from legislation. That is, their authority comes from the members' agreement to abide by the association's rules. They must comply with the rules of the association but are not subject to the general legal requirements that apply to statutory tribunals.<sup>13</sup>



**Fig. 1.** PRISMA flow diagram with search results for College bullying, discrimination, and harassment (BDH) policies.<sup>41</sup>



**Fig. 2.** Timeline showing years that individual Colleges first introduced their BDH policy.

policies were assessed as having the best readability and clarity. Collectively, these three policies are suggested reading for policy makers.<sup>14,18,23</sup>

Audit results are summarised and presented for each checklist item, which have been grouped into thematic findings (Fig. 3 and Table 2).

Discussion

Validity and limitations of the audit

The Comcare checklist is subjective and some of its items (15, 18, 25) are ambiguous. It is a generic checklist that aims to cater for many industries and, although

**Table 1.** Audit of BDH policy scores ranged from 44 to 91%, with an interquartile range of 11.75% (rounded).

No policy	1st quartile (<57%)	2nd quartile (57–68%)	3rd quartile (69–79%)	4th quartile (>79%)
RACP	RACMA	RACS	ACEM	RANZCR
RACGP	ACD	ANZCA	RACDS	
	CICM	RANZCP	RANZCO	
		ACCRM	ACSEP	
		RCPA	RANZCOG	

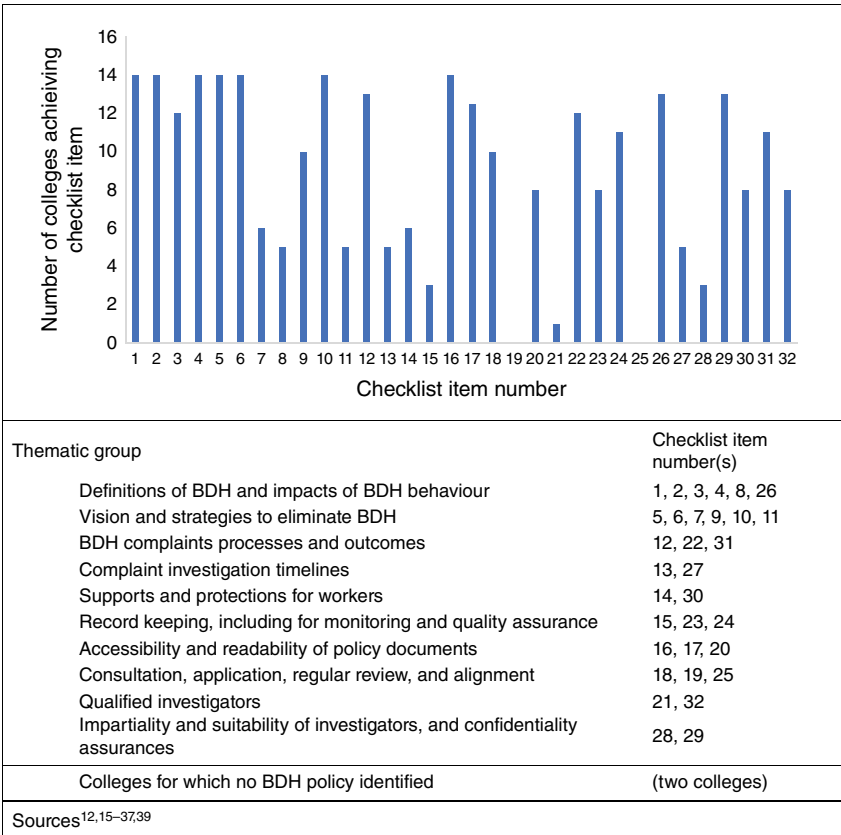
comprehensive, it may not be perfectly suited to the specialty Colleges. It is nevertheless informative.

The thematic analysis of audit findings is presented to support BDH policy and process improvements (Table 3). Each of the 14 Colleges with BDH policies performed well in some areas and poorly in others – some produced interesting ideas and others give rise to specific concerns relating to themes of BDH handling (Table 3).

A new direction

Overall, the crucial observation from this audit is the discordance between the homogeneity of the BDH problem that is common to all Colleges and the heterogeneity of each College’s response. The audit findings also suggest that individual Colleges each try to replicate concepts in-house but lack sufficient expertise and resources. It is hard to envisage that this is what the Senate Inquiry had in mind when it called for collaboration between the various entities responsible for regulating professional behaviour.<sup>1</sup>

The extensive variation in quality, content, and accessibility of BDH policies and procedures across all the Colleges sabotages their potential, especially in the context of cross-college reporting. For example, if an anaesthetist bullies a surgical registrar and medical intern (i.e. not a trainee) at a code blue emergency call, then which policies apply and what mechanisms are available to the involved parties?



**Fig. 3.** Performance of each College’s BDH policy, with audit tool checklist items grouped into themes.

**Table 2.** Detailed results of audit by thematic group.

Theme and checklist items	Audit findings
Definitions of BDH and impacts of BDH behaviour (checklist items 1, 2, 3, 4, 8, 26)	All policies acknowledged that BDH is in breach of workplace health and safety legislation and many included relevant references. Policies overall performed well regarding definitions of what does and does not constitute BDH. RANZCP, RANZCOG and RACDS comprehensively address the damaging impacts of BDH behaviour. <sup>15,18,26</sup> Policies that simply alluded to 'health and safety' implications of BDH scored zero for item 8.
Vision and strategies to eliminate BDH (checklist items 5, 6, 7, 9, 10, 11)	<p>Most policies (8/14) did not clearly articulate evidence of broad strategies for Colleges to achieve their vision of a workplace free from BDH. RANZCO acknowledges that policy is only one of many measures necessary to improve BDH, and lists member support, education, and training as other important elements.<sup>21</sup></p> <p>RACMA's policy emphasises that BDH is a leadership issue and instructs members to show leadership commensurate with their position, act as role-models, recognise poor behaviour that may escalate to BDH, and encourage specific actions to intervene and thereby prevent BDH (RACMA policy sections 5 and 11).<sup>22</sup></p> <p>One-third of Colleges' policies explicitly encourage victims to report BDH (5/14 Colleges: ACSEP, RANZCOG, RANZCR, RACDS, RANZCO), although many policies acknowledge the risks of reporting.<sup>14,15,18,21,23</sup> RANZCO states that all members are expected to report BDH whether or not they are directly affected by the behaviour.<sup>21</sup></p>
BDH complaints processes and outcomes (checklist items 12, 22, 31)	<p>Pathways for trainees and other College members to raise BDH concerns should be explicit. Concerningly, several policies did not specify the mechanism to make a complaint, and others described complicated algorithms for complaints handling. ACRRM include a simplified flowchart in their policy to specify the process algorithms once a complaint investigation begins.<sup>19</sup></p> <p>For checklist item 12, policies that did not state to whom the complaint should be addressed, or those that did specify the recipient (for example, the Chief Executive Officer (CEO)) but failed to provide the recipients' contact details within the policy, scored zero. Likewise, policies that listed multiple but unclear pathways of referral scored zero because this potentially undermines accountability for the response.</p> <p>Most policies specified a range of escalating outcomes and sanctions for proven BDH. Many policies state that no party can be forced to participate in the complaints process. However, in that instance, no policy refers to the Medical Board of Australia's code of conduct section 9.2, which stipulates that as part of continuing professional development, doctors must participate in activities focused on reviewing their performance.<sup>43</sup> Additionally, section 10.11.2 stipulates that compliance is required with any investigation into one's personal or a colleague's conduct, performance, or health.<sup>43</sup> Therefore, if an alleged BDH perpetrator refuses to participate in mediation and/or investigative processes, a notification to Ahpra appears to be required.</p>
Complaint investigation timelines (checklist items 13, 27)	For policies to score a mark in relation to timeframes for complaint investigations, a <i>specific</i> timeframe both for <i>acknowledging receipt</i> and for <i>finalising</i> the complaint was required. Most policies (9/14) did not fulfil these criteria. Vague wording, such as 'timely' or 'as soon as reasonably possible', scored zero. RANZCR commits to delivering complaint outcomes within 4 weeks, RCPA commits to 60 days, and RANZCO sets timelines between 7 and 21 days depending on the type of response. <sup>23,33,36</sup>
Supports and protection for workers (checklist items 14, 30)	<p>Given the distressing nature of a BDH complaint, it is notable that most policies do not specify requirements or timelines to contact the complainant or the alleged perpetrators with regards to their welfare. Interestingly, RANZCO's policy specifies that the College can automatically cancel a complaint investigation if a complainant does not supply requested information within 14 days (RANZCO section 12).<sup>36</sup></p> <p>Several Colleges have engaged external counselling firms to support members involved in a BDH complaint, and others, such as the RANZCP policy, provide links to support services.<sup>23,24,26,34,37,44</sup></p> <p>RACDS policy advises the use of external mediation firms at an early stage of their informal resolution pathway, although it notes that if the parties refuse to participate in the mediation process, the College may take no further action.<sup>37</sup></p> <p>ACEM and CICM are among several policies that include summary tables that present the rights of the relevant parties.<sup>16,25,31,34,38</sup></p>
Record keeping, including for monitoring and quality assurance (checklist items 15, 23, 24)	<p><i>Assurance processes to identify cultural or underlying issues</i> is an ambiguous component (item 15), taken by the authors to mean mechanisms that identify socio-cultural BDH contributors and/or workplace culture where repeat offenders exist in systems that enable them. Both interpretations are important and require reflective practice with monitoring at the organisational level.</p> <p>RANZCO's policy dedicates a section to 'record keeping', which is a helpful structural element and states that outcomes will be monitored for negative trends and will form part of the basis on which policies are updated.<sup>36</sup> The RANZCR policy requires all complaints to be logged and contains proformas that outline information that will be recorded by people handling complaints, as well as separate proformas for subsequent stages of complaints resolution processes, including outcomes.<sup>23</sup> Collectively, this gives confidence in sound process, including monitoring, record keeping, and quality assurance.</p>

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Table 2. (Continued)

Theme and checklist items	Audit findings
Accessibility and readability (checklist items 16, 17, 20)	<p>The ACD policy states that interviews with the complainant will be recorded, but it does not mention if interviews with alleged perpetrators or witnesses are recorded.<sup>30</sup> Of note, recordings could intimidate some complainants or involved parties, or alternatively, they could be welcomed as a clear account.</p> <p>Most policies are publicly available through their respective College websites and are found under relevant titles and search terms. The RACS' BDH policy, named the <i>Equal Opportunity and Acceptable Workplace Behaviour</i> policy, was therefore not found using predictable search terms and could be renamed for better accessibility. It is easily accessed when searching the exact policy title online.<sup>28</sup> RANZCP policies require a member login but were freely supplied on email request.<sup>26,27</sup></p> <p>Most College policies are written as dual policy documents that comprise a BDH policy and a related complaints policy; however, some Colleges condense it into a single policy document. Both formats were acceptable and were able to be navigated without confusion.</p> <p>Conversely, ACEM's policy framework is fragmented and requires involved parties – whether a complainant, respondent or investigator – to refer to six separate policies to understand the College's relevant processes, which are cumbersome to navigate.<sup>20,38,44–47</sup> For the purposes of this audit, only two of the ACEM policies were audited: the BDH policy and the Complaints and Procedures for Submitting a Complaint policy.<sup>20,38</sup></p>
Consultation, application, regular review, and alignment (checklist items 18, 19, 25)	<p>None of the College policies specified that they were developed in consultation with their members or member representatives, nor described which stakeholders were consulted or how policy was formed.</p> <p>It was beyond the scope of the audit to determine whether policies are applied consistently, and the term 'regular review' is ambiguous. Therefore, for scoring item 18, it was decided that a mark would be awarded if a policy was within its scheduled review date. If no review date was specified, then a mark was given for recency if the document was dated on or after the year 2020. Checklist item 25, that 'new complaint handling procedures align as much as possible with existing procedures', was ambiguous. As for policy evolution, it was not assessable from an iterative perspective, as the author does not have access to previous College documents nor knowledge of their past procedures.</p>
Qualified investigators (checklist items 21, 32)	<p>People appointed to manage complaints are required to be trained in the process; this is a crucial aspect.<sup>13</sup> Assessing whether Colleges apply this principle was largely beyond the scope of the audit. It cannot be assumed that College-appointed investigators are suitably qualified in BDH complaints handling. Only one College strongly implied that the people handling its complaints are trained in their complaints duties (RANZCR), and no College stated this to be a requirement.<sup>23</sup> Only the RACDS policy defines the burden of proof as 'the balance of probabilities'.<sup>15</sup></p>
Impartiality and suitability of investigators, and confidentiality assurances (checklist items 28, 29)	<p>Although some policies alluded to aspects of impartiality, none specified a framework that addressed all of the following: suitability of investigators, investigative qualifications and experience, and specific ways to mitigate bias of investigators.<sup>13,48</sup> Specifying diversity of the investigating team does not necessarily ensure impartiality. RANZCO's policy acknowledges and seeks to address potential conflicts of interest of investigators.<sup>36</sup> Policies that simply stated the process would be impartial, without specifying the measures taken to ensure impartiality, scored zero.</p> <p>The RACDS BDH policy advises complainants to include as much detail as possible, including the identities of alleged perpetrators and witnesses.<sup>15,37</sup> This appears to contradict the RACDS complaints policy that advises complainants to deidentify their complaints, which are reviewed by the CEO. Hypothetically, the CEO could unwittingly seek advice from, or refer that complaint to a person implicated but deidentified within it, who could then advise closure of the complaint without investigation or victimise the complainant.</p>
Policy not accessible	<p>The two largest Colleges either do not have a BDH policy for their members (RACP) and/or have one that has been inaccessible to the authors (RACGP).<sup>39</sup></p>

Consider a refreshing possibility: specialty training environments where legitimate BDH complaints are regularly investigated and upheld at a believable rate that reflects the reported incidence. Complainants could be confident that a timely and transparent process would deliver just outcomes. Member groups would not fear vexatious complaints. Frequent, proportionate sanctions that support professional development could be applied. Perpetrators, who may still have a lot to offer the societies they serve, could reform and continue to practice. This would constitute a robust complaints process that can be trusted by all.

The Colleges' current siloed and inconsistent methods to tackle BDH in healthcare training sites are not functioning as intended, and they are not in line with national recommendations provided to the profession.<sup>1</sup> However, feasible solutions exist if Colleges and other relevant sectors of the medical profession are committed and willing to collaborate.

## Recommendations

A unified and centralised set of BDH policy and procedures can allow quality and consistency to then apply to all

**Table 3.** Discussion of thematic findings of this BDH policy audit.

Theme	Commentary of audit findings
1. Set expectations and strategies for appropriate behaviour	<p>Numerous policies could more explicitly state the damaging impacts of BDH behaviour. Although not an item on the checklist, providing clear actions to mitigate negative behaviour when it occurs is valuable. RANZCOG's policy (section 9) specifically encourages bystanders to report BDH and gives advice on how to be a supportive colleague.<sup>18</sup></p> <p>In terms of organisational strategies to combat BDH (item 7), the 6/14 Colleges that fulfilled this could be more explicit. ANZCA visually represented its BDH strategy and used a Venn diagram to good effect (section 1.1), although the diagram is limited to policies and could be expanded to incorporate other strategic pillars to combat BDH.<sup>35</sup> RACS has committed to BDH research through establishing an Expert Advisory Group for this purpose, which has produced valuable findings and resources.<sup>49,50</sup></p> <p>RACP and probably RACGP do not have BDH policies, perhaps because their very large membership bases logistically preclude internal College complaints processes (RACGP has &gt;40 000 members and RACP has &gt;28 000 members).<sup>51,52</sup> Of note, although commenting on a separate process and not BDH complaints, the AMC acknowledged in their 2014 accreditation report that large membership was an issue for RACP administrators handling trainee disputes regarding supervision.<sup>53</sup></p>
2. Set clear pathways for what to do when BDH occurs	<p>Pathways for trainees and other College members to raise BDH concerns should be explicit. The ACD policy provides a clear summary of informal and formal pathways – a similar format could be considered for inclusion by other Colleges along with a flowchart, such as ACRRM's, that specifies the process algorithms once a complaint investigation begins.<sup>19,30</sup></p> <p>To optimise access, support, and clarity for all persons involved in a BDH complaint, BDH policies and complaints procedures should be publicly available online. Due to the distress that is generally inherent to BDH episodes and complaints, it would seem beneficial for BDH policies to be easily accessible by all stakeholders, including complainants, respondents, investigators, and support persons – some of whom may not be College members, such as interns, multidisciplinary staff, or personnel managers.</p> <p>Although not a checklist item, most policies include valuable provisions to address vexatious complaints, clearly stating that these are unacceptable and will attract significant repercussions.</p>
3. Initiating a complaint	<p>BDH processes should align with the principle that complaints are valid upon receipt. Responsibility of complaints handling should be transparent and refrain from opaque discretionary powers of people in senior leadership roles who could decline to pursue a complaint without formal consideration. Policies could further include a requirement that if a complaint is deemed unsuitable to progress to investigation, then a written response to the complainant, that sets out the rationale of that decision, should be provided.</p> <p>A mechanism for all complaints to automatically delegate handling to external investigators is suggested by the authors. This would provide options if, for example, a senior College member is a BDH perpetrator who could block a legitimate complaint.</p>
4. Allocate qualified investigators	<p>BDH complaints are notoriously difficult to investigate and uphold.<sup>54</sup> Colleges must honestly evaluate their expertise and suitability in conducting investigations. College members often generously donate their time to participate in College committees and other unpaid service roles, balancing this with their clinical and other commitments. Using 'experience' or 'being a doctor' as being synonymous with 'investigation-qualified' and 'suitable investigators' is not appropriate.</p> <p>College members who are allocated responsibility to handle BDH investigations by their College without relevant training can contribute to stress for all involved and are likely to compromise investigative standards. ACEM states that its Complaints Committee is an ad hoc committee, and other Colleges' policies include similar implications.<sup>37,38</sup> The absence of a permanent Complaints Committee raises concern about the BDH handling skills of such a committee which, if only temporary in nature, is unlikely to be versed and practiced in the complex, specialised, and difficult tasks of complaints investigation and resolution.</p> <p>Overall, Colleges may best serve their members – including investigators, complainants, and respondents – by delegating BDH handling processes to paid external professional organisations.</p>
5. Allocate suitable investigative standards	<p>Although not an item on the Comcare checklist, all policies should state the investigative standards that will be applied for College complaints processes.<sup>13</sup> Without this component, parties may incorrectly assume that the burden of proof is 'beyond reasonable doubt' (as for criminal allegations), which could dissuade a BDH target from submitting a complaint and could distract an underqualified investigator.</p> <p>For Colleges with large membership, it is revealing that in its position paper, <i>Natural Justice – Information for Decision Makers</i>, RACS acknowledges that 'it is not possible to produce a person from among the membership who will be completely disinterested and impartial in the sense that a judge or statutory tribunal is.'<sup>55</sup> For Colleges with smaller membership bases, it is even harder to safeguard impartiality and confidentiality. Routinely outsourcing complaints handling to external investigators would bypass these issues.</p>

(Continued on next page)



Table 3. (Continued)

Theme	Commentary of audit findings
6. Participating in investigations	<p>Most policies do not specify pathways for when a party declines to participate in investigation and/or mediation processes. Different pathways are possible, and the examples discussed below are to generate conversation (and are not necessarily recommendations).</p> <ul style="list-style-type: none"> <li>• If the alleged victim declined to participate, the College policy might either dismiss the complaint without further investigation or still investigate available evidence, such as witness statements.</li> <li>• If an alleged witness declined to participate, the policy could note reasons why, for example concern for personal safety and career.</li> <li>• If the alleged perpetrator declined to participate, conceivably a pathway could indicate that the presumption of innocence applies or, alternatively, the complaint will be deemed to be upheld based on unopposed evidence and reported to Ahpra as a breach of the MBA's professional code of conduct.<sup>43</sup></li> </ul>
7. Timely, quality, unbiased investigation	<p>In line with some of the Colleges, a complaints outcome deadline of 30 working days from the submission of the complaint, and within 2 months at most, seems appropriate and achievable, especially if complaints handling is outsourced to independent external investigators. Undue delays in conducting BDH investigations can adversely impact the collection of evidence that informs outcome decisions.</p> <p>Investigative delays favour perpetrators, many of whom are shown to be specialists, including supervisors, that target trainees.<sup>2–4,56</sup> Their presence and influence in clinical units tend to persist long after trainees rotate through. Investigative delays disadvantage trainees through the stresses of drawn-out timelines and ongoing exposure to unbridled perpetrators.</p> <p>Trainees in Australia are often required to apply annually for College-accredited training positions. Applications can begin up to 9 months in advance of commencing those roles and can be sabotaged by BDH-related behaviour, particularly if perpetrated by supervisors.</p>
8. Support involved parties	<p>It is sensible for BDH policies to specify the rights and responsibilities of relevant parties and to state details on how to support College members affected by BDH, including victims, witnesses, and perpetrators.</p> <p>Support processes could broadly encompass more effective and cohesive BDH policies and procedures with clear and timely communication, as well as details for onsite and offsite professionals (e.g. mediation, general practitioners, helplines), and encourage parties to involve their trusted mentors, friends, and family. Policies could acknowledge that, in line with WHS law, protections exist for people reporting BDH that, in theory, prohibit retribution for people raising BDH issues but also acknowledge the reality that repercussions are common.</p>
9. Outcomes and sanctions	<p>Transparency is important. BDH investigation findings should be provided to involved parties and clear appeals processes made available. The respondent's right to privacy and confidentiality is not an absolute right and should not be guaranteed if BDH allegations are proven. This principle should equally apply to proven vexatious complainants.</p> <p>One purpose of College BDH policies is to improve behavioural standards throughout the profession. This is undermined if perpetrators are not publicly held to account when their behaviour has fallen below standard. The right to maintain a good reputation, based on the concealment of proven wrongdoing, is not supportable and instead seems to mandate notification to Ahpra.<sup>43</sup></p>
10. Data, monitoring, consultation, and regular review	<p>It is important for parties to know what will and will not be recorded as well as how data are kept and include assurances, for example that records will be held in accordance with data privacy regulations.<sup>57</sup> This supports transparent decisions and informs quality assurance and central monitoring.</p> <p>BDH policies relate to workplace health and safety and, as such, should be the subject of consultation with relevant stakeholders, including a range of College members. There is also a clear need for input from legal, investigative, and other experts to ensure policies are robust, practical, and effective.</p>

members of all Colleges. Ideally, the overarching policy would be designed and endorsed by the Colleges, external BDH experts, and the regulatory authorities. This includes the AMC in its College-accreditation capacity, the Medical Board of Australia (MBA) in its professional standards capacity, and the Australian Health Practitioners Regulation Agency (Ahpra) in its professional registration and compliance capacities.

In support of collaborative efforts for a unified BDH policy, a tailored checklist is offered (Table 4). It expands

on the Comcare checklist used in this audit and is customised to the requirements of Colleges and regulators. Colleges' compliance with the proposed policy would ultimately determine its efficacy. If administered externally by appropriately skilled and impartial BDH investigators, the new set of BDH policy and procedures tailored to Australia's specialty medical healthcare settings would bring clarity to College members and other stakeholders. Justification for this novel approach is extensively discussed elsewhere (T. Haskell, J. Stankovich, N. Merridew, unpubl. data).

**Table 4.** Tailored checklist for a unified BDH policy for Colleges and regulators to endorse and for external investigators to administer.<sup>11</sup>

Number	Description of required BDH policy items	Tick if included
<b>1. Definitions and scope of the unified BDH policy</b>		
1.1	State that the policy and related procedures are unified across all Colleges and endorsed by each College's leadership, Ahpra, and the MBA	<input type="checkbox"/>
1.2	Define BDH in line with the Fair Work Australia definition, provide examples of BDH behaviours, and clarify what behaviours do not constitute BDH	<input type="checkbox"/>
1.3	State the possible effects of BDH on victims, witnesses, patient safety, healthcare sustainability, public health, and organisations <sup>1</sup>	<input type="checkbox"/>
1.4	Define expected standards of professional behaviour in College training environments, which include hospitals, other training sites, and non-clinical settings	<input type="checkbox"/>
1.5	Define the policy's aims to: <ul style="list-style-type: none"> <li>• prevent BDH behaviours,</li> <li>• be restorative for parties who have been affected by BDH, and</li> <li>• support remedial actions for perpetrators of BDH</li> </ul>	<input type="checkbox"/>
1.6	Define vexatious complaints; specify that these are unacceptable and will attract appropriate sanctions	<input type="checkbox"/>
1.7	Clearly state that the BDH policy applies to all members and staff of all Colleges and all related activities, including but not limited to duties across training sites and out-of-work requirements, such as conference attendance	<input type="checkbox"/>
1.8	Identify that the College has direct influence over its own members and some influence over hospital employers due to accreditation but is limited in the action that it can take regarding BDH perpetrators who are not College members, for example, nurses, non-member doctors, administrators, other staff, patients, families, and other people	<input type="checkbox"/>
1.9	Clearly indicate that BDH will not be tolerated, and that BDH behaviours may constitute a breach of the following: <ul style="list-style-type: none"> <li>• anti-discrimination and WHS legislation,</li> <li>• organisational and industry codes of conduct,</li> <li>• Ahpra registration requirements for professionalism standards, and</li> <li>• a member's suitability for ongoing College membership privileges</li> </ul>	<input type="checkbox"/>
1.10	Outline organisational strategies for promoting a workplace culture free from BDH, such as conflict resolution skills training, encourage bystander intervention, research, education, cohesive policy, and collaborative leadership	<input type="checkbox"/>
1.11	Encourage members to address BDH that they have witnessed or experienced. The policy could outline, for example, ways that bystanders can intervene; practical ways to be supportive; and ways to invest in safe, effective reporting processes	<input type="checkbox"/>
<b>2. Process of BDH complaints reporting and handling</b>		
2.1	Ensure that informal and formal complaints processes are available and specified	<input type="checkbox"/>
2.2	Articulate clear processes for members to report BDH complaints, including initial contact, that ensure discretion and endeavour to achieve confidentiality	<input type="checkbox"/>
2.3	Allocate accountability to investigate BDH complaints to external strategy consulting firms, which advise all involved parties of findings and suggested outcomes	<input type="checkbox"/>
2.4	Provide information to the complainant and the alleged perpetrator(s) about support available, such as through independent counselling organisations	<input type="checkbox"/>
2.5	Specify that the investigator will contact the complainant, by phone and by email, to acknowledge receipt of their complaint. The stipulated timeframe for this will be as soon as possible and within 5 working days	<input type="checkbox"/>
2.6	Timely outcomes – investigate and resolve the complaint ideally within 1 month and with an upper limit of 2 months	<input type="checkbox"/>
2.7	Investigation outcomes for all informal and formal complaints will be provided in writing to all parties that set out transparent rationale for the findings	<input type="checkbox"/>
2.8	An appeals process is supported by an independent review process, which is also conducted by suitably qualified external investigators who do not have conflicts of interest	<input type="checkbox"/>
<b>3. Standards for suitable, qualified investigators</b>		
3.1	All investigators will: <ul style="list-style-type: none"> <li>• be external and appropriately qualified to mitigate bias,</li> <li>• be qualified to investigate training site complaints,</li> <li>• adhere to robust and specified investigative standards,<sup>13</sup></li> </ul>	<input type="checkbox"/>

(Continued on next page)

Table 4. (Continued)

Number	Description of required BDH policy items	Tick if included
	<ul style="list-style-type: none"> <li>• be familiar with this BDH policy and processes relating to human resources and Fair Work Australia and professional obligations to Ahpra, and</li> <li>• be unrelated to parties involved and lack any other conflicts of interest</li> </ul>	
3.2	Define the burden of proof for complaints relating to BDH investigations. <ul style="list-style-type: none"> <li>• In most instances, this will be 'the balance of probabilities'.</li> <li>• Criminal allegations, such as sexual assault, will be referred to the police.</li> </ul>	<input type="checkbox"/>
3.3	Discretion at all times, with concerted efforts to ensure confidentiality and privacy of all parties involved, to be maintained to the best of investigators' ability	<input type="checkbox"/>
3.4	Commit to transparency – aggregated training site data regarding BDH rates, and outcomes of BDH investigations, will be recorded by the external services firm and will supply regular reports for public access on the website for each College	<input type="checkbox"/>
4. Consequences of investigation findings		
4.1	A range of supportive, punitive, and escalating options for confirmed perpetrators of BDH includes the following, but is not limited to: <ul style="list-style-type: none"> <li>• mediate between parties,</li> <li>• recognise that the event(s) occurred, which may include public disclosure with consent of the aggrieved party/parties. Although the perpetrator should be supported, they and their organisations do not have veto power,</li> <li>• establish behaviour improvement plans and reviews for the perpetrator; and</li> <li>• notify the outcome that a BDH complaint has been upheld to any other bodies where the perpetrator holds a position, such as other Colleges, university roles, and other healthcare institutions, and</li> <li>• penalise, or disqualify perpetrator(s) from continuing College membership and appointments, or withdraw specialist privileges if BDH behaviour is severe or fails to improve despite supports, and notify Ahpra of their failure to adhere to professional standards</li> </ul>	<input type="checkbox"/>
4.2	Regarding compliance with BDH complaint investigations: <ul style="list-style-type: none"> <li>• If an alleged perpetrator does not comply with the investigation, then Ahpra will be notified that they have not met professional conduct requirements 9.2 and 10.11.2.<sup>43</sup></li> <li>• Compliance is a mandatory requirement for training site accreditation.</li> <li>• If a College, does not cooperate with or obstructs the investigation, this will be notified to the AMC.</li> <li>• If a training site (hospital or other employer) does not cooperate with or obstructs the investigation, this will be notified to the Australian Commission on Safety and Quality in Healthcare, the relevant state or territory department of health, and to all Colleges to review site accreditation.</li> </ul>	<input type="checkbox"/>
4.3	Complaints proven to be vexatious will be subject to the same range of appropriate consequences as outlined in this policy (4.1 and 4.2)	<input type="checkbox"/>
4.4	Principles of restorative justice are applied to the victim(s). Examples may include: <ul style="list-style-type: none"> <li>• accredit training time, extend maximum allowable training time, offer opportunities to repeat assessments, annul falsely negative assessments, and other such actions</li> </ul>	<input type="checkbox"/>
5. Policy style, consultation, publication, and review		
5.1	Develop policy through consultation with College members (including trainees), the MBA, Ahpra, experts in workplace law, human resources, and investigative tribunals	<input type="checkbox"/>
5.2	Adhere to accessible resources that set out the principles of investigative standards, such as the <i>Practice Manual for Tribunals of the Council of Australasian Tribunals</i> . <sup>13</sup>	<input type="checkbox"/>
5.3	Accessibility of the policy and related documents will: <ul style="list-style-type: none"> <li>• be written in plain language and contain relevant details,</li> <li>• be presented in a maximum of two documents (policy and procedure),</li> <li>• have suitable document titles easily identified by BDH search terms, and</li> <li>• be publicly available and free to access on stakeholder websites</li> </ul>	<input type="checkbox"/>
5.4	Policy is applied consistently	<input type="checkbox"/>
5.5	Policy is reviewed regularly (at least every 2 years)	<input type="checkbox"/>

## Conclusions

Despite most Colleges having formal policies to handle the high rates of BDH that impact their members, there is wide variation in BDH policy design, content, and

implementation, with sparse commitment to suitable investigative standards. Inconsistency limits transparency, efficiency, and due process. Ideally, all Colleges would collaborate with Australia's healthcare regulators to develop and endorse a single BDH policy and engage external

professional organisations to handle investigations, which is overarched by the MBA and linked to annual Aphra registration requirements and the AMC accreditation processes for adhering to professional conduct standards. This could bring BDH processes in line with new Australian WHS legislation for psychological safety and address the BDH epidemic in Australian specialty training sites.

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**Data availability.** The audited policies are publicly available, and further data that support this study will be shared upon reasonable request to the corresponding author.

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