A new framework for Australian specialty colleges and other healthcare leaders to address bullying, discrimination, and harassment that involves doctors

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Summary

Bullying, discrimination, and harassment (BDH) within healthcare teams is a global issue that risks healthcare worker wellbeing, patient safety, public health, and industry reputations. Collectively, fragmented regulation, weak detection and correction processes, conflicts of interest, and fear of retribution for complainants create an environment that enables perpetrators. Specialty training Colleges and other stakeholders can collaborate to address this issue more effectively. This paper examines Australian processes and proposes that the existing disparate mechanisms should be replaced with a national BDH framework that is supported by an independent investigation body. The authors seek to stimulate discussion to reform practice in Australia and in other countries with similar health systems.

Keywords: Bullying; Discrimination; Harassment; Psychosocial hazards and risks; Health policy; Health services administration; Occupational health; Work health and safety; Professional conduct

Background

Healthcare professionals worldwide are subject to unacceptably high rates of bullying, discrimination (including racism), and harassment (BDH), which is estimated to affect 26.3% of healthcare workers.[1] In Australia, BDH is prohibited under the *Fair Work Act 2009* and the *Sex Discrimination Act 1984,* both of which include detailed definitions and are summarised by the Australian Human Rights Commission.[2–5]

Australian-trained specialist doctors generally attain their qualifications through a sequence of "junior doctor" requirements that may take a decade *after* graduating from university medical school (Appendix—Panel A1). The annual incidence of BDH experienced by junior doctors in Australian healthcare settings has remained fixed at 21–22% for the years 2019–2023.[6–10] This is over 2.5 times the Australian national average for BDH measured across all industries, which by contrast improved from 9.4% in 2014–2015 to 8.6% in 2020–2021.[11,12] Doctors who work in Australian public hospitals can be considered public servants under government funding arrangements, which support more than 90% of College specialist training positions.[13] Yet, within the broader Australian public sector, the reported rate of BDH has decreased from 16.6% in 2014 to 10.4% in 2023.[14]

The high prevalence of BDH in the Australian health system, including problematic handling of complaints, has been known for decades and attracted national scrutiny in 2016.[15–17] A Federal Senate Inquiry into BDH in Australian healthcare emphasised the need for collaboration between key stakeholders to address BDH. The Inquiry found that BDH is a significant threat to patient safety and workforce stability that has not been addressed by multiple stakeholders, and delivered significant findings (Appendix—Panel A2).[17] It also threatens the credibility and reputations of governing organisations. Nobody benefits when BDH prevention, detection, and response (BDH handling) mechanisms fail, including perpetrators who miss the chance to adjust their behaviour when they are neither held to account nor offered necessary supports (Fig. 1).[1,16,18–21]

Overall, this paper aims to improve BDH handling that involves doctors in Australian healthcare settings and proposes an Australia-wide Framework which has been constructed by researching and then integrating principles and evidence from relevant sectors. The comprehensive methodology is included in the supplementary materials (Appendix—Methods). At the outset, we specifically aimed to:

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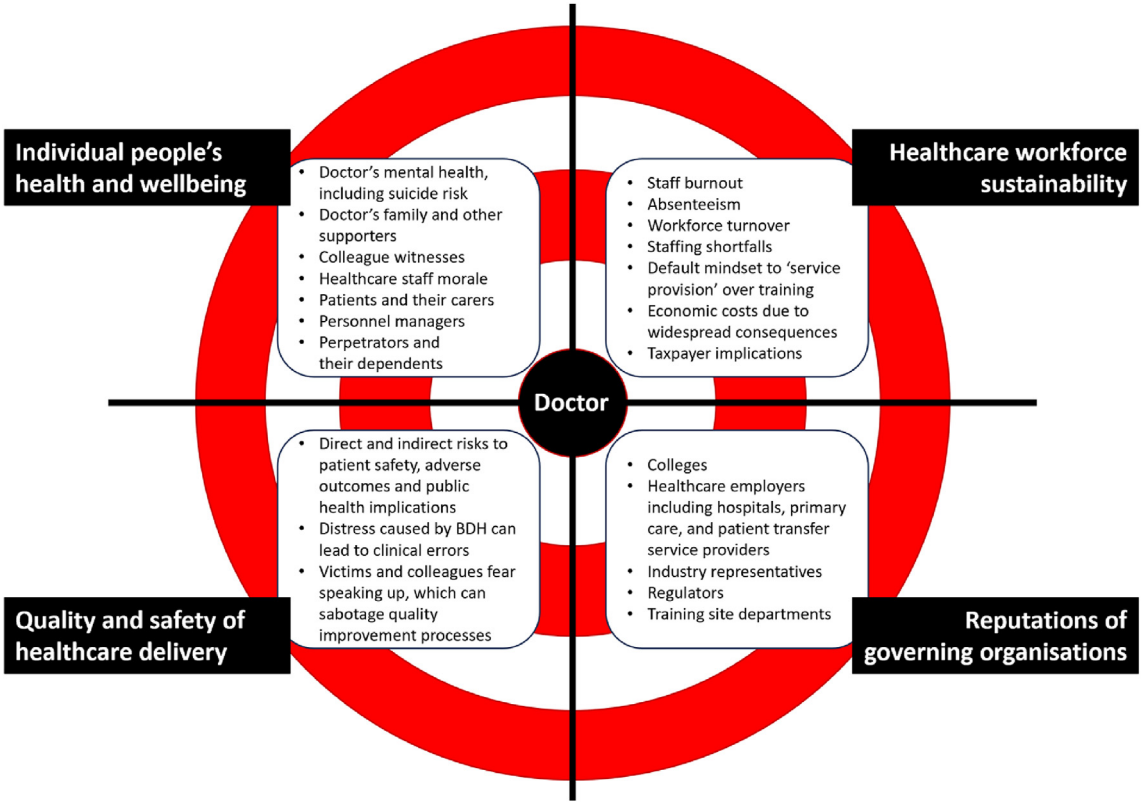

Fig. 1: **The potential consequences for people and organisations when BDH is perpetrated by healthcare professionals.**

1 Use recognised problem-solving tools to identify resources and articulate the scope of current BDH handling arrangements, obligations of stakeholders including Colleges, best practice guidelines, barriers to progress, and opportunities to improve BDH handling;
2 Quantitatively analyse the incidence, severity, and patterns of BDH affecting junior doctors, in particular, *trainees* (defined in Appendix—Panel A2) in Australia. This cohort was selected because of trainees' direct links with Colleges; and
3 Qualitatively appraise the College policies that are currently available to trainees affected by BDH.

The insights presented in this paper are relevant beyond Australia. Many Australian Colleges have established formal partnership arrangements with New Zealand, and worldwide there are many parallels with other health systems.[19]

Regulatory cascade

For doctors in Australia, BDH complaints processes are myriad and inconsistent because they function in complicated administrative landscapes that make it difficult to navigate the varied avenues, stakeholders, and regulators that exist among multiple legal and political jurisdictions. The overarching regulator in this context is the National Health Practitioner Ombudsman (NHPO) and health systems are regulated by national, state, and territory governments.[22,23]

Each healthcare employer is individually accredited and regulated as a *healthcare provider* by the Australian Commission on Safety and Quality in Healthcare (ACSQH).[24] In parallel, specialty departments of each healthcare employer can seek accreditation by the relevant College(s) to be recognised as a College-accredited training site. Colleges themselves are accredited and regulated as *education providers* by the Australian Medical Council (AMC).[25]

Individual doctors are regulated by the Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board of Australia (MBA), which publish codes of conduct that define minimum practice and behavioural standards for doctors (chapters 5 and 10).[26] The regulatory focus of these organisations relates to individual practitioners and protecting the public, rather than healthcare systems or processes. Fig. 2 illustrates the challenges of the Australian healthcare landscape for doctors involved in BDH; for further details of stakeholders see Appendix—Table A1.

Existing BDH handling arrangements

BDH can be resolved locally through the relevant healthcare employer department(s) of the parties

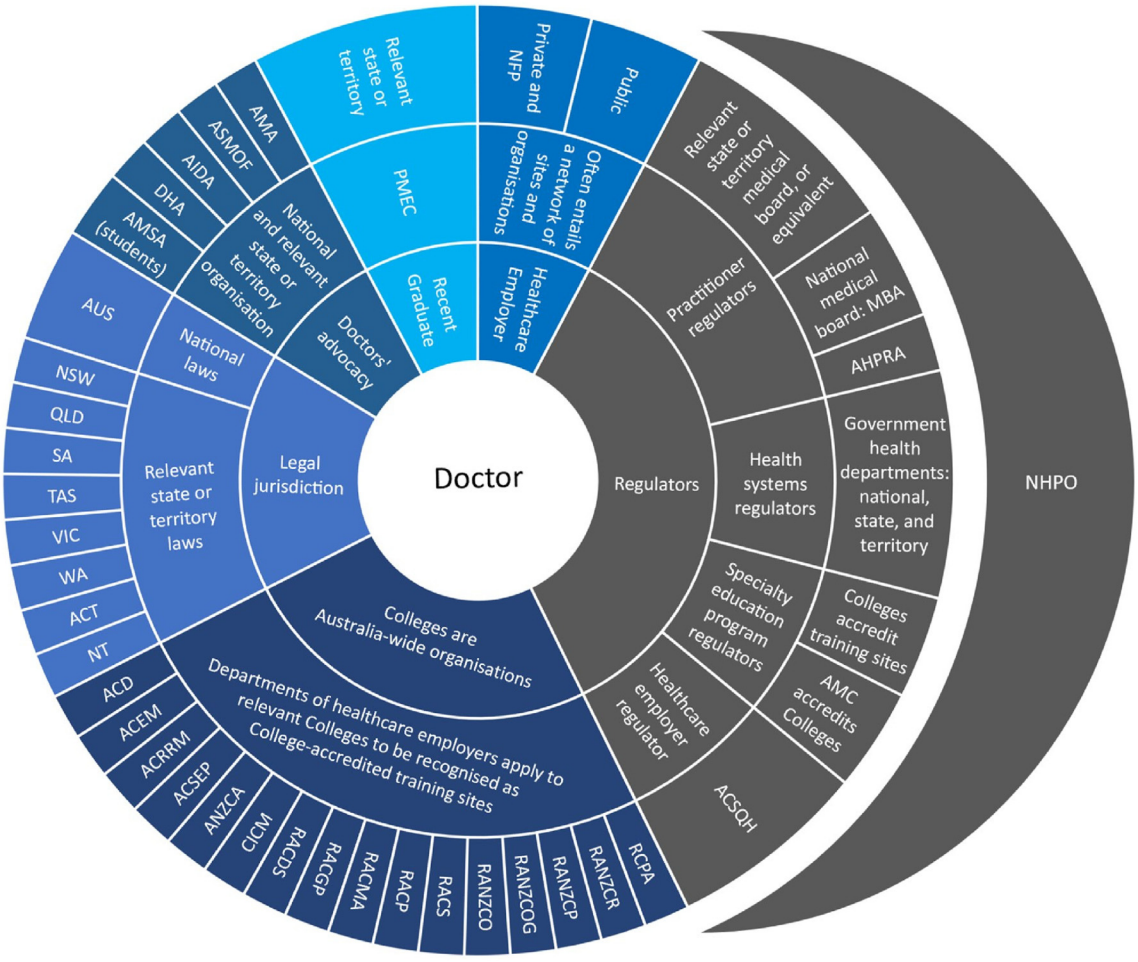

Fig. 2: **The Australian healthcare landscape in which doctors work and train**. Doctors in Australia work and train in administratively complex regulatory, legal, and professional landscapes. Frameworks for BDH offered by the Fair Work Commission and by state and territory WHS regulators are generic and not specific to the medical profession. Legally, the employment landscape is complex and involves state or territory WHS laws, anti-discrimination laws, as well as national employment law—under which BDH allegations are difficult to prove.[27] All doctors are required to be registered with AHPRA, a condition of which is to comply with the code of conduct established by the MBA.[26] The MBA is supported by the relevant state or territory medical boards (or equivalent). Other industry regulators include the AMC, which regulates the Colleges, and the ACSQH, which regulates healthcare employers. Australia's universal public health system is taxpayer-subsidised, co-funded by federal and state/territory governments, and overlaps with a partially-subsidised private health system.[22] College training sites exist in all areas and their governance is complex. See Appendix—Glossary of abbreviations, and Appendix—TableA1 for a detailed explanation of regulators and other key stakeholders in this context. The figure does not include the corresponding structures for nurses, pharmacists, allied health professionals, psychologists, paramedics, or other multidisciplinary colleagues.

involved and through the healthcare employer's human resources (HR) processes. This can avoid unnecessary escalation, respect the reputations and dignity of involved parties, and is claimed to be more efficient. However, the role of HR in this context can be confusing.[28]

If BDH complaints involving College training programs are not resolved by the healthcare employer, some mechanisms exist whereby the relevant College(s) can work with the employer to seek resolution. In practice, such attempts at co-investigation are often undermined by a lack of cooperation along with opaque and limited mechanisms to mitigate inherent conflicts of interest (Appendix—Panel A3).[10,28–32]

Remarkably, however, if a BDH investigation by a healthcare employer is ineffective, many Colleges advise trainees to involve other entities such as WorkSafe (the state/territory workplace safety regulator), the Fair Work Commission, or even the Australian Human Rights Commission *before* approaching their College.[33–38] From a governance perspective, Colleges appear to have significant responsibilities to address BDH involving their members (Appendix—Panel A4).[39–43]

The Australian Council of Presidents of Medical Colleges states that each College has created its own BDH policy for its members.[44] Based on a separately published audit of Colleges' BDH policies, it was found that excessive variation arises because each College has taken its own approach and tends to focus on strategies that are reactive, rather than preventative.[45] Gaps in each policy permit poor implementation, opaque investigative processes, unsuitable investigators, undefined timelines, and preclude a centralised capacity to identify and deal with repeat offenders. The audit identified the *Practice Manual for Tribunals* as a national resource for appropriate processes and standards to make findings of fact, and discusses its relevance to BDH in healthcare.[46] The audit recommends the development of a single, comprehensive BDH policy endorsed by all Colleges Australia-wide. It presents a new tailored BDH policy checklist to support policy makers.[45]

The ability of the Colleges to implement their BDH policies has been questioned by the AMC who in their 2022 accreditation report conceded that BDH *"is a longstanding problem across all medical disciplines"*.[47] For one College, the AMC reported that for *"trainees who are experiencing problems with their Supervisors of Training or unsafe workplace environments, the College does not have adequate pathways for conflict resolution and is inconsistent with the inclusion of workplace culture and wellbeing as a flagship principle of the College's Strategic Plan 2021–2023* [...] *Concerningly, several trainees reported that attempts to raise concerns with the College did not receive any response"*.[47]

Interestingly, whereas that College had at least attempted to establish BDH processes, the AMC accreditors noted that another College expressly states that it has no internal BDH pathways for its members.[33,48,49] The NHPO identified that Colleges lack sufficient investigative powers and agreed with the Royal Australasian College of Surgeons' stance that BDH complaints should be referred to an external entity.[23]

Inconsistency between Colleges' BDH policies undermines their value for trainees affected by BDH when rotating through *other* specialties, which is usually required as part of core training requirements. The lack of consistency also affects other doctors and healthcare workers who are *not* College members (and thereby not covered by College BDH polices), even though they work in their employers' College-accredited training sites. For staff in a single healthcare workplace, there may be 17 different applicable BDH policies—the employer's own BDH processes, plus the policies of up to 16 Colleges.

Most stakeholders agree on the need to improve BDH complaints handling. The situation has attracted longstanding efforts from conscientious stakeholders to address it, including special interest advocacy groups such as the Doctors' Health Alliance and Beyond Blue.[50]

Some doctors emphasise concerns about vexatious BDH complaints.[51,52] However, a 2017 report commissioned by AHPRA found *"essentially no empirical evidence on the incidence of professionals lodging vexatious complaints about each other"*.[53] The report concluded that overall, of complaints in the health sector from patients and practitioners combined, *"the best available estimates suggest that no more than 1% of complaints are vexatious... [and] practitioners' claims that complaints about them are vexatious must be considered with caution"*.[53] As such, it is important to retain focus on the main issue—a proven BDH epidemic that each year directly affects thousands of junior doctors around Australia.[6–10]

Characteristics of BDH

Each year in Australian training sites, more than one in five (21–22%) junior doctors *experience* BDH and over one third (34–35%) of trainees are *exposed* to (witness and/or experience) BDH.[7–10] Of the junior doctors exposed, 66–70% of those who experienced it, and 75–78% of those who witnessed it, did not make a complaint, citing concerns for repercussions, a sense of futility, and unclear processes.[7–10,54]

Of the colleagues who perpetrate BDH against junior doctors (totals can exceed 100 percent because multiple responses are permitted)[7–10]:

- 'Senior medical staff' (specialists) account for 45–51% of experienced episodes and 47–54% of witnessed episodes;
- 'nurse or midwife' colleagues account for 33–36% of experienced episodes and 38–41% of witnessed episodes;
- 'medical colleague' (non-specialist doctors) account for 30–33% of experienced episodes and 34–37% of witnessed episodes;
- 'hospital management/administrative staff' account for 14–16% of experienced episodes and 15–17% of witnessed episodes; and
- 'other health practitioner' colleagues account for 6–7% of experienced episodes and 8–9% of witnessed episodes.

There are many individual specialists who do not perpetrate BDH and who are supportive of their colleagues when it occurs but, as a cohort, specialists are consistently identified as perpetrating half of BDH episodes that involve junior doctors.

Fig. 3 presents an analysis of Australia's annual Medical Training Survey (MTS) data, compares it with BDH rates across all industries in Australia, and demonstrates that a clear ranking of Colleges emerged in the *trainee* cohort (a subset of junior doctors) who are exposed to BDH as part of their enrolment in College training programs.[12,55] The BDH rates vary markedly between Colleges (Fig. 3a and b). Additionally, the ranking of each College is generally consistent across

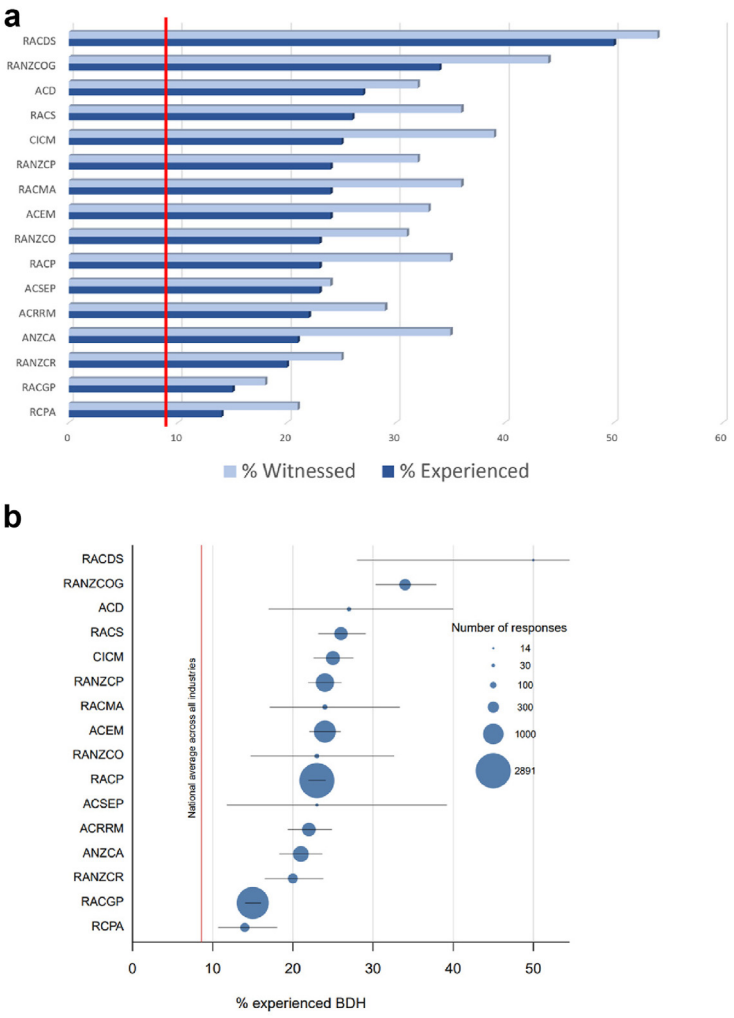

Fig. 3: **BDH profiles for each college in healthcare settings around Australia**. Vertical red lines on the figures represent the average incidence of bullying across all industries of 8.6% (n=1588) as reported by the Australian Workplace Barometer Project 2021. 3a) Percentage of trainees by College specialty training program who witnessed or experienced BDH in 2022, compared with the national average across other industries (vertical red line); 3b) Percentage of trainees in each College who in 2022 experienced BDH, with 95% confidence intervals, compared with the national average across other industries (vertical red line). Varying width of confidence intervals in Figure 3b reflects the varying size of College membership, whereby Colleges with smaller membership numbers consequently have wider confidence intervals; 3c) Bar chart showing each College's annual incidence of BDH experienced by percentage of trainees, compared with the national average across other industries (vertical red dashed line). The ranking of each College is generally consistent for four consecutive years 2020, 2021, 2022, and 2023; each College is ranked by its average incidence. Abbreviations for each the 16 Colleges are listed below. The average annual number of trainees of each College who responded to the MTS (for each of the years 2020, 2021, 2022, 2023) *overall* is presented below as $\bar{x}$= (range), noting that not all respondents answer all questions. The MTS analyses 'completed' surveys only, which is defined as answering ≥75% of the questions. The average of the MTS whole survey response rate for these years was 55.8% (54.5–57.1%) with a margin of error ±0.7 at a 95% confidence level. **ACD**, Australasian College of Dermatologists, $\bar{x}$ = 55 (49–61); **ACEM**, Australasian College for Emergency Medicine, $\bar{x}$ = 1396 (1215–1519); **ACRRM**, Australian College of Rural and Remote Medicine, $\bar{x}$ = 532 (507–554); **ACSEP**, Australasian College of Sport and Exercise Physicians, $\bar{x}$ = 31 (30–33); **ANZCA**, Australian and New Zealand College of Anaesthetists, $\bar{x}$ = 731 (712–754); **CICM**, College of Intensive Care Medicine $\bar{x}$ = 562, (519–596); **RACDS**, Royal Australasian College of Dental Surgeons, $\bar{x}$ = 22 (16–26); **RACGP**, Royal Australian College of General Practitioners, $\bar{x}$ = 2754 (2639–2949); **RACMA**, Royal Australasian College of Medical Administrators, $\bar{x}$ = 76 (70–81); **RACP**, Royal Australasian College of Physicians, $\bar{x}$ = 3519 (3305–3717); **RACS**, Royal Australasian College of Surgeons, $\bar{x}$ = 527 (483–553); **RANZCO**, Royal Australian and New Zealand College of Ophthalmologists, $\bar{x}$ = 71 (67–75); **RANZCOG**, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, $\bar{x}$ = 377 (346–400); **RANZCP**, Royal Australian and New Zealand College of Psychiatrists, $\bar{x}$ = 929 (876–976); **RANZCR**, Royal Australian and New Zealand College of Radiologists, $\bar{x}$ = 290 (265–308); **RCPA**, Royal College of Pathologists of Australasia, $\bar{x}$ = 260 (248–286).

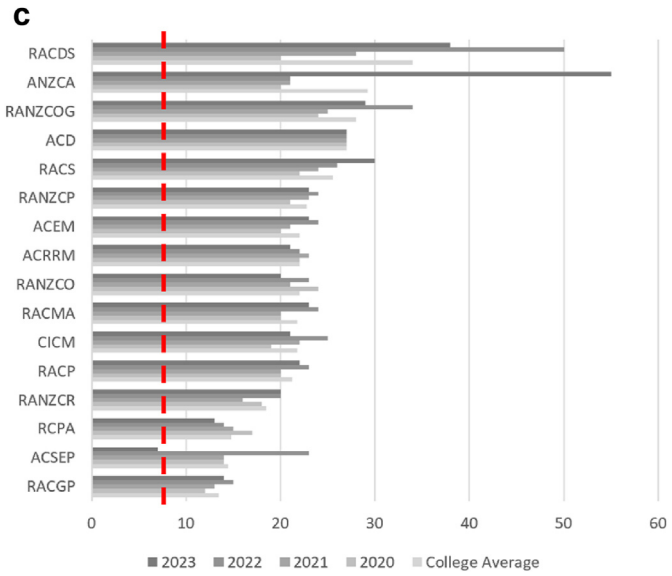

Fig. 3: (continued)

four years of data (Fig. 3c). These patterns raise the possibility that healthcare employers do not have sole influence over the problem.

Work health and safety legislation

The position shared by the Australian Medical Association (AMA) and many of the Colleges' BDH policies is that healthcare employers, specifically health service boards and executives, have almost all practical responsibility for BDH handling.[56,57] The AMA is currently pursuing legislative changes to allocate most responsibility to healthcare employers for BDH that occurs in their workplaces.[57] While it is important to clarify the employers' obligations, this strategy does not recognise the shared responsibility for BDH beyond healthcare employers and is contrary to the recommendations of the 2016 Senate Inquiry to collaborate.

Amendments in 2023 to Australian work health and safety (WHS) regulations (Part 3.2 Division 11) specified explicit obligations for "*persons conducting a business or undertaking*" (PCBU) to manage psychosocial hazards and risks, including BDH.[58–60]

At present, Colleges each separately self-regulate in relation to BDH (Appendix—Panel A5).[61] However, in respect of their educational programs of College specialist-led training of College-enrolled trainees at College-accredited training sites, it appears possible that each College is a "*person conducting [an] … undertaking*" within the meaning of Australia's WHS laws (section 19).[62–64] "*Person*" in this context includes an entity and the concept of a PCBU is explicitly intended to expand upon the traditional and much narrower employer–employee relationship, while "*workers*" who participate in the "*undertaking*" can include "*trainees*" (Panel 1a).[64]

Australian WHS laws specify that more than one entity (PCBU) can have WHS duties in relation to the same issue (section 16) and that those duties cannot be delegated (section 14). Where two or more PCBUs have overlapping WHS duties, each one is legally required to properly "*consult, co-operate, and coordinate*" with each other to ensure those duties are fulfilled (section 46).[64]

Each College appears to be functioning as a PCBU because they exert substantial control over the activities of their trainee and supervisor specialist members, and have substantial influence over accredited training sites where the training is undertaken (Panel 1b, 1c, 1d). If legally deemed to be PCBUs, Colleges thereby share WHS obligations with the relevant healthcare employers at their accredited training sites for matters relating to College members' participation in training programs.

Methods and key findings that underpin the Proposed Framework for effective BDH handling

BDH in healthcare is an organisational leadership and management issue that requires relevant problem solving approaches. Business decision-making tools help to classify the type of problem faced and to determine appropriate responses. Well known examples include pros and cons analyses, the Eisenhower Matrix, and logic trees. For nuanced problems, the Cynefin and Certainties, Suppositions and Doubts (CSD) templates enable shared understanding and are recognised to have strengths in establishing starting points for problem solving and the ability to grow with a project.[67,68]

The Cynefin and CSD concepts were selected to guide our BDH decision-making approach and iterative research

Panel 1: **Australian work health and safety duties in the context of college training programs.**

Due to Australian federal and constitutional arrangements, WHS laws are separately enacted by the Commonwealth and each state and territory parliaments. In Australia, Safe Work Australia has been established by agreement between all jurisdictions as a national body for WHS and, since 2011, has led and administered a framework of model WHS legislation and regulations that have been developed through extensive consultation with a wide range of government, industry, and union stakeholders.[65] All Australian jurisdictions, except Victoria, have adopted the Model WHS Act and Model WHS Regulations into their own laws. To maximise cross-jurisdictional relevance in this paper, the Model WHS Act and Model WHS Regulations will be referenced hereafter.[64,65]

1 a) The Model WHS Act provides expansive legal definitions of a "*person conducting a business or undertaking*" (PCBU) and related concepts and duties:[64]
- The definition of a PCBU includes not-for-profit activities (section 5);
- "*Worker*" is defined to include "*if the person carries out work in any capacity for a person conducting a business or undertaking including work as … (f) an apprentice or trainee, (g) a student gaining work experience, or (h) a volunteer*" (section 7); and
- A "*workplace*" is a "*place where work is carried out for a business or undertaking and includes any place where a worker goes, or is likely to be, while at work*" (section 8).

1 b) In relation to College training programs, the authors believe that Colleges appear to meet the definition of being PCBUs in their capacity as education providers[63]:

i) **The *undertaking*—Colleges**, As self-defined peak national bodies for specialist training, Colleges set their own membership fees, eligibility criteria, policies, behavioural expectations, proficiency standards, training curricula, rotation requirements, assessments, and formal examinations.

ii) ***Workers*—trainees and specialist supervisors.** Each College stipulates where their trainees can train, for how long at each site, set requirements that often require moving home, and who can be a supervisor. Colleges thereby control much of their trainees' lives until they are conferred the College's specialist qualification ("fellowship"). Colleges then direct and control the activities of specialists who are appointed as College supervisors (of trainees), and/or examiners, including mandatory training for supervisors and mandate regular trainee assessments by supervisors.

iii) ***Workplaces*—accredited training sites.** Colleges accredit healthcare employers to be formally recognised as College training sites. This is a mutually-beneficial, transactional bond between Colleges and healthcare employers – whereby Colleges gain a training site that enables them to fulfil the Colleges' educational duties, and the employer is able to attract and retain competent doctors (specialists and trainees). Training site accreditation is an important part of national strategies to ensure health services as part of the national scheme for specialist training.[13] The processes of acquiring and maintaining College-accredited training site status enables Colleges to exert substantial influence and control by imposing conditions upon healthcare employers in relation to matters such as rostering, protected teaching time for College trainees and College supervisors, provision of mandatory workplace-based assessments of College trainees by College supervisors, participation in specified clinical and non-clinical events, and that the employer familiarises the trainee with College policies including the College's BDH policy.[66]

1 c) Under the Model WHS Act, PCBUs have legal duties to[64]:
- ensure as far as is reasonably practicable, the health and safety of workers (in this context, their specialists and trainees) whose activities in carrying out work are influenced or directed by the PCBU (College) while the workers (specialists and trainees) are at work in the undertaking (performing work placements required for College training purposes) (section 19); and
- consult, cooperate and coordinate with other duty holders, which would include the healthcare employer (accredited training site) and other relevant Colleges (sections 16 and 46).

1 d) Additionally, under recent changes to the *Sex Discrimination Act 1984*, PCBUs have a positive duty to prevent sexual discrimination, sexual harassment, and related forms of misconduct (section 47C).[3]

Note for Panel 1: Interpreting legislation is beyond the authors' expertise. Interpretive guidance resources published by regulators and other appropriately qualified organisations were used to identify the legal and governance status of the Colleges and their obligations with respect to relevant laws, psychosocial hazards, industry guidelines, and regulatory bodies for BDH handling.[63]

method. These were effective and transformed the authors' general understanding of BDH in Australian healthcare from a 'Complex Domain' at baseline, to a more focused understanding in the 'Complicated Domain' problem type of the Cynefin model—which identified clearer action pathways that enable experts to act.[67]

After the first round of questions, we identified the need for more detailed knowledge about the Colleges' current governance, WHS obligations, and activities in relation to BDH. These were assessed by setting and researching a second round of questions. Table 1 summarises the questions that we articulated at each

Questions	Evolution of answers through the iterative problem-solving process		Level of confidence (certainty/supposition/doubt) in answers,		
	Type of resources used to ascertain findings	Answer after evaluating relevant resources	before research	→	after research
First round of questions to establish baseline context					
1.1 How does the healthcare sector compare with other industries in terms of incidence of BDH?	National surveys	The healthcare sector in Australia performs poorly when compared with the broader public sector, (which has seen improvements), and is more than double the national average across all industries.[6–12,14]	Doubt	→	Certainty
1.2 What are the relevant laws and guidelines that relate to this issue?	Legislation; Fair Work Commission; Safe Work Australia; Australian Human Rights Commission	BDH is illegal in Australian workplaces and clear national guidance documents are available.[2–5,58,59]	Doubt	→	Supposition
1.3 What are the consequences of BDH in healthcare settings?	Systematic reviews in healthcare literature; national BDH surveys; parliamentary inquiries and reviews; audit reports	BDH has consequences throughout healthcare systems for individuals, patient safety, workforce sustainability, public health, and organisations[16,18–21,69]	Supposition	→	Certainty
1.4 How is BDH currently handled?	Regulators' websites; independent research publications; Human Resources publications	There are many separate pathways that are challenging to navigate.[17,28,30,44,64]	Doubt	→	Supposition
1.5 Are there any barriers to progress?	Parliamentary inquiries and reviews; audit reports; reports by independent research organisations commissioned by regulators; reports by regulators; deterrence theories; ethics publications; published case studies	There are many barriers to progress that include excessive avenues, unclear lines of accountability, evidence of unmitigated potential for bias, mistrust of the process, and distracting over-emphasis on vexatious complaints.[9,17,23,28,30,31,47,51–53,69–73] See also Appendix – Panel A3.	Supposition	→	Certainty
1.6 Have there been any recommendations or guidelines made on this issue?	Parliamentary inquiries and reviews; audit reports; regulators' reports	Numerous reports by authoritative investigations have delivered extensive recommendations, notably to collaborate.[17,23,30,56,57]	Supposition	→	Certainty
Second round of questions arising from the above process					
2.1 Who holds formal responsibility for BDH involving doctors in Australian healthcare settings?	Legislation, professional codes of conduct; regulators' publications; position statements of advocacy groups; Parliamentary inquiries and reviews; audit reports	Individuals are responsible for their own behaviour. Legislation strongly suggests that the Colleges share WHS responsibilities with healthcare employers, but the legal argument has not been tested.[63–66] From a governance perspective, regulators are responsible for the people and organisations they accredit.[24–26,39,42]	Doubt	→	Supposition
2.2 Is the incidence of BDH consistent between Colleges and can it be further characterised?	Analysis of published Medical Training Survey results	Around 50% of the incidence of BDH that affects junior doctors is perpetrated by specialists, there are clear differences between Colleges' BDH rates.[6–10,55]	Supposition	→	Certainty
2.3 How do Colleges address BDH involving members?	Systematic audit of Colleges' BDH policies	There are clear differences between how each College handles BDH that involves their members.[45]	Supposition	→	Certainty
2.4 Have recommendations to address BDH been followed by all stakeholder organisations?	Parliamentary inquiries and reviews; audit reports; regulators' reports; Audit of Colleges BDH policies; position statements of advocacy groups	Recommendations for stakeholders to collaborate appear not to have been implemented in an effective way.[23,45,56,57]	Supposition	→	Certainty
2.5 What is known generally about how to address BDH in Australian workplaces?	National guidance documents	There are well-defined national resources to support organisations to handle BDH, including complaints investigation processes.[46,60,74–77]	Supposition	→	Certainty
2.6 Are there any other systemic risks of inadequate BDH handling systems?	Systematic reviews of BDH in healthcare; publications of statutory integrity agencies including IBAC; inquiries by the Australian Human Rights Commission; regulator reports; independent journalism. Of note, responsible journalism publishes to high standards of investigation and integrity, and aspires to facilitate accountability that is in the public interest.[78]	Failure to address BDH between doctors has wider implications for healthcare systems, including risks of misconduct between staff and/or healthcare leadership and/or against patients by the same perpetrators.[18,19,21,32,79–82] The NHPO recognised that media articles can raise legitimate concerns about training site psychological safety and may provide evidence of a breach of standards for College training site accreditation.[23]	Supposition	→	Certainty

(Table 1 continues on next page)

Questions	Evolution of answers through the iterative problem-solving process		Level of confidence (certainty/supposition/doubt) in answers,		
	Type of resources used to ascertain findings	Answer after evaluating relevant resources	before research	→	after research
(Continued from previous page)					
2.7 Has this problem been addressed before in another industry?	Parliamentary inquiries and reviews; audit reports	Sports Integrity Australia (SIA) has established a national framework to address various forms of misconduct in sport, including preventive and reactive mechanisms, and a national complaints investigatory function. SIA could serve as a valuable template and group of experts to consult with to address BDH in healthcare.[83]	Supposition	→	Certainty
Third round of questions arising from the above process					
3.1 Can there be a unified national response and what is the best course of action?	Integrated findings of this paper	A unified Australia-wide BDH framework appears to be feasible; further debate and action by experts and stakeholders is needed.	Supposition	→	Experts to assess next steps

The authors set questions (column 1) to better characterise the complexities of the problem of BDH in Australian healthcare settings involving doctors. The authors identified the types of resources (column 2) that would be valuable to inform answers to each question. The authors summarised their answers, which were derived from the research process, and cited key references (column 3). The authors self-assessed their level of confidence in their mutual understanding of each aspect of the problem that they had sought to characterise—before the research was undertaken (column 4) and after (column 5). Throughout the iterative research process, the authors attributed the relevant categories of confidence (presented in columns 4 and 5) according to concepts of the Certainties, Supposition, and Doubts framework.[68] This enabled serial rounds of questions (rows) to generate increasing evidence-informed confidence in characterising the problem through each round of questions, and to offer potential solutions. See Appendix—Methods 1 for more details.

Table 1: **Cumulative CSD analysis.**

iteration, resources accessed to identify key concepts and data, and our analyses with self-assessed levels of confidence to re-focus subsequent iterations.

Altogether, this process culminated in identifying the general need for a unified Australia-wide framework to address BDH involving doctors in Australian healthcare settings (hereafter the Proposed Framework). By integrating the research findings, we have offered specific, evidence-informed recommendations for the Proposed Framework.

This section sets out the Proposed Framework, the foundations of which integrate this paper's findings to help develop fair, robust mechanisms to unify BDH policy and processes for all doctors Australia-wide. Crucially, most of the elements of the framework are already present. It aligns with existing governance, accreditation, and regulatory requirements. The AMC, the 16 Colleges, healthcare employers, ACSQH, AHPRA, and the MBA all have their established, albeit siloed, lines of governance and indeed are well placed to endorse a unified national process. What is needed is a conductor to both coordinate inter-organisational reporting and to hold each organisation to account. We recommend that these and other key stakeholders commit to establishing the Proposed Framework which enshrines processes that:

1 Delineate clear accountabilities;
2 Develop and deliver supportive and preventive approaches;
3 Eliminate bias, through effective investigation of complaints by an independent Australia-wide Investigation Body (AIB);
4 Retain stakeholder authority to decide on the response/sanctions based on the AIB's findings; and
5 Enable continuous improvement for quality and safety through data collection, analysis, and reporting.

Colleges and the AMA are industry organisations led by specialists, represent the interests of doctors, are stewards of quality healthcare provision, and have complicated agendas.[84] From a jurisdictional perspective, Colleges are well placed to support the Proposed Framework because their stringent stipulations (for members leading or undergoing training) and training site requirements (for healthcare employers) transcend the complicated bureaucracies of employers, states, and territories throughout the Australian healthcare landscape.

Fig. 4 shows how the process might work in practice and details its intentions, including clear lines of accountability, and Table 2 specifies further principles and processes to guide the design and implementation of the Proposed Framework.

Discussion

Healthcare leaders around Australia continue to lament the ongoing BDH epidemic.[9,87] The resources and findings presented in Table 1 allow an informed appraisal of the current strategies for tackling the BDH problem. A national framework with an independent investigating organisation is proposed as the best way forward for the following reasons.

BDH has traditionally been mischaracterised as a predominantly healthcare employer 'workplace' issue. We caution against this approach and present new

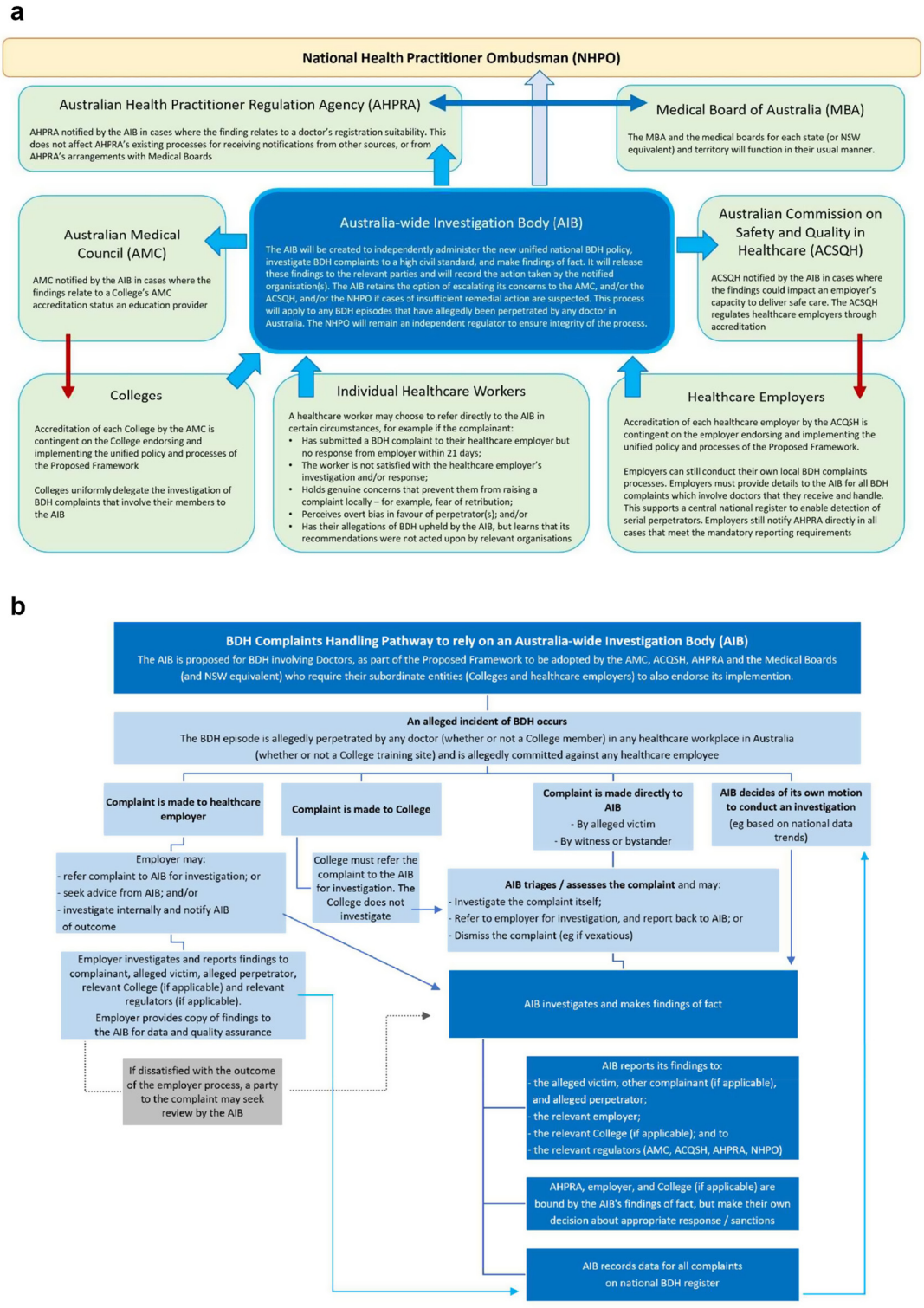

Fig. 4: **Functional mechanisms of the proposed Australia-wide framework for BDH handling that involves doctors**. The Proposed Framework unifies BDH handling processes that support all doctors in Australia—whether they are the alleged victim or the alleged perpetrator and independent of their organisational affiliations—by providing clarity, consistency, and due process with timely, effective outcomes for BDH complaints at all Australian healthcare workplaces.[45,74] See also Table 2. 4a. Accountabilities of key stakeholders in the Proposed Framework. 4b. Suggested pathways for BDH complaints handling by a proposed Australia-wide Investigation Body (AIB).

1. Scope of the proposed framework	
1.1 Application of the Proposed Framework	(i) The Proposed Framework would apply to all healthcare workplaces and all College training programs in Australia.
	(ii) The Proposed Framework would apply to all BDH allegedly perpetrated by doctors in Australia, whether or not they are a member of any College. It would encompass BDH perpetrated by a doctor against another doctor or against any workers in a healthcare workplace.
1.2 Participants	(i) The following organisations would be responsible for designing and implementing the Proposed Framework: the Australian Medical Council (AMC), the Australian Commission on Safety and Quality in Healthcare (ACSQH), the Australian Health Practitioner Regulation Agency (AHPRA), the Medical Board of Australia (MBA), and the National Health Practitioner Ombudsman (NHPO)
	(ii) Colleges and healthcare employers would participate in and be subject to the Proposed Framework, once established
2. Define values and principles	
2.1 Values and principles that align with codes of conduct and industry standards[26,46,75–77]	(i) Invest in healthy workplaces that value respect and diversity
	(ii) Establishing the truth is achieved with open mindedness, eagerness to listen, and excellence in investigative standards
	(iii) Clear lines of streamlined accountability with standardised processes
	(iv) Omissions can be as harmful as acts
	(v) Versatility and continuous improvement
3. Develop and implement	
3.1 Consultation, as part of the *Model WHS Act*'s duty to consult (section 16 and 46)[64]	Developed by medical stakeholders and non-medical experts (for example, in policy writing, workplace law, workplace bullying investigations, psychology, human resources, change management, healthcare economics), in line with relevant national and state/territory laws, regulatory processes, and current professional standards for doctors.[2,26,32,39]
3.2 Consensus	Achieve agreement without exception between the AMC, AHPRA, ACSQH, and the NHPO.
3.3 Establish the powers of an Australia-wide Investigation Body (AIB)	The independent AIB would be invested, by agreement, with authority to initiate, receive, assess, investigate, and determine complaints, and corresponding processes to notify stakeholders (employers, Colleges, AHPRA, AMC, ACSQH) of their investigative findings.[46] Ideally, the agreement would include powers for the AIB to require organisations and individuals to produce records, and/or to require attendance of witnesses.
3.4 Execution	Maintain one unified national BDH policy and Proposed Framework. The AMC and ACSQH will ensure that all Colleges and healthcare employers comply as part of accreditation requirements.
3.5 Commit resources	Healthcare economists could develop a funding model based on contributions from stakeholders that is commensurate with financial and workforce sustainability returns on investment compared with the current high current costs of BDH in Australia's health system.[20]
4. Prevent, support, and empower	
4.1 Support key stakeholders and share responsibility	(i) The Proposed Framework supports regulators, by enabling them to uphold professional codes of conduct for doctors (AHPRA) and accreditation requirements for Colleges (AMC) and healthcare employers (ACSQH)[24–26]
	(ii) The Proposed Framework supports Colleges, by alleviating them of all responsibility for investigating BDH allegations that involve their members. These will be investigated by the AIB, which then presents Colleges with findings of fact.
	(iii) The Proposed Framework supports healthcare employers, by enabling access to confidential, independent, and expert advice from the AIB, and providing a pathway for employers to refer serious or complex matters to the AIB.
	(iv) The Proposed Framework supports individual doctors and other workers affected by BDH in healthcare workplaces by reducing the incidence of BDH and addressing it effectively when it occurs, by providing an independent process led by qualified investigators.
	(v) The Proposed Framework affords wider benefits to patients and the community, who are directly and indirectly affected by BDH in healthcare teams.[18]
4.2 Educate doctors (at all levels of seniority), to prevent BDH and to respond effectively when it occurs[32,75,76]	(i) Set explicit standards of workplace behaviour
	(ii) Demonstrate the variety of communication, personality, leadership, and management styles
	(iii) Provide skills in supervision, feedback, and conflict resolution
	(iv) Define BDH and expected responses (including of bystanders)
	(v) Explain the AIB complaints processes

(Table 2 continues on next page)

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4.3 Deliver training regularly	(i) Colleges set educational requirements (see 4.2) for members: examinable curriculum for trainees, and annual continuing professional development (CPD) requirements of specialists (ii) AHPRA set annual educational requirements (see 4.2) for all doctors (iii) Employers provide relevant training and performance reviews (a requirement of ACSQH Standard 1: Clinical Governance) of all doctors, including feedback on interpersonal styles
4.4 Defuse, resolve, and evolve locally where possible	(i) Use mediation where indicated, deliver tailored remediation including supports for victims and perpetrators. Define and apply feasible consequences if expectations are not met.[74,75] (ii) Consider the potential benefits of publicly acknowledging an episode of BDH including in morbidity and mortality meetings, given that BDH is well documented to contribute to adverse patient outcomes and therefore should be recognised as an adverse clinical event.
5. Investigate complaints effectively with an independent AIB	
5.1 Employer-led investigations	Healthcare employers would continue to be able to receive and investigate BDH complaints within their workplaces and would report the outcomes to the AIB (see 7). A party to the complaint can refer the matter to the AIB if dissatisfied with the employer's process and/or outcome. Employers can also seek advice from the AIB and/or refer complaints to the AIB directly.
5.2 Initiating AIB investigations	(i) Healthcare workers, healthcare employers, and/or Colleges can submit or refer a BDH complaint to the AIB to investigate BDH allegedly perpetrated by a doctor in Australia. See Fig. 4a and 4b. (ii) The AIB would have its own triage processes, including to identify matters that are particularly serious, referral to police where indicated (the AIB may continue to investigate in parallel), and to exclude complaints that are trivial or vexatious. (iii) The AIB could also initiate own motion investigations, based on analysis of data trends in the central register (see 7).
5.3 Qualified and suitable investigators[46,75,76]	All AIB investigations will be conducted by independent, appropriately skilled investigators.
5.4 AIB findings	The AIB's findings of fact, made to the usual tribunal (civil) standard of proof which is the 'balance of probabilities', would be binding. Stakeholders then decide on their actions.
6. Respond to findings of the AIB	
6.1 Guidance on severity and suggested interventions	The Proposed Framework would include guidance on evidenced-based interventions through tiered responses (for individuals) and sanctions/systems checkpoints for organisations (Colleges, healthcare employers, AHPRA) to encourage consistency. The Proposed Framework should also define clear thresholds of when a doctor's BDH behaviour is required to be reported to AHPRA under the existing mandatory reporting requirements.
6.2 Tiered responses for effective risk management, based on severity, frequency, and outcomes of remedial interventions[60,75]	(i) Low level infractions and low frequency: response may include simple acknowledgement between parties of events, private apologies, mediation, corrective supports, and restorative processes for involved parties. (ii) Mid-level and/or persisting infractions: modify practice and departmental responses with supervision. Restrict duties within relevant College(s) and workplace(s) such as supervisor privileges. Notify other organisations where the perpetrator holds a position such as university appointments. Refer for further training and psychological supports. (iii) High level event and/or not responding: If a doctor's BDH behaviour persists despite intervention and/or poses serious safety risks then consider limitations of practice. In severe cases, Colleges can withdraw membership privileges and some already include such provisions in this context.[35,36,85,86] Consider practice restrictions published on the AHPRA register of practitioners.
6.3 Role of sanctions and systems checkpoints	(i) Prioritise supportive and corrective measures through tiered escalation as above. Include provisions for disincentives and acknowledge that proportionate penalties may be indicated if there is no other way to ensure safety for healthcare staff and patients.[75] (ii) Review accreditation status of healthcare employers as College(s)' training sites. When the AIB identifies training sites where BDH appears to be an entrenched issue, it can notify College(s) to initiate accreditation visits and consider accreditation warnings to the relevant healthcare employer and department(s) to take urgent corrective action. If this fails, then de-accreditation of College training sites should be considered a last resort. While de-accreditation can be very disruptive to service provision and substantially inconvenience healthcare workers, it can be necessary in severe cases and can lead to positive change. (iii) The AIB notifies regulators (ACSQH for healthcare employers, AMC for Colleges, NHPO for other regulators) if it has concerns regarding the adequacy of the relevant organisation(s)' response to the AIB's findings or if it finds that an healthcare employer or College has obstructed or otherwise undermined an investigation.
6.4 Stakeholders determine their own responses based on AIB findings	The AIB will report its findings of fact, including assessment of severity, to relevant stakeholders. The stakeholder organisations will retain authority to determine their response to the findings in accordance with the tiered responses and sanctions framework.

(Table 2 continues on next page)

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6.5 Integrity of the AIB	(i) Articulate clear appeals processes for AIB findings (ii) Activities of the AIB would be overseen by the National Health Practitioner Ombudsman
7. Monitor	
7.1 Centralised, secure data register	(i) The AIB would establish and maintain a confidential Australia-wide central register which would encompass data on the parties, findings, and outcomes of BDH complaints whether investigated by the employer or by the AIB. (ii) Healthcare employers would be required to report to the AIB on the parties to and outcomes of all healthcare employer-led BDH complaints investigations, for data and quality assurance purposes. (iii) The AIB maintains a record of all its investigation findings. (iv) Stakeholders are required to report back to the AIB on their response to AIB findings, including any sanctions applied.
7.2 Data analysis and reporting	AIB monitors and analyses BDH data to identify trends and to initiate own motion investigations if indicated, for multiple purposes:[51–53] (i) The central data register would enable the identification of repeat BDH perpetrators, for the AIB to report to AHPRA and relevant College(s). (ii) The central register would also enable valuable insights, including on the effectiveness of BDH prevention measures, rate of valid versus vexatious complaints, and consistency of organisational responses to BDH. This could include publication of deidentified data to support research and accountability.
7.3 Externally administer anonymised workforce BDH surveys	Continue the annual Medical Training Survey for junior doctors. Establish a survey to include all specialists to better assess and characterise how BDH impacts this important group.
7.4 Continuous improvement	The AIB will use the data collected to inform regulators of trends and to improve its own performance. Its processes will also be informed by external data and reports that collectively inform continuous improvement of the Proposed Framework and BDH processes in healthcare.

Table 2: **Foundations for the Australia-wide proposed framework, to be read in conjunction with Fig. 4a and 4b.**

evidence that Colleges appear to share legal responsibility for BDH that affects their trainee and supervisor members and training sites over which they do have control.[57] Even if Colleges contest their status as PCBUs in this context, they could nevertheless accept a greater degree of responsibility in generating effective solutions.

If healthcare employers were the only variable that could influence BDH incidence and outcomes, one would expect that the incidence of BDH would be similar across all Colleges—especially for Colleges whose trainees work in hospital training sites. However, the pattern observed in the MTS data shows that there are consistent differences, sustained over several years, in the ranked incidences of BDH between Colleges (Fig. 3c).

The profile of BDH rankings suggests that factor(s) other than healthcare employers influence BDH behaviour and its regulation. The pattern may indicate that Colleges somehow directly influence the incidence of BDH at their training sites which collectively form the BDH epicentre. This may be inherent to a College's training process and/or reflect characteristics of the relevant specialty practice.

Many doctors have a well-justified mistrust of Colleges' and healthcare employers' complaints processes.[6–10,17,30,73] MTS data shows there has been no improvement in the overall incidence of BDH in 5 years, despite the existence of College BDH policies for over two decades.[6–10] Therefore, redrafting these individual policies will not improve the impact of BDH on College members, other doctors and healthcare staff, or patients.

The logical solution is to create a permanent and truly independent complaints investigation service. A Commonwealth House of Representatives Standing Committee relating to workplace bullying recommended a *"single entry point to regulators"* to address BDH.[27] The NHPO delivered numerous high priority recommendations regarding training site BDH and relevant accreditation processes, including the creation a national BDH framework.[23] A comparable precedent in a different industry is Sports Integrity Australia, which has a national framework to address various forms of misconduct in Australian sporting clubs and associations.[83]

Risks of maintaining the status quo

Given the explicit professional guidelines, industry position statements, and media attention on BDH, it would be reasonable to expect such behaviours to take place in private and without the presence of witnesses in order to remain undetected and minimise the likelihood of a complaint being made—all signs of a professional culture that rejects such behaviour. However, Australia's pattern of BDH, where rates of "*witnessed*" BDH uniformly exceed rates of "*experienced*" BDH, implies a healthcare culture that tolerates public displays of BDH (Fig. 3a). Robust investigations show that Australian healthcare settings consistently fail to provide safe, effective pathways for victims and bystanders to speak up and have thereby normalised BDH.[6–10,30,73]

High rates of witnessed BDH and ineffective handling contribute to an environment where misconduct is more likely to occur. The Australian Human Rights Commission and Victoria's Independent Broad-based Anti-corruption Commission each have broad jurisdictions that include public sector bodies. They report that certain behaviours contribute to negative workplace culture and are conducive to various forms of professional misconduct, for which risk factors include[79,80]:

- Cultural and systemic factors can give rise to "*workplaces where high-value workers are 'protected' and where there is a culture of general incivility*"[79];
- "*Colleagues who suspect or witness the officer's conduct are reluctant or unwilling to report, including for fear of being punished*"[80];
- "*A supervisor fails to apply rigour and sufficient standards within their team. They are apathetic or unwilling to fully explore wrongdoing, or to consider the role (including the involvement or inaction) of other team members*"[80];
- "*Internal integrity and governance teams have ineffective systems for identifying and reporting corrupt conduct, including not adequately assessing evidence of corruption. They focus on individual behaviour in the implicit assumption that removing "rotten apples" is enough*"[80]; and
- "*Senior management is focused on getting the job done at all costs, with insufficient focus on the need for systemic vigilance against poor standards. Senior management does not see how a culture of cutting corners enables corruption to take hold.*"[80]

Of concern, the Victorian Auditor General's review of healthcare workplaces found a "*consistent failure to hold senior staff to account for inappropriate behaviours and a 'double standard' whereby some staff are 'untouchable' despite their consistently inappropriate behaviour being common knowledge*".[30] This appears to fulfil the first risk factor. The MTS data also shows that it is widely perceived as being unsafe to raise concerns and is evidence of the second risk factor.[7–10] Finally, there is no centralised register for repeat offenders which has been noted by regulators and auditors, and is evidence of the third risk factor.[30,32,47,73] The consequences can be tragic when some or all the conditions that permit misconduct are present in healthcare organisations.[21,81,88] Self-regulation has also failed in other industries and the path to external regulation is well-trodden.[89–93]

Stakeholders must collaborate to systematically prevent BDH, support involved parties when it occurs, make formal findings against BDH perpetrators when indicated, and ensure safe healthcare settings. The current stalemate whereby Colleges and healthcare employers are locked in a state of division of power from accountability, can be ended by the Proposed Framework which, in the absence of a feasible alternative, allows all stakeholders to act.

Potential limitations of this paper

Articulating questions to distil such a multifaceted problem as BDH involving doctors in Australian healthcare, classifying the problem into Cynefin domains, and assessing confidence in findings, are subjective processes. The search strategy was not intended to be exhaustive, but rather to identify credible sources to inform comprehensive insights by accessing information compiled by experts from diverse professional sectors. It is impossible to meaningfully address the problem without reference to essential bodies of work that exist outside published medical research. The confidential nature and sporadic documentation of BDH complaints and outcomes results in poor data capture, which tends to culminate in low suitability for study design and publication in peer-reviewed medical literature.[30,53]

Despite the MTS providing assurances of independence and anonymity, through mechanisms that include aggregated data where necessary to deidentify reports, the data may be affected by potential concerns among some junior doctors that they may be identifiable because the survey link accompanies their AHPRA renewal and/or if they are trainees in programs with small membership numbers. While the MTS response rate is excellent, it is nevertheless an incomplete capture of the whole junior doctor cohort and any who have left the profession entirely (possibly due to BDH) are ineligible to participate in the MTS. Furthermore, the MTS data is annualised, whereas the effect of BDH on a doctor's career may only be realised well after the year in which it occurred—particularly if it influences major decisions such as leaving a specialty career pathway or medicine altogether. Some critics may attribute high rates of BDH to pressures created by the COVID-19 pandemic, however, high rates of BDH preceded the first cases of COVID by many years.[6,15–17,94–97]

Conclusion

Existing processes have failed to resolve the BDH epidemic involving professionals in Australian healthcare settings. This is not the sole responsibility of healthcare employers, indeed Colleges also share responsibility to address BDH in College training programs and can help to establish cohesive mechanisms Australia-wide. This paper offers a comprehensive, evidence-based framework for experts and all stakeholders to act.

Contributors

This analysis was motivated by witnessed and experienced unprofessional behaviour in healthcare. The International Ethics and Compliance Initiative states that "*employees who have observed or experienced inequity and bias should be empowered to be part of the design of the solution or changes.*"[72]

TLH—Conceptualisation (Lead), Data curation (Lead), Formal analysis (Lead), Methodology (Lead), Project administration (Lead), Validation (Lead), Visualisation (Lead), Writing—original draft (Lead), Writing—review and editing (Supporting).

JS—Conceptualisation (Supporting), Data curation (Supporting), Formal analysis (Supporting), Validation (Supporting), Visualisation (Supporting), Writing—review and editing (Supporting).

NLM—Conceptualisation (Supporting), Formal analysis (Supporting), Methodology (Supporting), Supervision (Lead), Validation (Supporting), Visualisation (Supporting), Writing—original draft (Supporting), Writing—review and editing (Lead).

Data sharing statement

The data are available in the public domain. To enable clarity of concepts presented in this paper, TLH liaised with the independent Medical Training Survey to access publicly available data, however, the Medical Training Survey had no involvement in writing or editing this manuscript.

Declaration of interests

Financial relationships exist for the authors with organisations that might have an interest in the submitted work in the previous three years. Specifically, these entail: TLH and NLM pay annual professional membership fees to their respective specialty Colleges, and pay annual professional registration fees to the national healthcare regulator (AHPRA). JS receives unrelated research grants (Australian Government Medical Research Future Fund). TLH and NLM have been directly impacted by Australia's high rates of BDH in training sites. Their experiences motivated this manuscript in support of systemic improvements to address BDH in healthcare. TLH and NLM are married to each other. No other relationships exist, nor activities occurred, that could appear to have influenced the submitted work. No funding was received for this manuscript.

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Appendix A. Supplementary data

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