

PREVENT/PROTECT/RESPOND



**ANZCA Bullying
Discrimination and
Sexual Harassment
Working Group
Report – 2017**



Executive summary

Conclusions

- ANZCA considers bullying, discrimination and sexual harassment (BDSH) to be unacceptable behaviours and is committed to ensuring that it is appropriately addressed into the future. There is a lot of work to be done.
- Evidence from external surveys and reports indicates that BDSH is prevalent in healthcare environments.
- Reports from ANZCA surveys of trainees and recent graduate Fellows have identified an incidence of bullying in the previous 12 months of approximately 34 per cent, and discrimination and sexual harassment at approximately 13 per cent. The rates of witnessing BDSH events were more than 20 per cent higher than those personally experienced.
- FPM trainees reported bullying at rates of 22 per cent during their pain medicine training and discrimination/sexual harassment at rates of 6 per cent.
- The majority of those surveyed by ANZCA and FPM were aware of local reporting mechanisms but fewer were aware of the role of the College or outside organisations.
- The majority of those surveyed by ANZCA felt adequately prepared and supported in regard to BDSH but only one-quarter had received formal education and training in this area. This was slightly better for FPM trainees.
- The management of cases that were reported was often informal, with less than one-third of reported incidents resolved at the time of the survey.
- Reluctance to report can be due to a number of factors including: lack of awareness of pathways; fear of “retaliation” in some form; or concerns regarding futility because of ineffective pathways or a lack of willingness to engage alleged perpetrators who are senior practitioners.
- ANZCA could and should be a strong influence in helping to manage cases of BDSH particularly in ANZCA- and FPM-accredited teaching hospitals and departments. Its influence in unaccredited public and private practice environments will rely on its status as a professional organisation.
- The most effective strategies will involve clear College education and training (prevention), clear reporting pathways and policies (protection), and clear and effective remediation and support (response).
- Extensive barriers exist in managing reported cases effectively because of jurisdictional responsibilities and privacy concerns, among others.
- Education and training about the roles and hierarchy of the bodies to which reporting may occur should help overcome barriers.
- The professionalism characteristics related to BDSH and supported by ANZCA must be consistent with the laws and codes of conduct of the Australian and New Zealand regulatory bodies.
- Collaboration and communication with other colleges, employers, external support organisations/ programs, and regulators is needed for an effective profession-wide response and to overcome the extensive barriers that exist in practice. This would include coherence between internal ANZCA and FPM policies, guidelines and regulations and external bodies.
- Ongoing review of cases and their management is important, as is repeat surveys of trainees and younger specialists and new investigations into the experiences of mid-career and more senior practitioners.

Summary of recommended actions

- Action 1: Formalise and adopt an *ANZCA Professionalism Framework for BDSH*.
- Action 2: Finalise and approve the *ANZCA Complaints Policy* (which includes reporting pathways).
- Action 3: Update *Regulation 26: Standards of professional practice* to be consistent with the intent of action 1 and action 2.
- Action 4: Identify and expand support resources for supervisors of training (SOTs) and education officers (EOs).
- Action 5: Identify and expand educational resources on BDSH for trainees.
- Action 6: Develop and approve a College-wide *values statement*.
- Action 7: Ensure the content of *Supporting Anaesthetists' Professionalism and Performance Guide* reflects BDSH principles.
- Action 8: Expand, develop and ratify connections with external organisations.
- Action 9: Implement an access line for complaints and concerns to reach the College.
- Action 10: Develop, maintain and report on a complaints and concerns register within the College.
- Action 11: Identify, develop and maintain a pool of education/remediation and support resources to assist complainants and alleged perpetrators.
- Action 12: Implement a process of ongoing audit and review of complaints and concerns processes, including feedback from participants and the capacity to provide appropriately de-identified reports or data as required.
- Action 13: Continue surveys, including into mid-career and older practitioners.

ANZCA Bullying Discrimination and Sexual Harassment Working Group Report – 2017

Introduction

The vast majority of health professionals, including specialist anaesthetists and specialist pain medicine physicians and trainees, behave in an extremely professional manner at all times in accordance with relevant codes of professional conduct.

However, the reality is that unprofessional behaviours occur, and even though this may be unintentional or related to stress, it is known that bullying, discrimination and sexual harassment (BDSH) can have a significant negative impact on an individual, the team and the safety of the work environment and therefore patient safety.

The Bullying, Discrimination and Sexual Harassment (BDSH) Working Group was established by the ANZCA Council in November 2015 to identify the presence and accessibility of resources within ANZCA and its Faculty of Pain Medicine (FPM) for trainees, members and College staff that address issues of BDSH, including support and reporting/complaint procedures.

The working group was also asked to identify gaps in information and resources and recommend changes to improve their delivery. Finally, it was asked to identify strategies that might improve recognition and prevention of BDSH. These points are included in the group's terms of reference (Appendix 1).

As part of its work, the working group contributed to College surveys that were undertaken over this time and used them to identify the prevalence and character of BDSH in anaesthesia and pain medicine workplaces using agreed descriptions of BDSH.

The group included an FPM representative nominated by the Faculty Board. This representative has liaised with Faculty members and has been involved in the establishment of a small working group chaired by the FPM Vice-Dean and with FPM trainee representation. This group has undertaken a separate survey of FPM trainees to understand their experiences.

This report provides an overview of the background to this issue, then summarises internal and external resources and data, and finally concludes with recommendations as to current and future directions for the College.

Background

Unprofessional behaviour in medical workplaces, and indeed the community as a whole, is considered completely unacceptable.

It has been identified and highlighted over many decades, and has persisted despite the establishment of professional codes of conduct by regulatory bodies and specialist colleges, and by workplace laws and regulations designed to protect employees (including volunteers).

A study of the Australian medical workforce conducted in 2008–2009 reported that 25 per cent of the responding doctors had experienced persistent bullying and/or harassment in the previous 12 months, and that consultants, registrars, and other senior doctors were the most commonly reported perpetrators of the bullying (44 per cent) (Askew, Schluter et al. 2012)¹. In particular, since March 2015, public attention has been drawn by the media to cases where workplace BDSH has been associated with impaired specialist training, a lack of employment opportunities pre- and post-specialist qualification, stress, poor health, and alleged association with suicide of hospital workers.

These cases and reports come from Australia and New Zealand, and although focused on the surgical training program in particular, also included other specialties, junior medical staff and nursing staff.

The overwhelming response from the public, government and specialist bodies has been that this behaviour is not acceptable, and needs further investigation and action. This was exemplified by the response to similar issues identified in the armed forces in 2013 when Lieutenant General David Morrison made the oft-quoted statement: “The standard you walk past is the standard you accept”.

The NSW Public Services Commission document *Positive and productive workplaces* states: “There is strong evidence that bullying can adversely affect the health and safety of employees, reduce the productivity of individuals and workplaces, have a detrimental impact on workplace culture and impede the capacity of organisations to provide quality services to consumers. There is also strong evidence that bullying is a manifestation of poor workforce management practice and culture”.

In addition to these significant effects, BDSH also impairs the ability of otherwise capable trainees to perform at their best and to successfully progress in training. In 2010, the Australian Productivity Commission estimated the total cost of workplace bullying to the Australian economy was between \$6 billion and \$36 billion annually.

Specialist colleges, notably the Royal Australasian College of Surgeons (RACS), the Australian Medical Association, and state governments have responded to these concerns. These responses are summarised below. In particular, the RACS expert advisory group and survey, and the Victorian Auditor General’s (VAGO) report identified that the prevalence of BDSH remained high and that responses have been inadequate at all levels of the health system.

ANZCA determined that a review of our organisation’s understanding, resources and responsiveness was required, in addition to better monitoring of the prevalence of BDSH in our trainees and specialties.

Definitions

The following definitions are widely accepted and consistent across Australian state jurisdictions and in New Zealand:

Bullying is repeated unreasonable behaviour directed towards a person or group that creates a risk to health and safety.

The following types of behaviour, where repeated or occurring as part of a pattern of behaviour, could be considered bullying:

- Excluding someone from workplace activities.
- Intimidating, hostile or threatening behaviour.
- Giving someone the majority of unpleasant tasks.
- Verbal abuse or rude, berating behaviour.
- Deliberately withholding information that is necessary for effective performance in a work function.
- Giving individuals assignments to complete within unreasonable timelines.
- Humiliating someone through sarcasm or insults.
- Intimidation.

Bullying is not just poor communication or interpersonal skills. It is not just unsatisfactory management or supervision skills. Bullying is not the communication and discussion of fair and reasonable workplace performance feedback.

Discrimination involves behaviour resulting in unfair or unfavourable treatment relating to a person’s:

- Age.
- Disability.
- Industrial activity.
- Employment activity.

- Lawful sexual activity.
- Marital status.
- Physical features.
- Political belief or activity.
- Race (including colour, nationality, ethnicity and ethnic origin).
- Pregnancy.
- Religious belief or activity.
- Sex.
- Parental status or status as a carer.
- Breastfeeding.
- Gender identity.
- Sexual orientation.
- Social origin.
- Irrelevant criminal record.
- Personal association (whether as a relative or otherwise) with a person who is identified by reference to any of the above attributes.

Harassment may be a single event. These attributes are legally “protected” and such discrimination is unlawful.

Sexual harassment is generally defined as an unwelcome sexual advance, or an unwelcome request for sexual favours; or engaging in any other unwelcome conduct of a sexual nature in relation to another person in circumstances in which a reasonable person, having regard to all the circumstances, would have anticipated that the other person would be offended, humiliated or intimidated.

Other terms:

Complainant – refers to the individual who makes the complaint based on first-hand experience. If proven, the individual would normally be referred to as the “recipient” or “victim”. If the complaint comes from a witness then they would be identified as a *witness*.

Alleged perpetrator – refers to the individual who has directed bullying, discriminatory or sexually harassing behaviour towards the complainant, that is, the individual who is the target of the complaint. If proven, this individual would be the “perpetrator”.

The size of the problem

1. Monash University survey of the Australian Nursing and Midwifery Federation – 2015

- a. Sample size = 4891 nursing professionals.
- b. 40 per cent reported experiencing bullying or harassment within the previous 12 months.
- c. 10 per cent experienced regular bullying over the previous 12 months.

2. Victorian Auditor General’s Report (VAGO) – 2016 (<http://bit.ly/2i2q8rs>)

- a. Victorian public sector commission (2013).
 - i. 42 per cent in the public health sector witnessed BDSH at work.
 - ii. 25 per cent personally experienced BDSH.
- b. Surveyed attitudes and processes in four public health services (two metropolitan, one regional, one rural) and took submissions.

c. Conclusions:

- i. Insufficient priority given to BDSH.
- ii. Poor accountability at multiple levels.
- iii. Poor understanding by leadership.
- iv. Lack of effective controls.
- v. No effective early intervention or response mechanisms.
- vi. Under-reporting.
- vii. Inadequate complaint mechanisms.
- viii. Poor collaboration across organisations.

d. Response: Strategy

- i. Our pathway to change: eliminating bullying and harassment in healthcare. Creating a culture and environment that supports both patient and staff safety in healthcare settings (April 2016).

3. RACS Expert Advisory Group Survey 2015 (<http://bit.ly/2cFZxA9>)

- a. Sample size = 3079 surgeons and 468 trainees.
- b. 39 per cent of all surgeons (54 per cent of trainees) reported experiencing bullying.
- c. 19 per cent (23 per cent of trainees) reported having experienced workplace harassment.
- d. 7 per cent (12 per cent of trainees) reported having experienced workplace sexual harassment
- e. Response: RACS Action Plan
 - i. Building Respect, Improving Patient Safety – November 2015
 1. Cultural change.
 2. Complaints handling.
 3. Education.
 4. Transparency.
 5. Leadership.
 6. Workplace structure.

4. Australian Medical Association (AMA)

- a. ACT Doctors in Training Survey
 - i. 50 per cent of junior doctors had experienced bullying in the last 12 months.
 - ii. 4 per cent experienced sexual harassment in last 12 months.
 - iii. 58 per cent considered there were inadequate structures to report concerns.
- b. "Setting the Standard" the AMA Victoria Response (<http://bit.ly/2hwO6hE>)
 - i. Meeting of 180 college leaders, hospital senior managers, senior politicians and health department managers.
 - ii. Key outcomes:
 1. Awareness.
 2. Accountability and voice.
 3. Training and education.
 4. Alignment.

5. Resident Doctors Association (New Zealand) (www.nzrda.org.nz/bullying/)

- a. A survey of members, released in August 2015, showed:
 - i. One in five junior doctors had experienced or witnessed bullying, sexual discrimination or inappropriate behaviour.
 - ii. Seven in 10 incidents came from more senior doctors.
 - iii. 10 per cent of incidents were sexual harassment.
 - iv. 47 per cent of incidents were bullying.
 - v. 43 per cent were inappropriate behaviour.

6. College of Intensive Care Medicine (CICM)

- a. CICM reported their internal BDSH survey results on June 5, 2016 and these were subsequently published (Venkatesh, Corke et al. 2016)³.
 - i. 51 per cent response rate from 1921 sent.
 - ii. More “general” question design.
- b. 32 per cent of respondents experienced bullying in the previous 12 months.
 - i. 44 per cent were from intensive care medicine specialists; 26 per cent were other specialists.
 - ii. Women reported a greater prevalence of sexual harassment (odds ratio [OR], 2.97 [95% CI, 1.35-6.51]; P = 0.006) and discrimination (OR, 2.10 [95% CI, 1.39-3.17]; P = 0.0004) than men.
- c. 12 per cent experienced discrimination in the previous 12 months.

7. ANZCA and related surveys (see next section)

The aims of the ANZCA and FPM surveys were to identify the prevalence and incidence of BDSH in anaesthesia training and at a junior consultant level, to identify the interactions associated with these events, and to assess the presence and effectiveness of support and resolution mechanisms. They also assessed similar experiences in recently graduated FPM Fellows. Issues were identified in the interpretation of responses to the initial trainee surveys, so the questions were improved and BDSH definitions included in subsequent surveys.

- a. Trainee welfare survey 2015 (Downey, McDonald et al. 2017)².
- b. ANZCA trainee surveys 2015.
- c. ANZCA and FPM Graduate Outcomes Survey 2016.
- d. ANZCA trainee surveys 2016.
- e. FPM Trainee Survey 2016.

ANZCA surveys

1. Trainee welfare survey 2015 (Downey, McDonald et al. 2017)²

- a. Response rate 43 per cent (427 of 999).
 - i. Aim: Determine wellbeing and stressors.
 - ii. Note: The terms “bullying” and “sexism” used were not given a definition within the survey.
- b. Factors:
 - i. 22 per cent reported “bullying”.
 - ii. 14 per cent reported “sexism”.
 - iii. 7 per cent reported racial discrimination.

2. Trainee surveys 2015

- a. Response rate 20 per cent (289 of 1442) (see table 1 below).
 - i. Q1: Can you recall witnessing or observing bullying and discriminatory behaviours in the workplace throughout the course of your training?
 - ii. Q2: Can you recall being subjected to any bullying and discriminatory behaviours in the workplace throughout the duration of your training program?
 - iii. Q3: In your current role, do you feel adequately prepared and supported to deal with bullying and discriminatory behaviours if you were subjected to it or were to witness it?
- b. The behaviours were predominantly from a consultant to registrar, across both anaesthetic and surgical specialties. Behaviours described most frequently included verbal abuse such as shouting, swearing and belittling; passive-aggressive behaviour and comments such as being ignored/excluded and sarcastic/rude remarks; physical intimidation; and gender discrimination.
- c. The great majority of respondents in Tasmania reported feeling adequately prepared and supported to deal with these workplace behaviours, however fewer than half in New Zealand reported the same feeling.

Table 1. Responses to ANZCA Trainee Survey 2015

| | A&NZ 289 | ACT 17/26 | NSW 29/399 | QLD 21/287 | SA/NT 33/95 | Tas 7/26 | VIC 59/281 | WA 49/70 | NZ 74/258 |
|-----------------------|-------------|--------------|---------------|---------------|----------------|-------------|---------------|-------------|--------------|
| Sample % | 20% | 65% | 7% | 7% | 35% | 27% | 21% | 70% | 29% |
| Witnessed | 39% | 29% | 8% | | 50% | 0% | 57% | 51% | 64% |
| Experienced | 37% | 47% | 28% | 42% | 45% | 0% | 34% | 44% | 44% |
| Preparation / support | 51% | 76% | 50% | | 61% | 86% | 48% | 66% | 44% |

3. Graduate Outcomes Survey 2016

- A total of 452 recent ANZCA Fellows completed the Graduates Outcomes Survey (response rate 52.4 per cent) – 416 were ANZCA-only Fellows, and 36 participants were ANZCA and FPM Fellows (and completed a parallel FPM Graduate Outcomes Survey with identical questions). Of these, 413 (90.6 per cent) chose to complete the survey section on workplace bullying, discrimination and sexual harassment (BDSH) behaviours (378 ANZCA-only graduate Fellows, and 35 ANZCA and FPM graduate Fellows).
- A total of 53 recently graduated FPM Fellows completed the Graduate Outcomes Survey (response rate 62 per cent).
- The numbers are noted in the tables below.
- Alleged perpetrators were predominantly (80 per cent) anaesthesia or surgery consultants, but some were peers, allied health or nursing staff.
- Formal training and education in BDSH and how to prevent and manage its occurrence was only identified by 25 per cent of participants, although two-thirds felt they were prepared and supported in dealing with it.
- Outcomes were variable. Frustration and impotence was often expressed. Comments noted the seniority or status of the alleged perpetrator prevented reporting or resulted in inadequate or ineffectual responses.
- Most actioned cases were informally managed.

Figure 1. Overview of Graduate Outcomes Survey 2016 – ANZCA Fellows

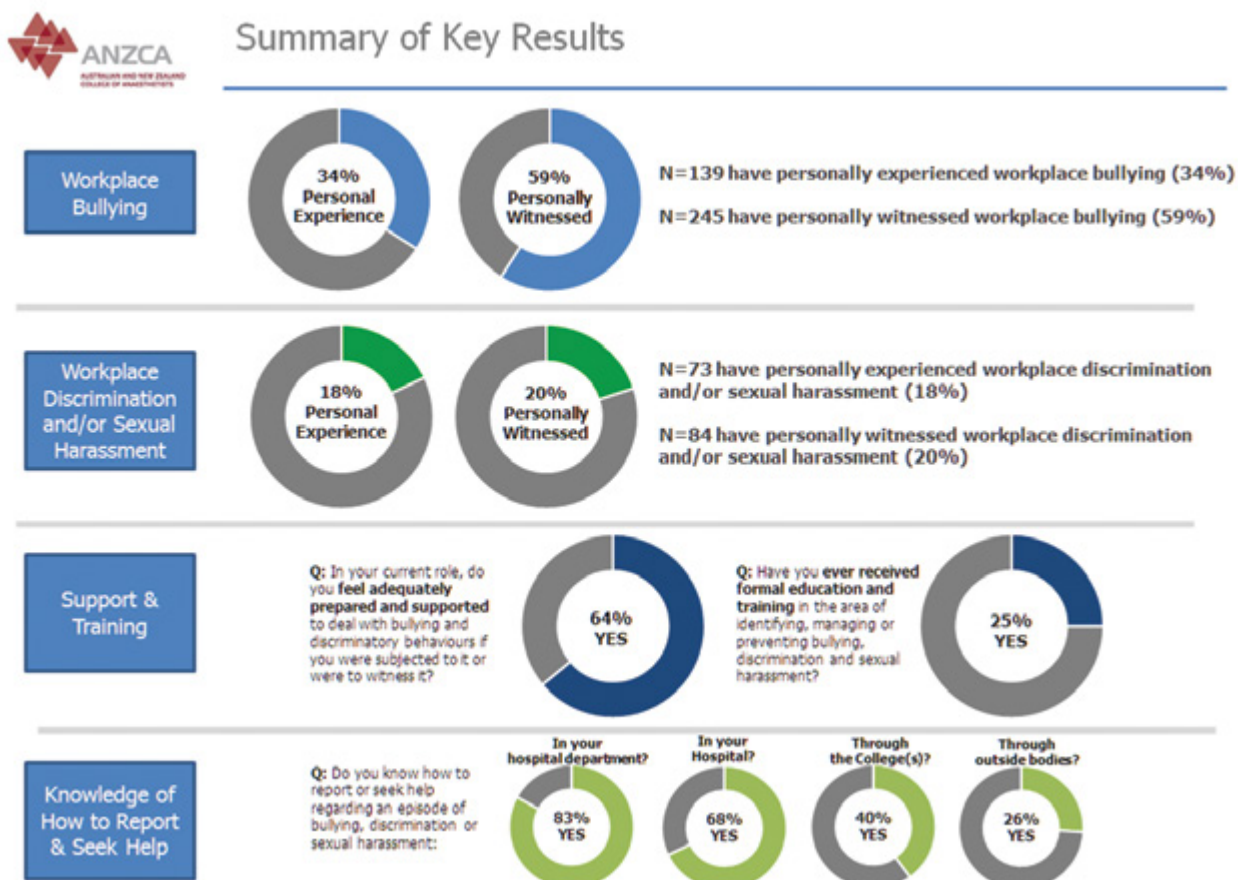
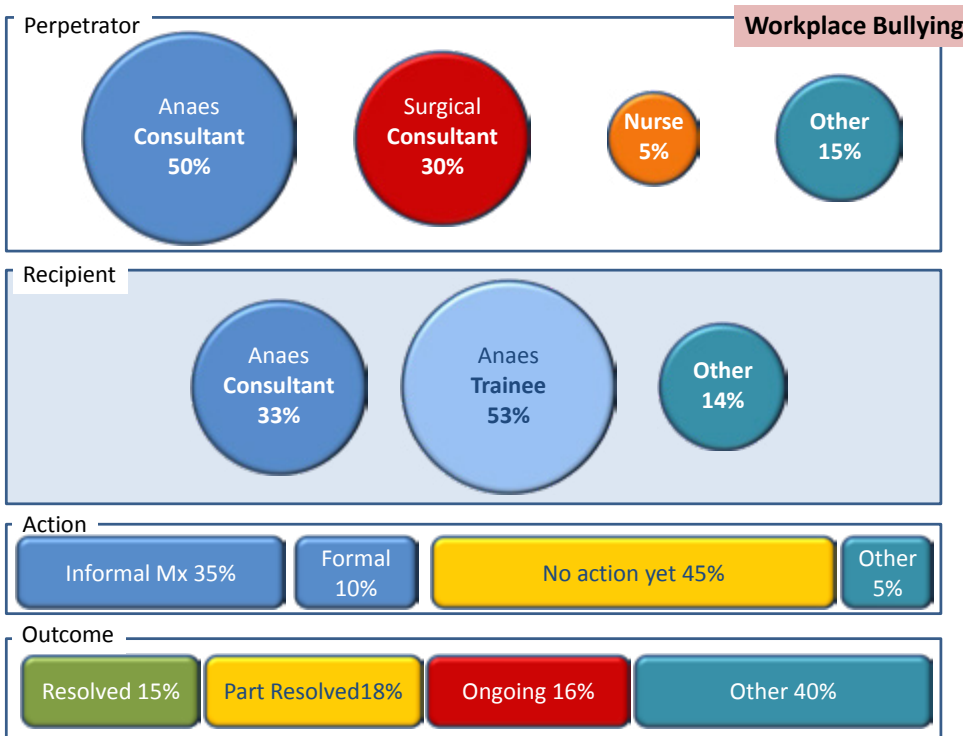
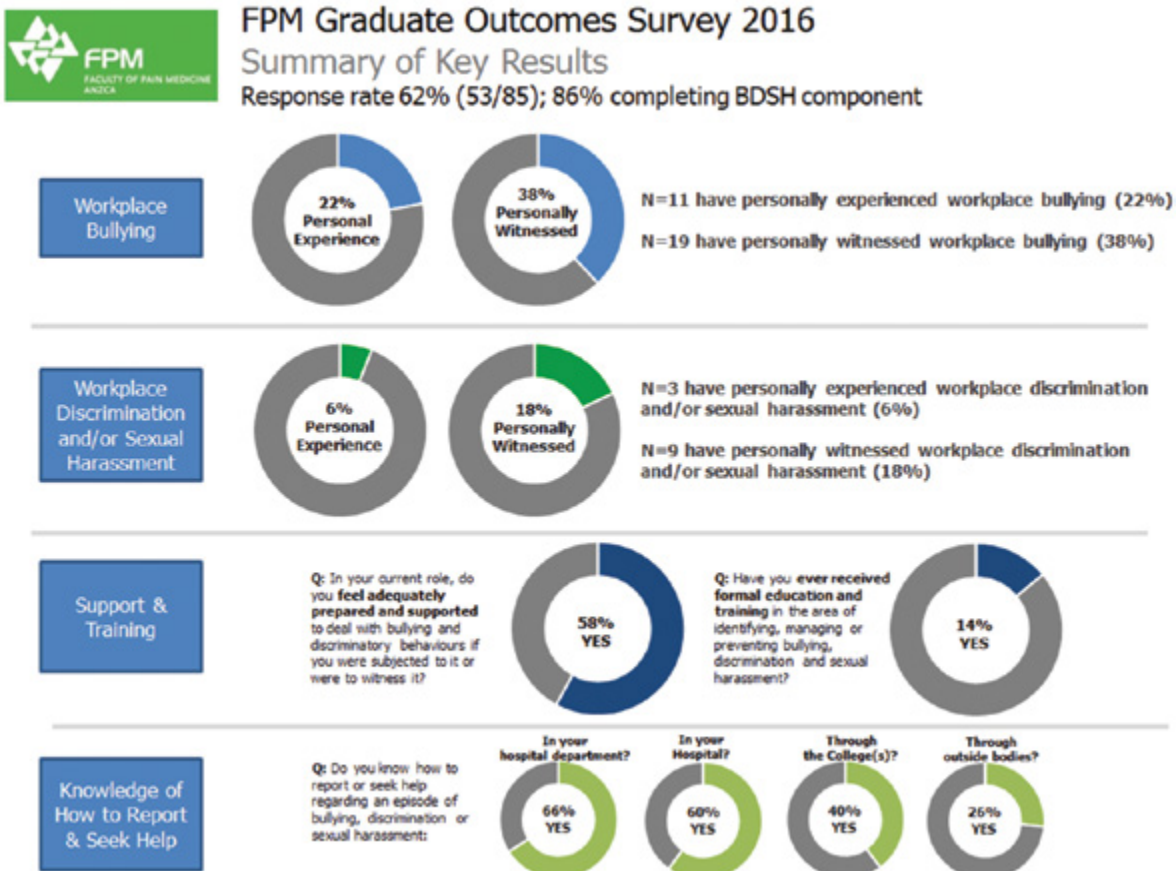


Figure 2. Alleged perpetrators and complainants (recipients) – Graduate Outcomes Survey 2016



4. Faculty of Pain Medicine



Those who indicated a desire to be contacted were followed up. There were no serious concerns raised by the new Fellows during the follow up.

5. ANZCA Trainee Survey 2016

- a. August 29 – September 19, 2016.
- b. A total of 582 trainees completed the ANZCA Trainee Committee survey. Out of 1484 trainees invited to provide feedback (response rate 39 per cent). Of these, 551 (95 per cent) chose to complete the survey section on workplace bullying, discrimination and sexual harassment behaviours.
- c. Close to one in three (30 per cent) of responding trainees reported they had been personally subjected to bullying in the workplace in the past 12 months – 18 per cent reported experiencing one incident, 7 per cent reported experiencing two separate incidents and 4 per cent reported three separate incidents, while 1 per cent chose not to report any details. Incident analysis shows that trainees were more likely to be the recipients of bullying by consultant anaesthetists. The majority of these incidents were reported as ongoing and, at the time of the survey, it was reported that no action had yet been taken to resolve them.
- d. A greater proportion (54 per cent) of trainees had witnessed workplace bullying in the previous 12 months. Of these, 34 per cent reported witnessing one incident, 7 per cent reported witnessing two separate incidents and 3 per cent reported three separate incidents. One in 10 respondents (11 per cent) chose not to report any details of the incident/s witnessed. Incident analysis shows that trainees were more likely to witness bullying of anaesthesia and surgical trainees by consultant anaesthetists and surgeons. Many of these incidents were reported as ongoing and, at the time of the survey, it was reported that no action had yet been taken to resolve them.
- e. When compared with those who reported workplace bullying, a notably lower proportion of trainees reported having experienced or witnessed discrimination and/or sexual harassment in the workplace in the previous 12 months. It should be noted that, although different issues, the questions in the survey were not designed to separate discrimination from sexual harassment in order to keep the questions reasonably succinct. One in eight (13 per cent) trainees reported being personally subjected to discrimination and/or sexual harassment in the workplace, while 18 per cent reported they had witnessed it.
 - i. Of the 13 per cent who had personally experienced discrimination and/or sexual harassment, most (9 per cent) reported only having experienced one incident, 0.5 per cent (n=3) reported experiencing two separate incidents and 0.4 per cent (n=2) reported three separate incidents with 3 per cent choosing not to disclose any details. Incident analysis shows that anaesthesia trainees were the main recipients of discrimination by consultant anaesthetists. The majority of these incidents were reported as ongoing and, at the time of the survey, no action had reportedly yet been taken to resolve them.

Table 2. Responses to ANZCA Trainee Survey 2016

| Location | Invited | Responded | Response Rate |
|--------------------|-------------|------------|---------------|
| Australia | | | |
| NSW | 397 | 149 | 38% |
| VIC | 274 | 93 | 34% |
| QLD | 289 | 101 | 35% |
| WA | 108 | 36 | 33% |
| SA | 94 | 47 | 50% |
| TAS | 25 | 12 | 48% |
| NT | 5 | 3 | 60% |
| New Zealand | 263 | 127 | 48% |
| TOTAL | 1484 | 582 | 39% |

Figure 4. Overview of ANZCA Trainee Survey 2016

Summary of Key Results



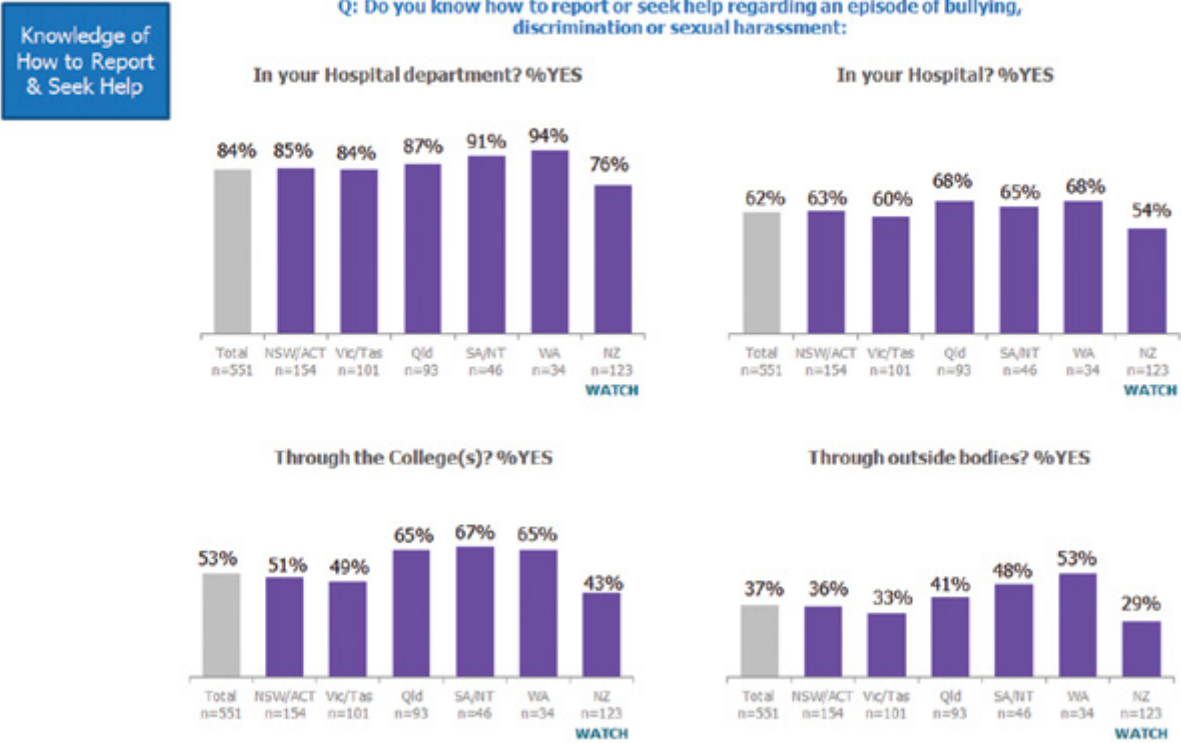
Figure 5. ANZCA Trainee Survey 2016 – BDSH reports by location

Key Results: By Location



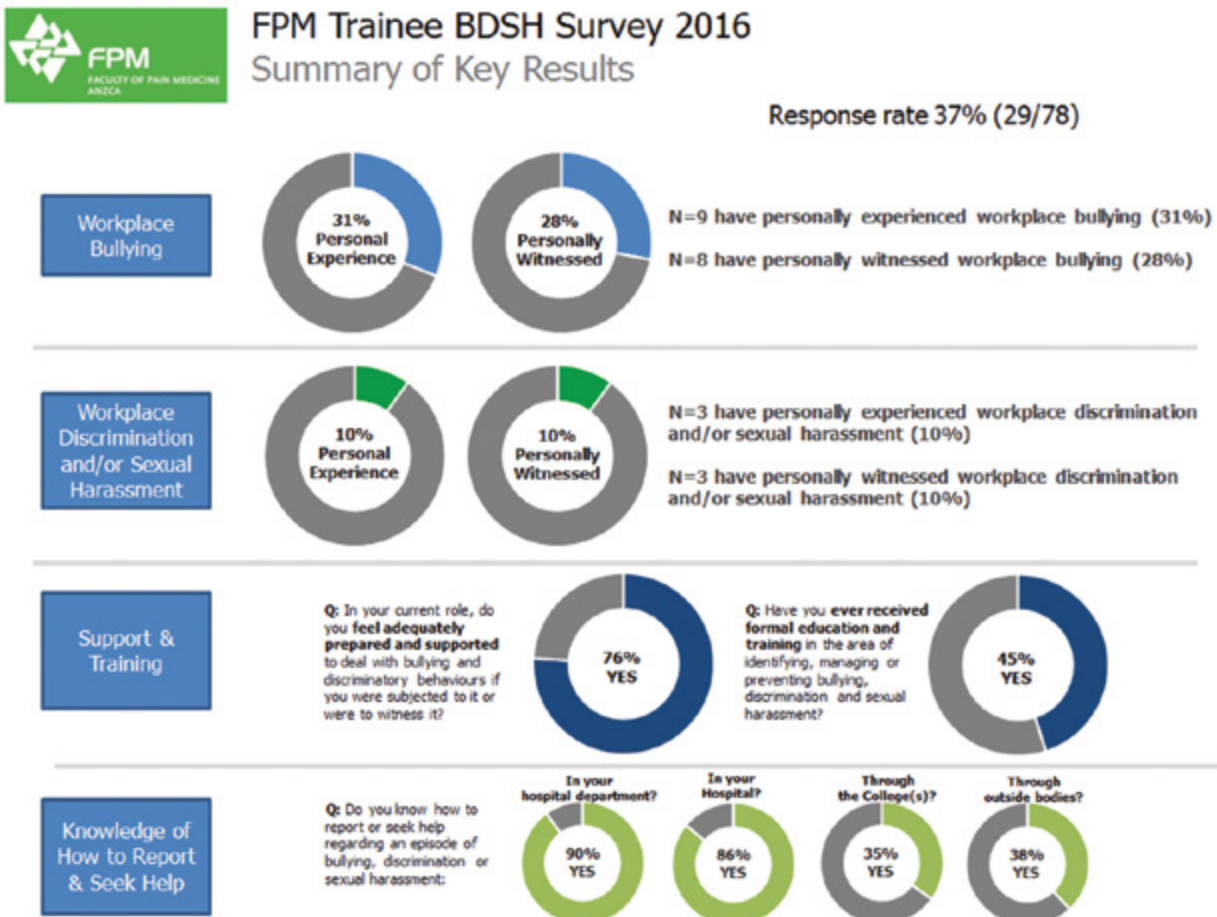
Figure 6. ANZCA Trainee Survey 2016 – BDSH education knowledge by location

Key Results: By Location



6. FPM Trainee Survey 2016

Figure 7. FPM BDSH Trainee Survey 2016 – summary



- a. FPM Trainee BDSH survey conducted from October 21 – November 21, 2016
- b. Twenty-nine FPM trainees completed the BDSH survey out of the 78 invited to provide feedback (response rate of 37 per cent).
- c. Close to one in three (31 per cent) of responding trainees reported they had been personally subjected to bullying in the workplace during their pain medicine training 28 per cent reported experiencing one incident and 3 per cent reported three separate incidents. In all reported incidents, the trainee was the recipient and in most incidents the alleged perpetrator was a consultant. The majority of respondents preferred not to identify the outcome of the incident.
- d. A smaller proportion (28 per cent) of trainees had witnessed workplace bullying during their pain medicine training. Of these, 14 per cent reported witnessing one incident, 7 per cent reported witnessing two separate incidents and 3 per cent reported three separate incidents.
- e. Ten per cent of trainees reported being personally subjected to discrimination and/or sexual harassment in the workplace during their pain medicine training, while 10 per cent reported they had witnessed it.

Incident analysis shows that pain medicine trainees were the main recipients of discrimination by consultants. Half of these incidents were informally addressed and either resolved or partially resolved.

Summary and comments on ANZCA and FPM survey findings

Bullying is common at a trainee/Fellow/junior consultant level:

- Most recent data using defined questions suggests 30-34 per cent have experienced bullying; with 54-59 per cent reporting witnessing such behaviours.
- The alleged perpetrators are most commonly anaesthesia consultants, followed by surgeons.
- Comments frequently referred to the seniority or status of the alleged perpetrator preventing reporting or resulting in inadequate or ineffectual responses.
- Multiple events were reported by 40 per cent of complainants.

Discrimination and/or sexual harassment was asked as a joint question in the recent ANZCA surveys:

- The incidence in the past 12 months ranges from 13-18 per cent with a similar number (up to 20 per cent) having observed these behaviours.
- The welfare of trainees survey (Downey, McDonald et al. 2017) identified a 14 per cent incidence of “sexism” (presumably interpreted as sexual discrimination or harassment), and a 7 per cent incidence of “racism” (presumably racial discrimination).
- Comments identified lack of support for pregnancy/maternity leave as a source of discrimination.

Training and education to identify and manage or prevent behaviours:

- 58-64 per cent of trainees report feeling adequately prepared.
- 75-79 per cent of trainees report receiving no formal education and training in dealing with BDSH.

This identifies a significant gap in support, especially for trainees.

Reporting and seeking help, knowledge of how to obtain assistance or advice:

- Via the anaesthesia department – 83-84 per cent.
- In hospital – 62-68 per cent.
- Through ANZCA – 40-53 per cent.

- Through outside bodies – 26-32 per cent. This was not defined but intended to include doctors' health resources, state and national regulators.
- Adequate reporting and assistance pathways are vital to ensure prompt and fair management of inappropriate behaviours. New Zealand respondents had the lowest rates of awareness of reporting pathways at all levels.
- Almost half of the respondents indicated that they had not actioned the events yet (for example, by reporting). A third had been actioned by informal resolution pathways.
- Of those that had been actioned by the respondent, two thirds were resolved or partly resolved.

Gaps

These survey data are limited to trainees and junior consultants, working in public hospital environments. Anecdotal data suggest that significant episodes of BDSH occur in private hospital practice, but the extent has not been quantified. Cases are reported of negative interactions between consultants in different specialties, for example, anaesthesia/surgery/intensive care.

Practitioners in mid-career or more senior practitioners have not been surveyed to date and may experience BDSH in different forms, including age discrimination.

Comments on FPM survey findings

Bullying is less common in FPM training and practice environments:

- Experienced by 22 per cent and witnessed by 38 per cent.
- The vast majority of alleged perpetrators were consultants.
- Complainants were equally divided between junior consultants and trainees.

Discrimination and/or sexual harassment was asked as a joint question in the recent ANZCA surveys:

- The incidence in the past 12 months was approximately 6 per cent with 18 per cent having observed these behaviours.

Support and training

- Reported as adequate in 58 per cent.
- Formal education and training in BDSH only in 14 per cent.

Knowledge of reporting pathways

- 60-66 per cent through hospital or department.
- 40 per cent through ANZCA.
- 26 per cent through outside bodies.

Barriers to effective management of BDSH

- The reports and surveys above identify a number of deficiencies in training and barriers to effectively managing BDSH in professional practice environments such as hospitals. These considerations are listed as follows:
- Insufficient cross-disciplinary education and training in professionalism.
- Problems with proof to the appropriate legal standard, especially if sanctions are to be applied.
- Balancing the desire of the complainant for anonymity with the need to observe the principles of natural justice for the alleged perpetrator.

- Reluctance to report:
 - Sense of futility that justice will be served.
 - Distrust of human resources departments and colleges.
 - Fear of escalation.
 - Fear of repercussions, especially for training and specialist employment.
 - Normalisation of inappropriate behaviours.
 - Concern that an unwitnessed event may not be provable to a satisfactory standard.
- Uncertainty about how/to whom to report, and the roles of different agencies.
- Lack of visible outcomes.
- Challenges of cross-specialty reporting.
 - Complainant and alleged perpetrator may be from different specialties or professions.
- Challenges of cross-jurisdictional reporting.
 - Employer, colleges, regulatory bodies (Australian Health Practitioners Regulation Agency, Medical Board of Australia, Medical Council of New Zealand).
 - Each of these bodies or organisation have legal or jurisdictional constraints which both require their involvement to some extent (if notified) and limit their ability to share information regarding reports, investigations and actions.
 - Privacy.
 - In addition to jurisdictional boundaries, some aspects of privacy legislation are often interpreted as limiting the ability of organisations to share case notifications or case details.
- “Ownership”
 - It may not be helpful for multiple organisations or bodies to conduct simultaneous or similar investigations. The decision as to who conducts the investigation is complex because this is impacted by what the outcomes of the investigation might be (for example, what support or remediation or sanctions might be applied).

College resources

ANZCA has a number of systems and guidelines in place to manage complaints, appeals, grievances and also matters relating to bullying, discrimination, harassment and sexual harassment (BDSH). These policies apply to all College members (specialist anaesthetists and specialist pain medicine physicians), specialist international medical graduates (SIMGs) and ANZCA and FPM trainees. These are covered in College regulations and the list below. FPM trainees are required to abide by the ANZCA corporate and professional policies.

In 2016, relevant policies and procedures were reviewed by Susan Halliday, (former Australian Federal Sex Discrimination Commissioner and Disability Discrimination Commissioner who also led the Australian Defence Abuse Response Taskforce 2012-2016), and are deemed to have the necessary scope to cover all issues. Some areas for improvement were highlighted and will be taken into consideration when policies are updated. The legal firm, Russell Kennedy, reviewed the staff policies in December 2015 and confirmed that all staff policies are compliant for Australian jurisdictions. Legal advice is to be sought for New Zealand.

College level

1. College policy documents.
 - *Policy on Bullying, Discrimination and Harassment for Fellows and Trainees Acting on Behalf of the College or Undertaking College Functions* (Appendix II).
 - *Whistleblower Policy* (www.anzca.edu.au/resources/corporate-policies).
 - *ANZCA Social Media Policy* (www.anzca.edu.au/documents/anzca-social-media-policy-fellows-imgs-trainees-fi.pdf).
2. The Australian Medical Council/Medical Board of Australia and Medical Council of New Zealand codes of conduct, which replace the recently retired ANZCA Code of Professional Conduct. (www.anzca.edu.au/resources/professional-documents).
3. *Supporting Anaesthetists' Professionalism and Performance – A guide for clinicians* (www.anzca.edu.au/resources/professional-documents). This provides guidance for clinicians based on the principles of the codes of conduct that the College identifies as those promulgated by the MCNZ and the MBA.
4. ANZCA and FPM training agreements.
5. Specialist International Medical Graduate (SIMG) agreement.
6. Agreements for Fellows acting as College and Faculty agents, for example, supervisors of training; rotational supervisors; education officers; SIMG supervisors.
7. FPM has established an informal, web-based mentoring facility to enable junior Fellows and trainees to access contact details of senior Fellows willing to act as mentors. Guidelines for mentors and mentees have been developed with the mentor/mentee relationship then established between the individuals.
8. A number of supportive documents from the tripartite Welfare of Anaesthetists Special Interest Group (SIG) supported by ANZCA, the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists (see www.anzca.edu.au/fellows/special-interest-groups/welfare-of-anaesthetists).

The resource documents developed by the Welfare SIG provide brief comment, give references, and identify strategies for use in dealing with the more common professional and personal stresses. They include: Sexual misconduct, mentors, the isolated anaesthetist (pilot), welfare issues in the anaesthetic department, the welfare advocate, and bullying and harassment.

Hospital department/local level

1. Supervisors of training and heads of department are advised to give support and report instances of BDSH to both the College and also to encourage relevant engagement with the employer.
2. The appointment of an independent welfare advocate (or welfare officer) is encouraged within all ANZCA-accredited anaesthesia departments (and has already occurred in many departments). This individual requires the skills and resources to manage low-level issues within a department and to engage the support of others as appropriate, independently of other College role holders. Welfare advocates must always work within their legal responsibilities as employees.
3. All ANZCA trainees are strongly encouraged to engage a mentor who is independent of the formal training and assessment processes within the department. Mentors and mentees have access to a limited amount of training opportunities to develop their skills and understanding of the role and the professional relationship.
4. In private practice, local remediation activities are assisted on an ad-hoc basis.

ANZCA's recent and ongoing actions

- Input to the Royal Australasian College of Surgeons' Expert Advisory Group issues paper – July 2015.
- Key surveys (above).
- Professionalism Working Group (reporting to ANZCA's Professional Affairs Executive Committee):
 - Leader Dr Rowan Thomas.
 - Developing a guideline on *Promoting good practice and managing poor performance in anaesthesia and pain medicine* (www.anzca.edu.au/resources/doctors-welfare/managing-poor-performance-in-anaesthesia-and-pain).
- Participation in the Victorian AMA Summit on BDSH – November 21, 2015.
- Establishment of a triage group to assess submissions directed to ANZCA or on request by an agency, organisation, or individual (see triage group below and Appendix III).
- Improved ANZCA website access clarity.
 - Doctors' welfare web pages (www.anzca.edu.au/resources/doctors-welfare).
 - Advice regarding direct contact with the ANZCA chief executive officer.
 - A shortcut to Welfare of Anaesthetists Special Interest Group pages.
 - Links to doctors' health emergency resources.
 - Homepage banner linking to "Doctors welfare" webpage.
- Endorsement of NSW Government "Statement of Agreed Principles" on respectful culture.
- A training session and workshop on BDSH for senior managers, ANZCA councillors and members of the BDSH Working Group conducted in February 2016 and led by Susan Halliday.
- Following the Graduate Outcomes Survey, and trainee surveys, all participants who indicated a desire to be contacted about BDSH were followed up and had the opportunity to express further concerns or to be guided to additional support and other resources.
- *ANZCA Bulletin* articles in June and September 2016 summarising results of graduate outcome surveys and progress to date.
- *ANZCA Bulletin* article in March 2017 summarising results of 2016 trainee surveys.
- Periodic reports to the ANZCA Executive Committee and ANZCA Council (July 2016) on progress.
- Interactive presentations at:
 - ANZCA Annual Scientific Meeting education officer workshop (Auckland, May 2016).
 - Combined Special Interest Group (SIG) meeting incorporating the Welfare of Anaesthetists Special Interest Group (Sydney, October 2016)
- National/regional supervisor of training (SOT) meeting presentations
 - In New Zealand – Dr Leona Wilson (November 2016).
 - In NSW – Ms Catherine Smith Work Matters principal consultant delivered a session on bullying and harassment at the NSW SOT meeting in November 2016 in response to the NSW education officer's concerns that SOTs were anxious about their lack of understanding around BDSH and are also deeply concerned about the impact on their own careers if they are accused of bullying or harassment.

- SOT support resources development.
 - College support and indemnity provision.
 - Frequently asked questions/scenarios.
 - Skills training.
- Senate Enquiry into Medical Complaints Processes in Australia (November 2016)
 - Mr John Ilott, ANZCA Chief Executive Officer, attended on behalf of ANZCA.
 - The outcome was to recommend some processes and reporting requirements.
 - Recommendation 1:

The committee recommends that all parties with responsibility for addressing bullying and harassment in the medical profession, including governments, hospitals, speciality colleges and universities:

 - ◇ Acknowledge that bullying and harassment remains prevalent within the profession, to the detriment of individual practitioners and patients alike.
 - ◇ Recognise that working together and addressing these issues in a collaborative way is the only solution.
 - ◇ Commit to ongoing and sustained action and resources to eliminate these behaviours.
 - Recommendation 5:

4.35 The committee recommends that all specialist training colleges publicly release an annual report detailing how many complaints of bullying and harassment their members and trainees have been subject to and how many sanctions the college has imposed as a result of those complaints.
- Australian Medical Council and Medical Council of New Zealand
 - Recent implementation of BDSH policies and management standards.

Shared actions – partnerships

Royal Australasian College of Surgeons

In June 2016, ANZCA's Chief Executive Officer Mr John Ilott and General Manager, Human Resources Ms Jenny Lethbridge met with Royal Australasian College of Surgeons (RACS) staff including Chief Executive Officer Associate Professor David Hillis, Director, Fellowship and Standards/Deputy CEO, Mr John Biviano, Director Relationships and Advocacy Ms Deborah Jenkins and communications consultant, Ms Nicole Newton, to explore opportunities for ANZCA to partner with RACS in addressing BDSH. RACS were six months into their three-year strategy and have committed considerable time and resources to delivering their *Building Respect, Improving Patient Safety Action Plan*. RACS launched the *Let's Operate with Respect* campaign in May 2016 which is the initial step in a three-phase process they describe as "Awareness, Call to Action and Reflect Review" (Appendix III) outlines the eight goals and projects now underway to achieve their goals.

A letter of agreement (Appendix IV) was signed by the RACS and ANZCA presidents on December 15, 2016. This strengthens our collaboration with communication and resources.

Other organisations

Consideration is being given to establish memoranda of understanding (MOU) or letters of agreement with hospitals and health organisations.

For RACS, this has been met with mixed responses. The MOU or letter of agreement sets up a negotiation about what information can and will be shared.

Limits

Beyond the barriers listed above, many of which can be overcome with improved structures, education, support and communication, there are limits to the direct influence that specialist colleges such as ANZCA can have on behaviours in the workplace. This applies to both public and private practice training environments.

This is not to say that ANZCA is powerless, but that influence in many circumstances will be indirect or coercive, and/or depend on the co-operation and support of other practitioners, management within organisations and regulators.

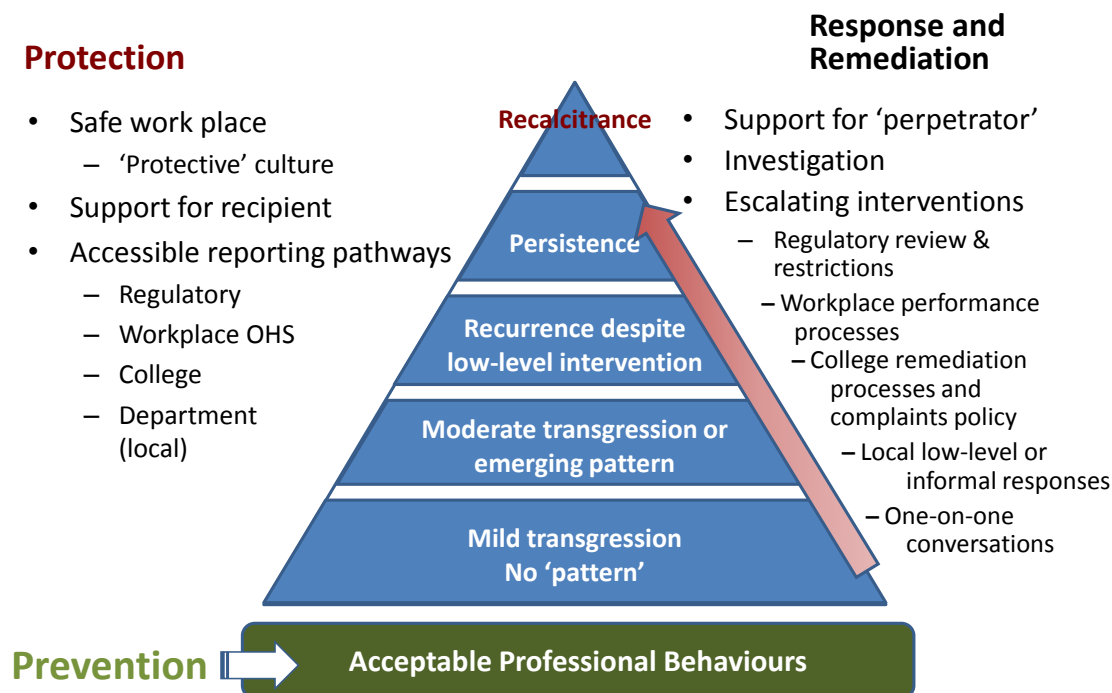
Recommended future actions for ANZCA

A. Development of an ANZCA framework for addressing BDSH

Three core components

1. Prevention – creating a respectful and safe workplace culture.
2. Protection – enabling identification and reporting of unprofessional behaviours.
3. Response – remediation and support – management of the issues.

Figure 8. Proposed ANZCA BDSH Framework – outline



1. Prevention

- Aim: Creating a shared understanding of acceptable professional behaviours and that certain behaviours are inappropriate, unacceptable and/or illegal; and will be reported and addressed should they occur.
- Awareness:
 - Code of conduct.
 - BDSH Policy.
 - Zero tolerance approach.
 - Visibility of actions should a complaint be made. This would be to complainants and other relevant parties about the progress of a complaint, with appropriate levels of confidentiality preserved. It would also require periodic reporting to college staff and members of aggregate data.
- Skills and behaviours development and maintenance in training and continuing professional development programs.
 - Professional identity development (for example, through professionalism training, mentoring, role modelling).
 - Expectations of social interactions being respectful.

- Communication:
 - Education in giving and receiving constructive feedback.
- Education in what BDSH are and what they are not.
- Role-modelling of appropriate behaviours, both in general interactions but also in response to allegations of BDSH.
- Research into underlying causes.

2. Protection

- Aim: Creating a safe work place environment, with clear expectations of good behaviour and accessible and supportive pathways should BDSH events occur.
- Safe work place.
 - “Protective” culture.
 - Collaboration with other organisations.
 - Expectation that unacceptable behaviour will be “called out”.
- Support for complainant.
 - Accurate ascertainment of the circumstances.
 - Counselling and advice.
 - Avoidance of repercussions.
- Well understood, safe and accessible reporting pathways that address some of the barriers listed above. This requires codified (written) arrangements with the relevant organisations or bodies. It also requires an understanding of entry points for different levels of concern or escalation pathways, and the hierarchy of the bodies that can receive reports/complaints:
 - Regulatory.
 - Guidelines, regulations and legislation.
 - Workplace occupational health and safety.
 - Memoranda of understanding/letters of agreement.
 - Legislation.
 - Local (departmental) – initial low-level responses.
 - College.
 - Guidelines and policies.
 - Clear access (website/“hotline”).
 - ◇ Noting that such a “hotline” would require training for responders and some form of 24-hour information.
 - Departmental or local.
 - While many complaints may be reported within a department, events occurring in private hospital environments would need a different structure (for example, the director of medical services).

3. Response and remediation

- Aim: Responsive and appropriate assessment and actioning of BDSH complaints with support for the complainant and protection of the rights of the alleged perpetrator.
- Evaluation of the information available about the event/s, that is, circumstances, “both sides of the story”.
 - Ranging from simple inquiry to formal assessment.
- Recognition of the need to support the alleged perpetrator.
- Escalating interventions.
 - Encouragement of local strategies (department, individual).
 - College evaluation, remediation processes, and sanctions.
 - College complaints policy.
 - Triage group etcetera (see below).
 - ◇ For example, low level responses, one-on-one conversations/mediation.
 - Workplace performance processes/mediation.
 - Regulatory review and restrictions.

B. Specific actions to implement framework aims

College policies and guidelines

- **ANZCA Professionalism Framework for BDSH** **[Action 1 – formalise and adopt]**
 - Formalise the overall principles and structure in this document into a formal framework.
- **Revised Complaints Policy (including pathways)** **[Action 2 – approve]**
- **Regulation 26: Standards of professional practice** **[Action 3 – update]**

Prevention

1. **Support** for agents of the College including supervisors of training and education officers (ANZCA); practice development stage supervisors (FPM).**[Action 4 – identify and expand]**
 - a. Feedback skills training.
 - a. Resources for management of the trainee experiencing difficulty.
2. **Educational resources** for trainees, Fellows and specialist international medical graduates (SIMG) **[Action 5 – identify and expand]**
 - a. Links to online modules regarding:
 - i. Mentoring.
 - ii. Feedback.
 - iii. BDSH (note: RACS linkage plus in-house).
 - iv. Welfare of Anaesthetists Special Interest Group.

- b. Onsite training sessions:
 - i. Hospitals (with surgical trainees).
 - ii. Departments.
 - iii. ANZCA Annual Scientific Meeting.
- 3. Principles of respect and professionalism throughout the organisation.
 - a. **Values statement** [Action 6 – develop and confirm]
 - i. Noting that FPM has an existing values statement.
 - b. Policy documents (existing)
 - i. Staff.
 - ii. Fellows acting as College “agents”.
 - iii. *Supporting Anaesthetists’ Professionalism and Performance: A guide for clinicians*
 - 1. Ensure content reflects BDSH principles. [Action 7 – update]
 - c. ANZCA pledge (existing).
- 4. **Connections** with external organisations for training and education. [Action 8 – expand, develop and ratify]
 - a. Hospitals (as employers).
 - b. Specialist colleges.
 - c. Private hospitals and other organisations that credential practitioners.
 - d. Medical defence organisations.

Protection

- 1. Knowledge of expectations of professional behaviours (see “Prevention”).
- 2. Knowledge of reporting pathways (see below).
- 3. Provision of support resources (relevant to character of the issue/Vanderbilt escalation).
 - a. Documents, for example, Welfare of Anaesthetists SIG.
 - b. Personal, for example, colleague, welfare officer.
 - c. Supervisor of training.
 - d. College advice:
 - i. Director of Professional Affairs.
 - ii. Link to supportive Fellow/colleague.
 - iii. Counselling/psychological.
 - 1. Employee Assistance Program (EAP) model that can be extended to agents of the College and those involved in BDSH processes. The access means for this needs to be determined.
 - iv. Legal support.
 - 1. Clear statements of indemnity and legal support for agents of the College acting legally and responsibly within their role.

- v. Recognition and interaction with other peer support programs.
 1. Australian Medical Association in Australia.
 2. New Zealand Medical Association /Association of Salaried Medical Specialists or Resident Doctors Association in New Zealand.
 3. Doctor's health advisory services (or similar).
 4. Own general practitioner.

Response: Remediation (intervention as needed) and support

1. Ensure consideration is given to both the complainant and the alleged perpetrator.

In consideration of the principles of natural justice and the stress that an alleged perpetrator may be experiencing:

- a. Appropriate support and consideration for the alleged perpetrator be ensured as much as possible.
- b. Appeals and reconsideration processes are available under *College Regulation 30: Reconsideration and review processes and Regulation 31: Appeals process*.

2. Develop clear reporting pathways.

Processes and pathways as outlined in the ANZCA Complaints Policy (see Action 2)

- a. Colleague.
- b. Welfare advocate (if ANZCA-accredited teaching hospital).
- c. Supervisor of training (if trainee).
- d. Hospital head of department (if teaching hospital).
- e. Employer local manager/human resources (trainee, consultant public or private).
- f. College (trainee, public or private consultant).
 - i. The identification of clear and confidential entry points to ANZCA advice and support resources. Web links and chief executive officer email exist but planning should commence for a "hotline" for complainants and supporters (for example, supervisors of training). This would have to be staffed/responded to by appropriately trained and resources personnel.
 - ii. Concerns and complaints to reach the College via an Access Line (email/phone/letter/web form) **[Action 9 – implement]**
- g. Australian Health Practitioner Regulation Agency – Medical Board of Australia/Medical Council of New Zealand.

3. Evaluation of the circumstances surrounding the reported event/sas per ANZCA Complaints Policy (see Action 2).

Step 1: Screened via the ANZCA chief executive officer who:

- a. Records all complaints/concerns into a Complaints and concerns register, assigning a case identification number. **[Action 10 – implement]**
- b. Determines an action pathway based on "Guidelines for consideration".
- c. Reports all cases (de-identified if necessary as determined by the chief executive officer and/or triage group) to ANZCA Executive Committee monthly.

Step 2: Action pathway.

- a. Local resolution/ANZCA director of professional affairs involvement/senior colleague – lower level reports.
- b. Appropriate training committees (if related to a trainee), for example, ANZCA Trainee Performance Review (TPR) Sub-Committee or FPM Trainee Assessment and Education Committee (TAEC).
- c. Triage Group – higher level reports or repetitive events.
- d. ANZCA Executive Committee or FPM TAEC for decision/referral (including to Council) depending on complexity.

Step 3: Pool of education/remediation strategies and resources to be developed and maintained, for example, psychological/behavioural counselling; process communication model, employee assistance program access for Fellows.

[Action 11 – develop and maintain]

Step 4: Escalation, if needed, maybe via Regulation 26: Standards of professional practice.

Audit and review of processes

[Action 12 – implement]

1. Ongoing identification of the potential for workplace bullying through data and identifying organisational risk factors.
2. Monitoring and reviewing the effectiveness of these control measures; this is to include feedback from participants.
3. Developing the capacity to provide appropriately de-identified reports or data as required. These could be aggregated for annual reporting to the College staff and membership and also provided to regulatory bodies as needed.

Ongoing surveys

[Action 13 – implement]

1. Conduct repeat surveys of trainees and recent graduates no more frequently than every two years.
2. Conduct new surveys of specialist medical graduate specialists and mid-career and older graduates.

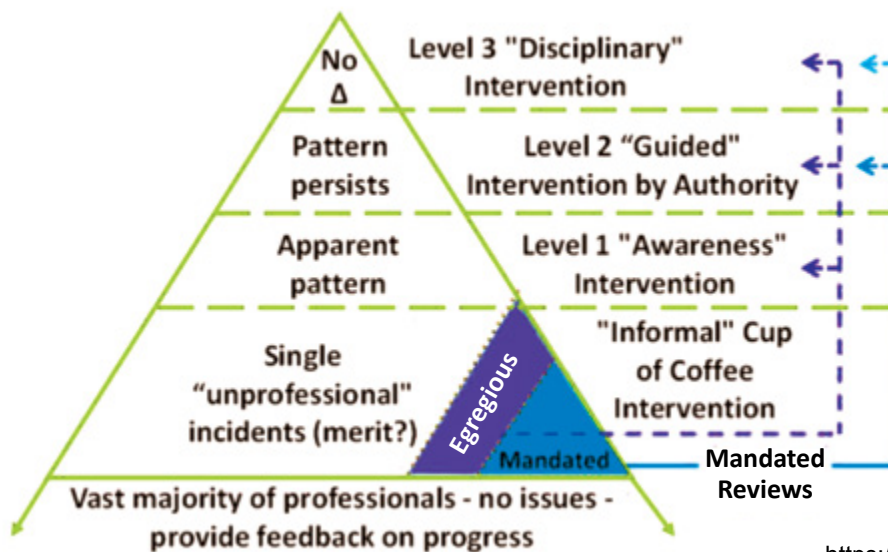
Vanderbilt principles (for information)

Interventions and complaints policies are based on a modified version of the Vanderbilt principles.

- The professionalism pyramid is built on a structure of escalated communication as patterns of unprofessional behaviour develop and is based in the concept that the vast majority of professionals conduct themselves in exemplary ways.
- All health professionals and administrators are subject to lapses and may engage in what appear to represent single “acts” of unprofessional conduct.
- Individuals who exhibit recurrent patterns of unprofessional conduct genuinely represent an anomaly, and therefore need to have their behaviour addressed.
- When a pattern of unprofessional conduct appears to exist, individuals need varying levels of intervention.
- Dotted lines separate various levels of intervention. They are not solid, to reflect the importance of professional judgment and differences among organisations in deciding when to use each level.
- Research reveals that for those who exhibit patterns of unprofessional conduct, most respond to an awareness intervention.
- Unfortunately, some individuals will not or cannot respond at the awareness level and need a more directive approach higher in the pyramid.
- The conversations establish a structure of escalated communication, and everyone needs a supported plan for responding to reactions to conversations.

Vanderbilt Professionalism Pyramid

Pyramid for Promoting Reliability and Professional Accountability



<https://ww2.mc.vanderbilt.edu/cppa/45627>

The Triage Group – professional conduct committee

1. Background

The Professional Conduct Triage Committee is an interim committee established by the ANZCA chief executive officer (CEO) to advise on the ongoing management of notifications of BDSH (as well as other professional conduct matters).

2. Membership

The group comprises the following ANZCA members:

- Mr John Illott, CEO.
- Dr Rodney Mitchell, Vice-President.
- Ms Carolyn Handley, Deputy CEO.
- Dr Leona Wilson, Executive Director of Professional Affairs.

3. Referral

Under the policy, all complaints and notifications should be made to the CEO. The committee advises the CEO on appropriate courses of action for reported matters. In the course of its work it also notes where improvements to resources and systems can be made.

The committee has received notification of a number of BDSH matters to date and has commissioned an external firm WorkMatters, to perform initial assessments and report back to the committee with recommendations.

4. Issues noted by the triage group

a. Referral of cases to the College where there is concern about bullying and harassment.

Different referring processes were used for many cases received to date. Most resulted from a person of authority being proactive rather than the trainee raising the concern.

ANZCA needs to consider if a reporting process for third parties should be developed.

b. Trainee involvement

A major difficulty was getting trainees to respond to or get involved in the assessment process. This has confirmed that trainees have a real fear of victimisation and will only raise their concerns when they have nothing to lose, but by then it could be too late.

Those involved with trainees first-hand seem to be better placed to pick up on any potential problems early and take preventative action or report the matter. These individuals are also well placed to identify if there is a pattern at a particular hospital.

Level 1 intervention under the Vanderbilt Model should be implemented quickly in order for it to be effective. It is a non-judgemental process that requires the subject to reflect on his or her management style and must be implemented at departmental level.

ANZCA needs to consider what training and education needs to be put in place to assist departments, including heads of departments, so that they are aware of their responsibilities and have the confidence to take appropriate action when required.

c. Lack of confidence in process

One of the reasons trainees may not be reporting problems is the lack of confidence in how the College will follow up on their concerns. The lack of a standard procedure may be adding to this lack of confidence. See also later comment about the need to share potentially sensitive information with heads of departments.

d. Support mechanisms

It is becoming clear that support mechanisms are required for trainees, supervisors of training and those who are alleged to have been perpetrators of BDSH. If level 1 action is to be effective, it is important that it is carried out in a manner that is non-judgemental.

In many cases, the knowledge of an allegation of bullying can be personally devastating for an individual. At this stage ANZCA has no established direct support mechanisms to call on for trainees or supervisors, but does have insurance/indemnity cover for fellows acting in College roles. In the first instance, however, practitioners should access these sorts of resources from their hospitals or their professional indemnity insurers. There is however a degree of uncertainty that exists within the fellowship.

ANZCA needs to consider what support mechanisms are appropriate for those in senior roles. These should include:

- i Training in areas of discrimination, harassment and bullying.
- ii Methods for managing and reporting concerns.
- iii Awareness of procedures developed by the College.

ANZCA should also consider further training and support for education officers. In many cases they find themselves dealing with trainees, supervisors and heads of departments over the same complaint. It is not only time consuming, but education officers are required to manage a fine balance in maintaining relationships and remaining non-judgemental.

Guidelines for deciding what information can be passed on to heads of departments would be helpful. ANZCA relies on the support of heads of departments to achieve quick resolution to BDSH issues and therefore should be open to sharing information. Notwithstanding that principle, reports received by ANZCA will frequently contain information that is sensitive and is given in confidence.

e. Private hospital settings

In the private hospital setting, the vast majority of doctors are visiting medical officers, that is, they are not employees of the hospitals. However they are accredited (appointed) by the hospitals and thus responsibility passes in both directions between the private hospital and the practitioner. Where allegations of BDSH arise, hospitals may be reluctant to investigate although there is evidence that this is changing.

ANZCA BDSH Working Group

Members

Professor David A Scott (Chair): head of department, ANZCA President (Victoria)

Dr Leona Wilson: former head of department, ANZCA Executive Director of Professional Affairs, former ANZCA President (New Zealand)

Dr Sam Lumb: former SA Trainee Committee Chair, New Fellow (SA)

Dr Sally Ure: Deputy Education Officer, head of department (New Zealand)

Ms Jenny Lethbridge: ANZCA General Manager, Human Resources (Victoria)

Ms Helen Maxwell-Wright: ANZCA Consumer Representative (Victoria)

Dr Lindy Roberts: former ANZCA President, FPM representative, Director of Professional Affairs Assessor (Western Australia)

Dr Maggie Wong: Former supervisor of training/education officer; Director of Professional Affairs, Assessor (Victoria)

Advisors

Dr Chris Hayes: Dean, FPM (NSW)

Dr Adriana Bibbo: ANZCA Trainee Committee Co-Chair, 2016 (Victoria)

Dr Christine Velayuthen: ANZCA Trainee Committee Co-Chair, 2016 (NSW)

Meetings

The BDSH Working Group met on December 15, 2015, March 16, 2016 and February 7, 2017.

Appendices

- I. *ANZCA BDSH Working Group – terms of reference* – www.anzca.edu.au/bdsh_tor
- II. *Policy on Bullying, Discrimination and Harassment for Fellows and Trainees Acting on Behalf of the College or Undertaking College Functions* – www.anzca.edu.au/resources/corporate-policies
- III. RACS Action Plan Key Items – www.surgeons.org/media/22260415/RACS-Action-Plan_Bullying-Harassment_F-Low-Res_FINAL.pdf
- IV. RACS letter of agreement – www.anzca.edu.au/bdsh_letter

References

1. Askew, D. A., P. J. Schluter, M. L. Dick, P. M. Rego, C. Turner and D. Wilkinson (2012). "Bullying in the Australian medical workforce: cross-sectional data from an Australian e-Cohort study." *Aust Health Rev* 36(2): 197-204.
2. Downey, G. B., J. M. McDonald and R. G. Downey (2017). "Welfare of anaesthesia trainees survey." *Anaesth Intensive Care* 45(1): 73-78.
3. Venkatesh, B., C. Corke, R. Raper, M. Pinder, D. Stephens, G. Joynt, P. Morley, R. Bellomo, R. Bevan, R. Freebairn, B. Varghese, M. Ashbolt, F. Hawker, S. Jacobe and S. Yong (2016). "Prevalence of bullying, discrimination and sexual harassment among trainees and Fellows of the College of Intensive Care Medicine of Australia and New Zealand." *Crit Care Resusc* 18(4): 230-234.

