Medical Deans
AUSTRALIA AND NEW ZEALAND

Preventing & Managing Bullying, Discrimination & Harassment

A Guide for Medical Schools

Acknowledgements

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Introduction

This guide is designed to assist medical schools to navigate and enhance their approach to the prevention and management of bullying, discrimination and harassment (BDH) of students in medical education.

Medical programs, along with nursing and allied health professional programs, operate in a unique space in terms of BDH, as they span both higher education and the health system. A whole-of-program approach must consider campus learning environments as well as the clinical learning environments where many of those teaching students are employees of health services, not universities.

Although there is a considerable amount of work underway within universities to prevent and manage BDH, central university policies are developed for students across all disciplines, whereas most of the BDH experienced by medical students occurs during clinical training in health services. Medical schools and students sit at the intersection of the two learning environments – universities and the health sector – and are impacted by the policies and cultures of both.

"A whole-of-program approach must consider campus learning environments as well as the clinical learning environments where many of those teaching are employees of health services."

The impetus for developing this guide came from Medical Deans' Student and Staff Support Committee, in recognition that there are few resources available to assist medical schools in building a context-specific response to BDH. The Committee set up a Working Group to investigate the evidence base, draw together information relevant for medical schools, and make recommendations on good practice elements of a whole-of-program response to BDH. [Note that while students on placements are exposed to BDH behaviours from patients as well as staff, patient behaviours are outside the scope of the guide.]

It is timely that the guide is published in 2024, the first year of operation of the new Accreditation Standards for Primary Medical Programs,[1] which include a new standard requiring medical schools to have in place "clear policies to effectively identify, address and prevent bullying, harassment, racism and discrimination…for all learning environments."

Most medical schools will already be utilising university-wide resources to address aspects of BDH, particularly those related to sexual harassment, and all schools must comply with the BDH policies and processes set by their universities. This guide is intended as a complementary resource, bringing together a range of information and advice specifically relevant for medical schools (and other health professional programs). It is based on a combination of:

- desk research
- responses to a 2023 survey of Medical Deans' member schools
- advice from Working Group members
- advice from other subject experts.

1 https://www.amc.org.au/wp-content/uploads/2023/08/AMC-Medical_School_Standards-FINAL.pdf

Section 1

The prevalence of BDH behaviours, particularly in clinical learning environments, is unacceptably high, and both universities and health services are under increasing regulatory pressure to ensure safe environments for their students and employees. Section 1 provides information and data on the incidence and impact of BDH, and the complex regulatory environment.

Section 2

The results from a survey of Medical Deans' member schools provide insight into how schools are currently addressing BDH issues. The Member Survey findings are accompanied by recommendations on good practice from the Working Group.

Section 3

While medical schools typically have no direct control over the culture of the health services where their students are on clinical placements, they have a duty of care for these students. Section 3 looks at the evidence base on the effectiveness of interventions to reduce BDH and other unprofessional behaviours in healthcare services and identifies some of the common elements, or 'success factors', for effective interventions.

Section 4

A list of training resources and links to key sites on the prevention and management of BDH in the health and education sectors.

Addressing BDH is ultimately about changing the culture of medicine, and while cultural change is never easy or fast, medical students and the medical school staff who support them have the power to make an important contribution. As new graduates move into the medical workforce, abusive behaviours which have been normalised or tolerated in some workplaces in the past are less likely to be accepted if graduates are better equipped to deal with the difficult situations that will inevitably arise during their careers. We hope this guide assists our member schools in navigating their approach to addressing BDH in this first and critical stage of the medical training continuum.

Recommended approaches for medical schools

Summarised below are the approaches recommended for medical schools, explored in more detail in *Section 2*.

Shared Understanding of BDH

- Students and staff have a shared understanding of the meaning of the terms 'bullying', 'discrimination', 'harassment' and 'sexual harassment' through the provision of bespoke examples of these behaviours within the context of medical education.
- Examples of these behaviours are co-designed with students.
- Examples of these behaviours engage student cohorts from diverse backgrounds, particularly cohorts at greater risk of experiencing BDH (e.g., Indigenous, people of colour, women, LGBTQI).

Layered Reporting System

- *Student choice:* A layered reporting system provides students with multiple reporting options, ranging from an informal conversation with a trusted staff member to a formal complaint. Students are provided with accurate and honest advice about what they can expect from each option. The reporting pathway chosen is the most acceptable, empowering, and least damaging to the person who has experienced or witnessed the behaviour.
- *Information clearly communicated through multiple channels:* The medical school has developed a flowchart identifying the reporting options available to students in all learning environments and the multiple contact points for students to seek advice or make a report. The flowchart is provided to students through multiple channels (e.g., online portals, bespoke publications, lectures/workshops, anti-BDH signage) with links to policy and procedures to ensure transparency.
- *Staff know what to do:* In case of disclosure by a student, all medical school staff (including tutors, sessional/casual staff, adjunct appointees) know the appropriate reporting or support contact (ideally someone who has had BDH training) if they are not able to provide the right information and support themselves.
- *Privacy is protected:* All staff are familiar with guidelines on privacy of student disclosures. Information disclosed is only provided to those who need to know, as per the guidelines, and the student is made aware of who will access any information.
- *Students see consequences for BDH*: Schools develop ways to provide ongoing, de-identified information to students about the actions taken in response to student reports/complaints about BDH incidents

Spiralled Training for Students

Information and training for students is spiralled through multiple points of the degree, most importantly at transition points:

- *Orientation/first year*: Students develop a shared understanding of BDH, including their role in contributing to a positive, inclusive medical school culture that rejects these behaviours.
- *Clinical orientation:* Students develop skills in responding to BDH and other unprofessional behaviours in the context of clinical training.
- *Clinical placements:* Students provided with information on who to go to in case of BDH concerns at each clinical placement site; students welcomed at each rotation with relevant placement information and oriented to support for next placement.
- *Rural & international placements:* Special consideration given to rural and international placements where students are removed from their existing support networks.
- *Pre-internship*: Further skills development in responding to BDH behaviours in clinical settings, including how to manage difficult situations involving patients.

Tiered Training for Staff

- *All staff*: Training provided to develop a shared understanding of individual BDH behaviours and the role of all staff members (including tutors, sessional/casual staff, adjunct appointees) in contributing to a positive, inclusive medical school culture that rejects these behaviours.
- *Senior leadership:* Additional training provided to equip leaders and managers (including clinical school directors, course directors, unit chairs) to support a whole-of-program approach, including modelling appropriate behaviours.
- *Frontline staff:* Academic and professional staff working most closely with students on campus and in clinical settings provided with additional training on how to respond in case of disclosure by students; special focus on support for cohorts at greater risk of experiencing BDH (e.g., Indigenous, people of colour, women, LGBTQI).
- *Student representatives:* Training provided for student representatives (e.g., medical society leadership*)* on how to respond in case of disclosure by peers; special focus on support for cohorts at greater risk (e.g., Indigenous, people of colour, women, LGBTQI).

Type of Training

Effective approaches:

- *Experiential:* Interactive, experiential learning methods, including opportunities for participants to practice skills development.
- *Context specific:* Use of training scenarios relevant to university and healthcare environments.
- *Risk informed*: Awareness that certain locations and particular student cohorts are potentially at higher risk (e.g. Indigenous, people of colour, women, LGBTQI).
- *Trauma informed:* The potential for BDH training to trigger some participants is anticipated, particularly in the case of students, through the use of trigger warnings at the beginning of the training and information about support services at the end.

Engagement with health services

Examples of effective practices:

- *Central team member designated as liaison point for all training sites:* A member of the central medical school team, who is largely campus-based and understands governance and policy, is designated as the contact point for all clinical leads at all training sites for information or advice on BDH issues. All medical school staff know this contact and understand their role.
- *An ongoing contact across changing placement sites*: Students are provided with a school-based contact for BDH-related issues for their whole clinical year, as well as a contact at each placement site/attachment.
- *Joint medical school discussions*: Development of a forum or process for sharing information amongst medical programs that use common training sites can deepen schools' insight into student experiences at particular sites.
- *Joint medical school/health service discussions:* Issues relating to the culture of clinical training environments are jointly discussed by medical schools and health service management/health jurisdictions.

1. Bullying in Medical Education

1.1 Defining BDH

There is no single agreed definition of 'bullying'. Different countries and organisations adopt various definitions with many common elements, for example:

- *Australia's National Centre Against Bullying*[2]*:* "An ongoing and deliberate misuse of power in relationships through repeated verbal, physical and/or social behaviour that intends to cause physical, social and/or psychological harm. It can involve an individual or a group misusing their power, or perceived power, over one or more persons who feel unable to stop it from happening. Bullying can happen in person or online, via various digital platforms and devices and it can be obvious (overt) or hidden (covert)."
- *WorkSafe New Zealand*[3]: "Repeated and unreasonable behaviour directed towards a worker or a group of workers that can lead to physical or psychological harm. The behaviour is persistent (occurs more than once) and can involve a range of actions over time. People targeted often feel they are unable to protect themselves due to real or perceived power imbalances.

The terms 'discrimination' and 'harassment' are often grouped together with bullying to cover a range of related behaviours (BDH). Below are the definitions used for these terms in the Medical Board of Australia's 2022 Medical Training Survey[4]:

- *Harassment* is behaviour which victimises, humiliates, insults, intimidates or threatens an individual or group due to the person's characteristics, like their race, religion, gender or sexual orientation.
- *Discrimination* includes adverse actions or being treated less favourably because of a person's characteristics, like their religion, gender or sexual orientation.

Given the high prevalence of sexual harassment identified by surveys of the higher education sector,[5] we also provide here the Australian Human Rights Commission's definition of this particular form or harassment:[6]

- *Sexual harassment* is an unwelcome sexual advance, unwelcome request for sexual favours or other unwelcome conduct of a sexual nature which makes a person feel offended, humiliated and/or intimidated, where a reasonable person would anticipate that reaction in the circumstances.

BDH can occur in person or online, through social media or emails. It is important that medical schools' policies and strategies address BDH behaviours experienced by students through all these channels.

[2] https://www.antibullyingcrusader.com/what-is-bullying
[3] Bullying | WorkSafe
[4] Medical Training Survey - Home
[5] According to Universities Australia 2021 survey report, one in six university students reported being sexually harassed since starting university according to: https://universitiesaustralia.edu.au/wp-content/uploads/2022/03/2021-NSSS-National-Report.pdf
[6] https://humanrights.gov.au/our-work/projects/sexual-harassment-workplace-legal-definition-sexual-harassment

1.2 Prevalence

Early BDH research and interventions targeted primary and secondary education as the environments where these behaviours generally occurred, however, over the past two decades the scope has widened to include tertiary education. In 2023, a systemic review of the research on bullying in higher education[7] found that:

- a significant minority of students were directly involved in bullying, as bully or bullied
- the behaviour was most commonly carried out by students but also by academic staff
- growing research into cyberbullying indicated that student to staff bullying was also common.

Multiple reviews[8-9] show that higher rates of BDH are experienced by students in health disciplines, during clinical training.

"Evidence suggests that a substantial portion of healthcare students worldwide experience bullying in clinical practice…Senior staff are reported to be the most likely perpetrators, and students of minority ethnicity, gender or sexuality are likely to fare worse. Verbal harassment, gender and racial discrimination, and academic harassment (e.g., withholding a grade in return for favours) are amongst the commonest recorded bullying acts."[10]

Surveys undertaken over the past decade provide insight into the size of this problem for medical students in Australia and New Zealand[11]:

- Nearly 800 medical students responded to a landmark survey conducted by the New Zealand Medical Students' Association in 2015, with 54% saying they had experienced what they perceived as bullying when on clinical placements, and 76% saying they had witnessed another student being bullied.
- A survey of student experiences by the University of Western Australia in 2018 indicated that approximately 40% of medical students had experienced bullying while on placement and 10% had experienced sexual harassment. A repeat survey in 2023 found a small improvement – a third of students compared with 40% - and identified certain year/location hotspots.
- A 2018 survey of Year 4 and 5 medical students at University of Newcastle found that 31% of Year 4 students and 45% of Year 5 students had experienced some aspects of BDH during their training. The students identified the sources as being overwhelmingly from the clinical environments where they were training: consultants (40%), registrars (25%), nurses/midwives (20%), junior doctors (6%), administrative staff (5%).

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[7] *Tertiary Education and Management (2023) 29:123–137* Malcolm Tight, Lancaster University, 30 June 2023; https://doi.org/10.1007/s11233-023-09124-z

[8] A landmark US study on this issue was published in the Journal of the American Medical Association in 1990, https://jamanetwork.com/journals/jama/article-abstract/380415found that 46.5% of participants reported being mistreated at some point during medical school.

[9] A UK survey by Timm, A. 2014. Survey reporting on undergraduates' exposure to bullying and harassment in their first placement year (2014)

[10] Althea Gamble Blakey, Kelby Smith-Han, Lynley Anderson, Emma Collins, Elizabeth Berryman and Tim J. Wilkinson BMC Medical Education, 2019.
Interventions addressing student bullying in the clinical workplace; 2019, BMC (1).pdf

[11] Source: Medical School Stories, Medical Deans Australia and New Zealand, 2021, https://medicaldeans.org.au/category/bullying-and-harassment/

- A Sydney University study looking specifically at final-year medical students' experience in Semester Two (2013) found that as many as 74% of respondents reported experiencing "teaching by humiliation" during rounds when on clinical placements, and 83% said they had witnessed it.

Medical Deans' Member survey

A higher incidence of BDH in clinical environments was also observed by the student support professionals who responded to a survey of Medical Deans' member schools (Member Survey), which was undertaken in 2023 to inform this report.[12]

The relevant questions, and responses, are provided below:

Q. Do you think BDH is a significant problem for medical students?

i) ***At university***

Response	*No. of Schools*[13]
Yes	6
Yes, but not significant	3
Unsure	3
No	1

ii) ***On Clinical placement***

Response	*No. of Schools*
Yes	14

The same BDH behaviours are also experienced by junior doctors in these training environments: 34% of junior doctors responding to the Medical Board of Australia's 2022 training survey reported having experienced and/or witnessed bullying, harassment, discrimination and racism, increasing to 55% for Aboriginal and Torres Strait Islander trainees.[14]

1.3 Impact

The negative impacts of BDH, both for individuals and groups, are well documented.[15] A 2019 review of the literature by a team from New Zealand's University of Otago[16] summarised the multiple harms that may impact medical students in the clinical context as follows:

"Bullying can harm a victim's learning and the learning of others in the workplace, influence career choices, create short- and long-term mental health issues and lead to self-harm and suicide. Student bullying can also be witnessed by, and be distressing to others, the consequences of which might also then impact on the functionality of a clinical service. Together with the bullying of staff more generally, student bullying is a potentially significant threat to quality (e.g., patient outcomes, clinical error), efficiency, levels of job satisfaction, staff retention and turnover."

Likewise, the Medical Board of Australia's code of conduct for doctors[17] links the effects of BDH to the functioning of healthcare teams and patient safety.

[12] Note: fourteen (or 60 per cent) of the 24 medical schools in Australia and New Zealand responded.
[13] Only 13 of the 14 schools that responded are counted here as one response was unclear.
[14] https://medicaltrainingsurvey.gov.au/Results/Reports-and-results
[15] NHS study
[16] Gamble Blakey et al, ibid
[17] https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx

1.4 Regulatory context

Knowing that the incidence is high and the negative impacts substantial, what then are the responsibilities of medical schools in addressing the bullying of their students? The answer to this question is complex due to the multiple regulatory bodies and frameworks which govern the environments where medical students learn.

Higher education

A 2020 report on Australian universities' anti-bullying policies for students[18] noted that while policies were mandated for workplaces and schools, they were not mandated for universities. Since then, the seminal Universities Accord Report released in February 2024 has called for greater scrutiny for higher education through a national student charter and a new ombudsman to respond to student complaints (Recommendation 18, below[19]).

> **Ensuring Student Safety and Experience**
>
> 18. That to improve the overall student experience and reflect domestic and international student expectations of their higher education outcomes, the Australian Government work with national student bodies and the higher education sector to:
>
> a. develop a national student charter that sets out a shared, national commitment to the welfare, safety and wellbeing of all students on campus and online
> b. establish a National Student Ombudsman to respond to student complaints.

The Interim version of the Universities Accord Report has already led to regulatory change, with the passing of the Higher Education Support Amendment Act in late 2023. This amendment requires higher education providers to have and comply with policies to support students to successfully complete units of study in which they are enrolled. Given the potential for BDH to disrupt student experiences and performance, this increases the onus on universities to prevent and manage students' exposure to BDH behaviours.[20]

Medical education and training

Regulatory requirements on BDH are now stronger for Australian and New Zealand medical programs than for universities in general, with the introduction of the following new standard in the Australian Medical Council (AMC)'s Accreditation Standards for Primary Medical Programs 2023:[21]

> **Standard 4.2 Student wellbeing**
>
> 4.2.7 There are clear policies to effectively identify, address and prevent bullying, harassment, racism and discrimination. The policies include safe, confidential and accessible reporting mechanisms for all learning environments, and processes for timely follow-up and support. The policies, reporting mechanisms and processes support the cultural safety of learning environments.

[18] https://www.tandfonline.com/doi/abs/10.1080/07294360.2020.1721440?journalCode=cher20
[19] Australian Universities Accord - Final Report P. 26. https://www.education.gov.au/accord-final-report
[20] https://www.education.gov.au/higher-education-provider-updates/higher-education-provider-updates-november-2023#toc-support-for-students-policy-and-pass-rate-requirements
[21] https://www.amc.org.au/wp-content/uploads/2023/08/AMC-Medical_School_Standards-FINAL.pdf

The reference to “all learning environments” in Standard 4.2.7 (above) reinforces the duty of care medical programs have for their students on clinical placements, as well as on campus.

A new standard relating to BDH also applies for interns and junior doctors in the Prevocational Training Framework (PGY1and PGY2), commencing in 2024.[22]

Section 2A D2 Professionals as Leaders, Domain 2

On completing training, Australian prevocational doctors are able to:

2.6 Contribute to safe and supportive work environments, including being aware of professional standards and institutional policies and processes regarding bullying, harassment and discrimination for themselves and others.

Health services

Health services are also under growing pressure to make their workplaces safer for staff and, by extension, the medical students training in these environments. The 2022 National Occupational Health and Safety Code of Practice states that workplaces are responsible for managing the psychosocial hazards of their employees; South Australia became the first state to enshrine this change into law, followed by Queensland, which recently amended the Hospital and Health Boards Act 2011 to provide a framework holding employers responsible for the psychosocial wellbeing of their employees.[23]

Conclusion

In summary, alongside greater regulatory protection for psychosocial safety in education and the workplace in general, regulators of the health system have made it clear that they are pushing back against an intergenerational medical culture that sometimes endorses, or turns a blind eye to, bullying and humiliation, in the belief that if trainees can’t take it, then they’re ‘not tough enough’ to be doctors.

This is an important and welcome development, although as demonstrated in the next section, regulation is just one aspect of culture change and not always effective. Nevertheless, it provides an important foundation for change.

[22] https://www.amc.org.au/wp-content/uploads/2022/12/Section-2A-Prevocational-outcome-statements.pdf

[23] *Insight*, MJA, 28 August 2023 https://insightplus.mja.com.au/2023/32/doctors-in-training-need-system-reform-not-more-resilience/

2. Addressing BDH

This section investigates how medical schools are currently addressing BDH issues and suggests some recommended approaches in developing a whole-of-program strategy.

2.1 Shared understanding

An anti-bullying policy that defines BDH behaviours is a critical first step for medical schools but will not guarantee that all students are equipped to recognise these behaviours.

Only six of the 14 schools responding to our Member Survey were confident that their students were generally able to recognise BDH; the remaining eight schools made the following comments:

- Early-year (junior) students and international students[24] are examples of cohorts whose members may be less likely to identify BDH behaviours.
- Students may be more likely to recognise these behaviours in other students but less likely to recognise them in the context of clinical training.
- Students may recognise some of these behaviours, but not necessary all, and may not be able to distinguish between them.

The capacity to recognise BDH behaviours is also a factor for those doing the bullying: "Just as the bullied have to recognise that they are being bullied for bullying to be identified, so the bullies may not realise that this is what they are doing until they are called out, and, even then, they may still not accept it for what it is. This also applies to those – individuals, departments, committees and institutions – called upon to rule on and resolve alleged instances of bullying." [25]

Another factor contributing to the problem is that perceptions between students and their teachers may differ.

A Macquarie University study[26] used clinical vignettes to assess differences in perceptions of medical student mistreatment between clinical faculty and medical students. Faculty and student perceptions aligned in themes of sexual abuse and physical abuse, and for a vignette depicting a constructive teaching style. Perceptions differed significantly between faculty and students across the themes of gender discrimination, requests of students to perform non-educational tasks, humiliation, specialty choice discrimination, and requests to perform tasks beyond the student's capacity.

This study found that agreement on what constitutes appropriate behaviour is crucial to ensuring that a culture of mistreatment can be replaced by one of equity and respect.[27]

Shared Understanding of BDH

Recommended approaches

- Students and staff have a shared understanding of the meaning of the terms 'bullying', 'discrimination', 'harassment' and 'sexual harassment' through the provision of bespoke examples of these behaviours within the context of medical education.
- Examples of these behaviours are co-designed with students.
- Examples of these behaviours engage student cohorts from diverse backgrounds, particularly cohorts at greater risk of experiencing BDH (e.g., Indigenous, people of colour, women, LGBTQI).

[24] Cross-cultural communication can lead to messages being interpreted differently than intended.
[25] M. Tight. Ibid
[26] Dane Christopher Peckston, Rachel Urwin, Ryan McMullan, Johanna Westbrook; Student and clinician perceptions of medical student mistreatment: a cross-sectional vignette survey. BMJ Open, 2022.
[27] Ibid. P. 1

2.2 Reporting

2.2.1 Under reporting

Student support professionals responding to the Member Survey said that students often chose not to report bullying for fear of negative consequences. This view is reflected in the University of Otago's narrative review of the literature[28]: "Policy about behaviour and complaints processes has been shown to be generally ineffective because bullying is notoriously under-reported... Kohut… estimates that 40% of bullying victims fail to verbally inform their employer, let alone formally complain".

The Working Group that developed this guide identified the following factors as key reasons for under-reporting by medical students in Australian and New Zealand medical schools:

- *Lack of awareness*
    - Many students are not aware of the reporting processes available to them, even though they may have been given this information at some point in their course.
    - Staff may not know or provide the right information to students.
- *Power dynamic*
    - Students fear the power imbalance between themselves and those they are reporting; they believe they will be seen as a troublemaker, which will negatively impact their career progression.
- *Lack of impartiality of staff*
    - Reporting to a staff member, particularly a clinical trainer/supervisor, can result in the offending behaviour being normalised to the student by the staff member.
    - In some cases the school placement leadership is worried about availability of placements, which are at a premium, and don't want to 'rock the boat'.
- *Tolerance of micro-aggressions*
    - Students report witnessing frequent examples of micro-aggression or incivility – unpleasant behaviours that stop short of BDH but are nonetheless unprofessional – that are not dealt with in a positive, impactful manner. This erodes confidence in the reporting pathways for more serious behaviours.
- *Real or perceived lack of outcome from reporting*
    - Students may see reporting as futile where schools do not inform students about the consequences of reports/complaints. There is a perception amongst some students that reporting will be a difficult experience with no positive outcomes.

2.2.2 Hotspots

Given that students often don't want to be identified, is there a role for anonymous reporting[29] in addressing BDH?

Some medical schools offer an anonymous reporting pathway for students as part of a suite of reporting options but there are generally poor take-up rates, potentially related to the difficulty of actioning anonymous complaints.

[28] Althea Gamble Blakey, Kelby Smith-Han, Lynley Anderson, Emma Collins, Elizabeth Berryman and Tim J. Wilkinson. Interventions addressing student bullying in the clinical workplace; 2019, BMC.pdf

[29] Note: research indicates that identifying any unintended consequences of anonymous reporting (e.g. filing false reports) is essential: Jill Maben, Justin Avery Aunger, Ruth Abrams, Judy M. Wright, Mark Pearson , Johanna I. Westbrook, Aled Jones and Russell Mannion.
2023 Maben Unrpf Behav Review Interventions.pdf

Another approach being trialled by some schools is adding a question or two to the evaluation surveys run by the university/faculty after students' clinical placements: for example, "How would you describe the culture and support at your placement site/s?". The benefit is that while the identity of the students responding is unknown to the school, multiple instances of negative feedback may alert schools to problematic clinical sites.

This approach has been taken to another level through the Hotspots program, created by Dr Fiona Moir and a team from Auckland University medical school in New Zealand. Hotspots was developed in response to demand from students for an anonymous system to report inappropriate behaviours experienced while on clinical placements, and for action to be taken. The program uses surveys and bespoke visual software to map sites or specialty rotations which are 'outliers', where multiple students report poor behaviours (hotspots), and also to identify positive and supportive student experiences. When a problem is identified, Hotspots informs chief medical officers or heads of department, and it is then up to these clinical leaders to decide how to identify issues and respond.

Anecdotally, the Hotspots program has been successful, with relatively high student participation and regular, de-identified reporting to students about what actions have been taken by health services in response to complaints. The Auckland team is working on a formal evaluation process for Hotspots and has developed resources to enable implementation of the system by other programs, with a pilot transfer project underway.

2.2.3 Reporting policy

Despite the issues which undercut the effectiveness of reporting systems, formal reporting policies and procedures are a critical aspect of addressing BDH behaviours. As well as being a requirement for medical program accreditation, they demonstrate the school's explicit commitment to tackling bullying.

Layered Reporting System

Recommended approaches

- *Student choice:* A layered reporting system provides students with multiple reporting options, ranging from an informal conversation with a trusted staff member to a formal complaint. Students are provided with accurate and honest advice about what they can expect from each option. The reporting pathway chosen is the most acceptable, empowering, and least damaging to the person who has experienced or witnessed the behaviour.
- *Information clearly communicated through multiple channels:* The medical school has developed a flowchart identifying the reporting options available to students in all learning environments and the multiple contact points for students to seek advice or make a report. The flowchart is provided to students through multiple channels (e.g., online portals, bespoke publications, lectures/workshops, anti-BDH signage) with links to policy and procedures to ensure transparency.
- *Staff know what to do:* In case of disclosure by a student, all medical school staff (including tutors, sessional/casual staff, adjunct appointees) know the appropriate reporting or support contact (ideally someone who has had BDH training) if they are not able to provide the right information and support themselves.
- *Privacy is protected:* All staff are familiar with guidelines on privacy of student disclosures. Information disclosed is only provided to those who need to know, as per the guidelines, and the student is made aware of who will access any information.
- *Students see consequences for BDH*: Schools develop ways to provide ongoing, de-identified information to students about the actions taken in response to student reports/complaints about BDH incidents.

2.3 Training

The evidence base is more positive about the provision of effective, targeted training as a strategy for the prevention and management of BDH. A 2010[30] international review of bullying and violence prevention programs found that the most effective strategy was cognitive rehearsal of responses to common workplace bullying behaviours: "This approach provides staff nurses with basic bullying information and a safe environment to learn and practice responses toward bullying behaviours through cooperative group work, building confidence in workplace bullying management for both experienced and new staff nurses."

Likewise, a 2013 report to inform decision-making in the National Health Service (NHS) [31] recommended training as a key strategy: "Focus on several key mechanisms: developing trainee insight into their own behaviour and its impact on others; creating a shared understanding of acceptable/unacceptable behaviours; developing interpersonal, communication and conflict managements skills; and identifying local problems and causes of conflict and generating solutions."

2.3.1 Student information and training: current approaches

Our Member Survey asked schools whether, and to what extent, they provided training and information for students to prevent and manage BDH behaviours.

Survey responses indicated significant variation between schools – from the more generic approach of directing students to university-wide information portals, usually at orientation or during first year, through to provision of experiential learning opportunities focusing on the medical context in tutorials or workshops. Note that training may focus on witnesses, as well as those who experience BDH behaviours, with ethical bystander training[32] introduced by a number of member schools.[33] The range of Member Survey responses is listed below:

- students linked to faculty/university guidelines and policies
- students offered self-directed learning resources provided by university/faculty
- students required to complete mandatory university training modules (e.g. Consent Matters, Safe and Respectful Communities)
- students linked to bespoke medical school publications/portals outlining relevant information on BDH – sometimes co-designed with students
- partial coverage of BDH issues in the curriculum (through streams including Indigenous health, professionalism, or communication in medicine)
- BDH concepts introduced through sessions run by health and wellbeing professionals – usually for junior students
- dedicated BDH training/workshops provided by medical schools as mandatory/part of the curriculum(e.g., assertiveness/speaking up training, bystander training, role-playing sessions on handling difficult situations).

[30] Sharon J. Stagg and Daniel Sheridan, *Effectiveness of Bullying and Violence Prevention Programs, A Systematic Review*, AAOHN Journal, Vol. 58, No. 10, 2010, P. 423.

[31] J. C. Illing, M. Carter, NJ Thompson, P.E.S Crampton, G.M. Morrow, J.H. Howse, A. Cooke, B.C. Burford; *Evidence synthesis on the occurrence, causes, consequences, prevention and management of bullying and harassing behaviours to inform decision making in the NHS*; National Institute for Health Research, February 2013.

[32] Australian Human Rights Commissions, https://humanrights.gov.au/our-work/publications/bystander-approaches-sexual-harassment-workplace

[33] For example, the University of Queensland introduced mandatory ethical bystander training for all medical students in 2021. See Medical Deans case study: https://medicaldeans.org.au/ethical-bystanders-moving-into-the-medical-workforce-university-of-queensland/

University training modules often dealt specifically with sexual harassment and consent. Only a small number of schools provided experiential training/workshops designed to prepare students to recognise and respond to BDH behaviours in clinical environments.

2.3.2 Spiralled information and training for students

Discussion by the Working Group identified some of the complexities of preparing students to manage unprofessional behaviours. As discussed, students are at greater risk of encountering BDH during clinical placements, where they may be rotated across a range of teams/sites over short periods of time and uncertain who to go to with a problem. The locations of the placements (e.g. rural, international, hospital, primary care) can also involve different risk profiles and information requirements. Furthermore, as the research demonstrates, certain student cohorts – including Indigenous, people of colour, women, LGBTQI cohorts – are at greater risk of experiencing BDH behaviours.

Based on the research and professional experience, members of the Working Group identified some recommended approaches to information and training for students.

Spiralled Information and Training for Students

Recommended approaches

Information and training for students is spiralled through multiple points of the degree, most importantly at transition points:

- *Orientation/first year*: Students develop a shared understanding of BDH, including their role in contributing to a positive, inclusive medical school culture that rejects these behaviours.
- *Clinical orientation:* Students develop skills in responding to BDH and other unprofessional behaviours in the context of clinical training.
- *Clinical placements:* Students provided with information on who to go to in case of BDH concerns at each clinical placement site; students welcomed at each rotation with relevant placement information and oriented to support for next placement.
- *Rural & international placements:* Special consideration given to rural and international placements where students are removed from their existing support networks.
- *Pre-internship*: Further skills development in responding to BDH behaviours in clinical settings, including how to manage difficult situations involving patients.

2.3.3 Staff training: current approaches

The Member Survey asked schools whether and to what extent they provided BDH-related training for staff.[34] Similar responses have been grouped into categories below.

- Five of the 14 respondents said staff training comprised university-wide online training modules – mandatory in some schools and voluntary in others – frequently on sexual misconduct:
    - Training in managing disclosures of sexual harassment or assault
    - First Responder Training: a one-hour online training course that helps improve the quality of staff response to a reported incident of sexual misconduct
    - The Respect[35] module.
    - All staff required to undertake online modules regularly.
    - Staff can apply for training sessions through the annual generic university staff development resources.

[34] Note that the responses do not take into account the skills/training of the personnel acquired prior to recruitment to their student support roles.

[35] Universities Australia, Respect. Now. Always; https://universitiesaustralia.edu.au/project/respect-now-always/

- Another five respondents said their schools offered targeted BDH training for a small staff cohort or single staff member, and generally on a voluntary basis:
    - Training is available to clinical teachers.
    - Some training, but it is likely not all staff are aware/trained. Currently developing training to support the key staff that students will have contact with.
    - Head of students has completed voluntary training, but other staff have no requirements other than normal onboard training for new staff.
    - Training for unit coordinators and sub-deans.
    - Introduction to Clinical Teaching (level 1): a one-hour session on prevalence and impact of bullying and harassment; being an active bystander; informal and formal reporting; support for students and staff; relevant policies and resources. Staff who support the Respect Now Always training receive additional training.
- For two schools, staff training comprised voluntary training for university/faculty anti-discrimination and harassment support roles:
    - Training in becoming a Discrimination, Harassment Contact Officer and/or an Ethical Bystander is offered but is not compulsory.
    - The university has a Discrimination and Harassment Contact Officer network, and academics from the medical program are promoted as contact points for student (and staff) matters.
- The remaining two respondents were not aware of any BDH-related training available to staff in their school.

2.3.4 Tiered training for staff

The Member Survey responses above suggest that while generic university-based modules related to sexual misconduct are typically available to medical school staff, few schools provide or require experiential training for their staff on how to prevent and manage BDH in medical education.

We note also that medical schools need to consider who is included in the term 'staff'. Continuing staff with fractional academic appointments may have greater access to information about managing BDH, however students learn and work with a broad range of health professionals, many of whom may not hold formal roles within a medical school (e.g. casual, sessional, affiliated or conjoint staff) and may be unfamiliar with pathways for managing a student report on BDH.

So what might good practice look like? The Australian student and doctor wellbeing framework *Every Doctor, Every Setting*[36] recommends that both health services and medical schools provide training to "ensure managers and supervisors have appropriate skills to address workplace bullying, including modelling appropriate behaviour, identifying risks related to bullying in the workplace, performance management, feedback, conflict management techniques and unconscious bias".

Health departments in Victoria[37] and South Australia[38] have now adopted evidence-based policies requiring a minimum level of training for all staff, and additional training for managers and leaders. Victoria's guidelines recommend that the training "maximises engagement, self-reflection, shared learnings, acquisition of knowledge and skill development (such as through the inclusion of scenarios, interactive sessions and case studies)".

[36] Every Doctor, Every Setting, https://lifeinmind.org.au/suicide-prevention/collaborations/every-doctor-every-setting

[37] Workplace culture and bullying, harassment and discrimination training – Guiding principles for Victorian health services, 2019.

[38] Respectful Behaviour (including management of bullying and harassment) Policy, SA Health, 2021

Based on the literature and their professional experience, the Working Group endorsed the following tiered approach to staff training for medical schools.

Tiered Training for Staff

Recommended approaches

- *All staff*: Training provided to develop a shared understanding of individual BDH behaviours and the role of all staff members (including tutors, sessional/casual staff, adjunct appointees) in contributing to a positive, inclusive medical school culture that rejects these behaviours.
- *Senior leadership:* Additional training provided to equip leaders and managers (including clinical school directors, course directors, unit chairs) to support a whole-of-program approach, including modelling appropriate behaviours.
- *Frontline staff:* Academic and professional staff working most closely with students on campus and in clinical settings provided with additional training on how to respond in case of disclosure by students; special focus on support for cohorts at greater risk of experiencing BDH (e.g., Indigenous, people of colour, women, LGBTQI).
- *Student representatives:* Training provided for student representatives (e.g., medical society leadership*)* on how to respond in case of disclosure by peers; special focus on support for cohorts at greater risk (e.g., Indigenous, people of colour, women, LGBTQI).

2.3.5 Type of training

Whether for students or staff, a 'tick-a-box' approach using passive training methods is likely to be least effective. Effective BDH training engages the learner and provides opportunities to test skills; uses examples relevant to learners; is informed by the increased risk for certain cohorts; and anticipates that some learners may be psychologically triggered by elements of the training.

Type of Training

Recommended approaches

- *Experiential:* Interactive, experiential learning methods, including opportunities for participants to practice skills development.
- *Context specific:* Use of training scenarios relevant to university and healthcare environments.
- *Risk informed*: Awareness that certain locations and particular student cohorts are potentially at higher risk (e.g. Indigenous, people of colour, women, LGBTQI).
- *Trauma informed:* The potential for BDH training to trigger some participants is anticipated, particularly in the case of students, through the use of trigger warnings at the beginning of the training and information about support services at the end.

IMO Technique

Section 4 of this guide links readers to a range of resources and organisations that may be useful for schools investigating the options for BDH-related training. We make reference here to one example – the IMO Technique – which is an evidence-based program directly applicable for medical and healthcare students as well as staff, and which has been incorporated into the Otago Medical School's program.

The IMO technique can be used to upskills students and staff to ask for their learning needs to be met and to communicate tricky things (e.g. giving feedback to another), while at the same time: avoiding conflict; neutralising potentially loaded conversations; refocusing discussion (e.g. where power struggles make things difficult); encouraging staff to fulfil the needs of others well (e.g. avoiding power play with their juniors); developing abilities of self-reflection and skilful speech.

2.4 Engagement with Health Services

While medical schools typically have no direct control over the workplace culture of the health services where their students are placed for clinical learning, they still have a duty of care for these students and must consider and seek to influence the psychosocial safety of placements sites.

Schools generally employ some form of deed/placement agreement requiring training sites to exercise a duty of care for their students, which provides a point of leverage for the school if students are exposed to psychosocial hazards like BDH. Another important factor is the quality and consistency of the engagement between the school and the site.

The Working Group raised several issues that contribute to the complexity of managing BDH while students are on placement:

- The workplace culture at training facilities is very much site specific: sites range from large metropolitan training hospitals to smaller hospitals, rural sites and GP practices. There are significant variations in the workplace cultures of these environments.
- University and healthcare staff may be unclear about the respective lines of responsibility for managing student-related BDH matters during placements – and which BDH policies apply – creating potential for 'passing the buck' and nil response.
- Clinical directors managing placements at different sites may have different views about the severity of an incident – one clinical dean will take no action where another will escalate a disclosure.
- Students are likely to use a variety of entry points to make a disclosure. Their first port of call is likely to be a trusted member of staff, who may well have no connection with the site where the problem occurred and/or limited understanding of university policy.
- If students report an issue to their clinical director or a staff member at the training site, the central school should generally be informed, but this does not always happen.

Working Group members contributed the examples below as recommended practices which have been implemented in certain schools to address the issues above through improved engagement with placement sites.

Engagement with Health Services

Recommended approaches

- *Central team member designated as liaison point for all training sites*[39]*:* A member of the central medical school team, who is largely campus-based and understands governance and policy, is designated as the contact point for all clinical leads at all training sites for information or advice on BDH issues. All medical school staff know this contact and understand their role.
- *An ongoing contact across changing placement sites*: Students are provided with a school-based contact for BDH-related issues for their whole clinical year, as well as a contact at each placement site/attachment.
- *Joint medical school discussions*: Development of a forum or process for sharing information amongst medical programs that use common training sites can deepen schools' insight into student experiences at particular sites.
- *Joint medical school/health service discussions:* Issues relating to the culture of clinical training environments are jointly discussed by medical schools and health service management/health jurisdictions.

2.5 Effectiveness of current whole-of-program approaches

The Member Survey asked student support leaders to evaluate their schools' overall approach to the management and prevention of BDH, and to comment on whether or not they considered existing measures to be adequate.

Three of the 14 respondents (21%) perceived their school's current approach to be adequate; the other eleven (79%) had concerns and suggested substantial improvements (see suggestions below).

I would certainly wish to enhance this through: o a formal session delivered to all student year groups by external BDH-trained staff. o similar sessions delivered to all academic and clinical staff as part of their annual mandatory staff development requirements. o Main challenges: (i) getting access to these teaching resources and (ii) getting staff to comply with these requirements if made mandatory.
We do not have a structured program to address BDH. I would like to see a program integrated across the four years. I am especially interested in something that shows students how best to respond to incivility, bullying from a supervisor *at that time*, as well as knowing how to report it.
We would like to enhance our response. Timeframes and resources for support to focus on this area have proved challenging.
Any BDH work should continually be evaluated as to what it is doing and how effective. However there continues to be relatively little evidence as to what works well.
No, I don't think the programs are adequate. In my opinion I think we need to enhance our response by providing more information and training for both students and staff on identifying BDH, reporting, bystander training etc.

[39] Note, this staff member should have no conflict of interest (e.g. an academic role involving student assessment).

The early years and supporting the transition to university are good. There are some great practices during orientation at some hospitals, but this needs to be consistent across the cohort – this exercise has demonstrated the gaps.
Our systems are not adequate. This year we are developing: o New online modules addressing workplace discrimination issues as they relate to professionalism, for use in 3rd and 4th year, as well as incorporating more examples of professionalism, implications of exclusion, inclusion etc. across the course in learning materials and activities. o Providing early explicit guidance for students across all year levels on appropriate and inclusive language, via cloud resources and references in assessment instructions. o We have already launched an e-resource for Y3/Y4 about inclusivity and advance care planning. o Remaining Challenges: Student and staff awareness of definitions, what the behaviour looks like, what to do about it in the moment, how and when to report it, what will happen to the student if they report it, what the lines of investigation/management of the issue will be.

The final Member Survey question nominated four different types of assistance that might enhance schools' approach to BDH and asked the respondents to pick which they thought would be most useful. The 14 respondents chose one or more options each (below).

Options	**No. schools**
Access to better training programs for students	13 schools
Information on good and best practice	12 schools
Staff Training	11 schools
Better communication with health services	8 schools

Other suggestions provided by respondents:

- Training for Local Health Districts and healthcare staff about what is appropriate and not, and how to support students with negative experiences.
- Support in setting up program-related guidelines to cultivate a culture with BDH champions.
- Training content about dealing with racism toward students from a range of cultural backgrounds as well as Aboriginal and Torres Strait Islander students.
- Examples of poor behaviour linked to definitions for students and staff.

3. Health System Interventions

Medical education is the first phase of a medical training continuum, not a discrete space. The health professionals who train medical students are engaged by both universities and health services, and the medical students of today are the junior doctors and specialists of tomorrow. Effective interventions implemented to address BDH in one part of the medical training continuum impact the training and workplace cultures in other parts of the continuum.

This section looks at some of the prominent interventions being applied to prevent and manage bullying within healthcare services and seeks to identify common elements of effective interventions. A review in 2013 by the UK National Institute for Health Research found "promising signs" of progress across the scope of interventions employed, while also reporting the need for a comprehensive review of the evidence base.[40]

One decade later, the lack of a substantive evidence base remains an issue,[41] due in part to the use of different outcome measures and program standards across interventions. However, the literature does convey certain 'success factors' (effective elements) and limitations. [42]

3.1 Professional accountability programs

One of the most prominent interventions is the professional accountability program developed by Vanderbilt University Medical Centre [43] in the United States. The Vanderbilt model includes supportive policies, surveillance tools to capture reports of unprofessional behaviour by physicians, and a tiered model of intervention that begins with informal, non-punitive peer feedback for less severe behaviour (e.g., a cup of coffee conversation with a trained peer) and escalates in formality for severe or persistent behaviour, which could ultimately result in disciplinary action (e.g., removal of hospital privileges).[44] The program provides doctors with an opportunity for reflection and to change behaviours, and aims to prevent such behaviours from being normalised.

The Vanderbilt Center for Patient and Professional Advocacy reports that, "If we give feedback early, most will transform their practice in ways that align with professional expectations."[45]

The Vanderbilt model has underpinned or significantly influenced a number of interventions in Australia, including in Ramsay Health Care and St Vincent's Health Australia (see box below), and the Central Adelaide Local Health Network in South Australia[46].

[40] Illing et al, p. 19
[41] 2023 Maben Unrpf Behav Review Interventions.pdf
[42] Little of this literature refers specifically to students: Gamble Blakey et al [Otago University] found that much of the literature lacked detail relevant to student bullying and how to address it.
[43] https://www.vumc.org/patient-professional-advocacy/promoting-professionalism-pyramid
[44] Churruca, Westbrook, Bagot, McMullan, Urwin, Cunningham, Mitchell, Sunderland, Loh, Taylor; *Retrospective analysis of factors influencing the implementation of a program to address unprofessional behaviour and improve Australian hospitals*; BMC Health Services Research 2023. P.2.
[45] Vanderbilt Center for Patient and Professional Advocacy, https://www.vumc.org/patient-professional-advocacy/vumc-cppa-home
[46] https://centraladelaide.health.sa.gov.au/professional-accountability-program/

Ramsay Health Care

Global company Ramsay Health Care[1] piloted its version of the Vanderbilt program in Australia in 2016 before systematically implementing the intervention across all its facilities in Australia, the UK and Asia.

Ramsay provides a framework for defining critical safety and professionalism standards, then works to identify, measure and address behaviours that don't align with these standards. It aims to build a checking culture where people can speak up in the moment, or where it is not safe or effective to speak up, can use the peer-to-peer support model to deliver feedback. [1]

According to a report by the Cognitive Institute, "Clinical indicators have consistently improved over the six years since the implementation began in 2016, with Ramsay Australia achieving its first ever 12-month period with zero sentinel events in June 2020."[1]

Ethos- St Vincents Health Australia[1]-[1]

The professional accountability and change program Ethos was developed by St Vincent's Health Australia and implemented in eight hospitals from 2017 to 2020.[1]

Ethos uses a secure online messaging system for all hospital staff, students and volunteers to make submissions, anonymously if desired, about both negative and positive behaviours. Where possible, staff are encouraged to speak up directly – education and graded assertiveness training is provided for all staff as well as guidance on seeking support from a co-worker or line manager or using formal reporting avenues if the behaviour is serious.

Between July 2017 and 2021, the Ethos Messaging System had 2,497 submissions, of which 54% were positive and 33% were anonymous. A key challenge to implementation was perceived lack of confidentiality of the online messaging system, which led to program revisions and the identification of 'champions' to normalise speaking up.

Five years into running the intervention, an evaluation found a drop in staff experiencing unprofessional behaviours across multiple hospitals, with a 24% reduction in bullying and 32% reduction in physical and sexual assaults.[1]

3.2 Freedom to Speak Up

An ambitious 'speaking up' intervention has been implemented across the healthcare system in England and Wales. The National Guardian's Office was established in 2016 to lead, train and support a network of Freedom to Speak Up guardians whose role is to support workers to speak up about any issues impacting their ability to do their job – from whistleblowing about patient safety to reporting BDH and other unprofessional behaviours amongst staff.

Since 2017, the Freedom to Speak Up guardians have been providing de-identified data to the National Guardian's Office to publish annual reports on the initiative. The most recent annual report (2022-23)[47] shows the highest level of reporting to date and a reduction in the percentage of anonymous reporting:

- Over 1,000 Freedom to Speak Up guardians supported workers in primary and secondary care, independent health care providers, integrated care systems and national bodies. They supported over 25,000 cases.

[47] Annual Data Report, National Guardian's Office, 2022-23; https://nationalguardian.org.uk/wp-content/uploads/2023/07/202223-Annual-Data-Report.pdf

- The number of reports from guardians reached their highest level[48] – a 25% increase on the large numbers reported during the pandemic.
- 22% of cases reported included an element of bullying or harassment; 30% of cases involved an element of inappropriate behaviours and attitudes (this new category was the most reported theme in 2022/23).
- The proportion of cases raised anonymously continued to fall – down to 9.3% from 17.7% when data was first collected (2017).
- More than 82% of those who gave feedback to their guardian about their experience said they would speak up again.

While these results show a strengthening of the initiative, the National Guardian commented that reluctance to report remained a barrier: "People do not reveal their identity – even to a guardian – when they are too fearful of the potential consequences of speaking up... For people to have confidence that speaking up is safe and indeed, celebrated, they need to see proof in practice. This means all leaders – from team leaders to chief executives and chairs – role modelling listening and following up in their day-to-day interactions, with every conversation.**"**

3.3 Success factors and limitations for interventions

Further insight into 'success factors' and limitations[49] for BDH interventions in healthcare settings is provided in the following reviews of the international evidence base:

- Review to inform decision-making by the UK's NHS (2013)[50]
- Review from University of Otago academics looking specifically at students in clinical environments (2019)[51]
- Guide for addressing unprofessional behaviours between healthcare staff from the University of Surrey (2024)[52].
- Review of interventions to address unprofessional behaviours between staff in acute care (2023)[53]

Based on these sources, the table below identifies some success factors associated with BDH interventions in health workplaces (see *Appendix 1* for a list of the key findings from each of the four reviews above).

[48] A high number of reports can be a positive outcome if it means staff have the confidence to raise issues.
[49] For example, while encouraging bystanders to intervene sends signals that unprofessional behaviour is unacceptable, it can also lead to moral injury if staff do not subsequently intervene and feel guilty for not doing so; further, intervening can place staff at risk of reprisal if performed in an unsafe organisational climate. *Source:* Interventions to address unprofessional behaviours between staff in acute care: what works for whom and why? A realist review Jill Maben, Justin Avery Aunger, Ruth Abrams, Judy M. Wright, Mark Pearson, Johanna I. Westbrook, Aled Jones and Russell Mannion.
[50] Illing et al, p. 15
[51] Gamble Blakey et al, ibid,
[52] University of Surrey, 2024. Addressing unprofessional behaviours between healthcare staff – University of Surrey (workforceresearchsurrey.health)
[53] Mabe et al, ibid, p. 18
2023 Maben Unrpf Behav Review Interventions.pdf

Success Factors

- *Understand the catalysts*: Bullying can be a consequence of a poor-quality work environment and/or personal factors such as values. It is vital to understand the catalysts and context before applying interventions.
- *Leadership:* Commitment to the program from the top down is critical. Leaders have the power to prevent and manage bullying and help change the culture by modelling appropriate behaviours.
- *A broad and positive approach:* An intervention risks being ineffective if not provided for a critical mass of staff. A positive focus targeting everyone is likely to be more effective than a punitive approach singling people/groups out.
- *Clear messaging and high visibility:* Demonstrate that the organisation is serious about culture change, and increase buy-in from staff, through clear and consistent messaging and high visibility of actions taken.
- *Intervention skills matter*: The skills and approach of those who deliver training or interventions can significantly influence outcomes (e.g. independence from the employer may be seen as positive; adult learners are unlikely to respond well to 'being lectured' or 'told').

3.4 Conclusion

Increasingly, with the introduction of new regulatory standards, schools are in a position to seek to influence health services regarding the safety and success of their students during clinical training placements, so it is important that schools are aware of the BDH policies and systems in the healthcare sites where their students are learning.

There is also work to do on campus. As a new generation of doctors moves through the medical workforce, they will be less likely to accept or adopt BDH behaviours if they have learned to recognise BDH and are familiar with the tools and systems to address these behaviours wherever they occur.

4. Links & Resources

Listed below are links to useful resources for schools considering how to address BDH. Further information can also be found in the sources footnoted in body of this report.

Universities Australia

- PRIMARY-PREVENTION-OF-SEXUAL-HARM-IN-THE-UNIVERSITY-SECTOR.pdf (universitiesaustralia.edu.au)'

Royal Australasian College of Surgeons - Operating with Respect

- https://www.surgeons.org/en/Education/Professional-Development/Operating-with-Respect

Workplace Resilience Development (WoRD) – the IMO Technique

- https://pubmed.ncbi.nlm.nih.gov/36761370/

Australian Healthcare and Hospitals Association (AHHA) and Australian Higher Education Industrial Association both promote the Bully Zero Culture of Excellence program

- [https://www.bullyzero.org.au/culture-of-excellence].

A Better Culture: coalition of health professionals led by CEO Dr Jillann Farmer.

- https://abetterculture.org.au/

Addressing Unprofessional Behaviours Between Healthcare Staff

University of Surrey, UK – a Guide

- https://workforceresearchsurrey.health/projects-resources/addressing-unprofessional-behaviours-between-healthcare-staff/

Our Watch: Respect and Equality in Tertiary Education

- https://tertiaryeducation.ourwatch.org.au/

Worksafe Australia Guide to preventing and responding to workplace bullying

- https://www.safeworkaustralia.gov.au/system/files/documents/1702/guide-preventing-responding-workplace-bullying.pdf

Rosalind Searle, Centre for Research and Evidence on Security Threats, UK: Assessing and Mitigating the Impact of Organisational Change on Counterproductive Work Behaviour: an operational (dis)trust based framework.

- https://crestresearch.ac.uk/projects/counterproductive-work-behaviour/

Oxford University peer support programme

- https://www.ox.ac.uk/students/welfare/peersupport/peer-support-training

Appendix 1.

As discussed in Section 3.3 of this guide, four reviews of the international evidence base provide insight into potential 'success factors' and limitations of BDH interventions. One review was undertaken in 2013 to inform decision-making by the NHS (see Table 1); the second, which is particularly relevant for medical schools as it looked specifically at students in clinical environments, was undertaken by a team from the University of Otago in 2019 (Table 2); the third is a guide on addressing unprofessional behaviours between healthcare staff from the University of Surrey in the UK in 2024 (Table 34); the fourth reviews interventions to address unprofessional behaviours between staff in acute care (Table 4).[54] A number of the findings are common to these reviews.

Table 1: Recommendations to inform decision-making by the NHS[55]

• ***A culture should be established*** in which employees have a heightened awareness of workplace bullying, negative behaviours are challenged, and positive behaviours endorsed.
• ***Focus preventative interventions firstly at the leaders and managers***, who have the power to prevent and manage bullying and to change the culture.
• ***The support of leaders and managers is critical*** to success when an intervention is introduced.
• ***Formal policies and procedures should be promoted*** to outline the organisation's explicit commitment to tackling bullying.
• ***Proactive monitoring of organisational data*** should be considered to identify patterns and outliers to help target interventions.
• ***Use effective training*** to prevent and manage bullying. Focus on several key mechanisms: developing trainee insight into their own behaviour and its impact on others; creating a shared understanding of acceptable/unacceptable behaviours; developing interpersonal, communication and conflict management skills; and identifying local problems and causes of conflict and generating solutions.
• ***Training should be delivered to a critical mass of appropriate staff*** *(particularly managers*) or it risks being ineffectual.
• Consider mediation for informal resolution of conflict but be aware of its limitations.
• ***Use counsellors who have knowledge of bullying*** and can draw upon a range of integrated therapeutic models.

[54] Mabe et al, ibid, p. 18
2023 Maben Unrpf Behav Review Interventions.pdf
[55] Illing et al, p. 15

Table 2: Findings of the Otago narrative review[56]

• ***Understand bullying catalysts***: An intervention should be designed only after developing an understanding of potential catalysts for bullying in a workplace. Bullying can be a consequence of a poor-quality work environment and/or personal factors such as values.
• ***Establish a relationship between the staff and interventionist, so staff needs are understood:*** Staff need an interventionist to understand what they do, and a department's clinical function within the health system. They need opportunity to develop a functional relationship with the interventionist to achieve learning outcomes, and their adult learning needs should be addressed.[57]
• ***Policy: necessary, but not sufficient***[58]: Policy about behaviour is an important feature of a clinical workplace but on its own has been shown to be generally ineffective for changing behaviour.
• ***Aim for saturation rather than targeting specific groups:*** A relatively broad approach, including all staff, can optimise engagement, particularly where positive relationships begin to be reinforced or forged between professional groups. "For example, an approach which crosses disciplines and groups of people, and aims to include everyone in developing a new work culture around students – as opposed to one aimed singularly at 'troublemakers' or 'the nurses'."[59]
• ***Frame the intervention to improve behaviour, not eradicate bad behaviour:*** A generally 'positive' focus aimed to improve behaviours can better effect behaviour change than one which is negative or punitive.
• ***Intervention teaching and facilitation skills matter:*** The skills of the interventionist can significantly influence its outcomes. Several studies specifically cite confidentiality as key to staff participant engagement (e.g. an interventionist who is independent of the participants' employer).

[56] Gamble Blakey et al, ibid,

[57] An important finding here is that adult learners are unlikely to respond well to 'being lectured' or 'told' as would likely be their experience in a lecture about behaviour…more active learning methods (e.g. small discussion group) have become widely accepted to cater specifically to these learners and generally enhance engagement and learning.

[58] The review also found emerging evidence that some behaviour policy/complaints processes, particularly requests to keep a complaint confidential, can have deleterious effects on staff and resultant behaviour. "McGregor stresses properly enacted bullying policy should entail skillfully nuanced practices that…withhold judgement and compassionately and respectfully offer support to both victim and accused."

[59] Gamble Blakey et al, ibid, p. 8.

Table 3: Findings from the University of Surrey guide[60]

• ***Present clear messaging***: for example, the consistent message of the NHS as a whole needs to be 'We do not tolerate unprofessional behaviours of any kind.' This message is conveyed effectively only if organisations respond to incidents rapidly. When it comes to taking action on unprofessional behaviours, doing something is often better than doing nothing (in the short term). This helps maintain trust between team members and management.
• ***Assess your organisational culture:*** before implementing longer-term interventions, to understand what factors are contributing to the behaviours. Keep the assessment going once interventions are implemented by planning ongoing evaluations of any interventions and your organisational culture.
• ***Use multiple interventions and strategies***: to foster culture change as this can increase uptake and spread. However, make sure they complement each other.
• ***Make sure the intervention is just and not overly punitive:*** for example, in the first instance, deal with relatively minor instances of unprofessional behaviours informally. Also, avoid singling out specific groups in your interventions – for example: blaming certain professions or staff with particular backgrounds. Any intervention needs to reflect changing societal expectations around bullying, harassment and racism – particularly towards staff at higher risk.
• ***Maximise visibility of actions:*** taken against unprofessional behaviours to engage staff in the issue and demonstrate that you are serious about it.
• ***Harness existing organisational processes:*** to further your organisation's commitment to reduce unprofessional behaviours. For example, repurpose existing meetings and build them into professional development reviews and appraisals, drawing on the support of Freedom to Speak Up Guardians, Patient Safety Specialists and staff networks. The skills of the interventionist can significantly influence its outcomes. Several studies specifically cite confidentiality as key to staff participant engagement (e.g. an interventionist who is independent of the participants' employer).
• ***Encourage allyship:*** and workplace democratisation efforts that foster support between staff and shift the balance towards responsibility at an organisational level.
• ***Involve staff in co-creating interventions***: to make sure they target the areas of greatest need as well as boosting buy-in and reach. Involve staff who are at greater risk to ensure their experiences are better addressed, such as members of minority groups and those in disempowered positions.
• ***Identify and nurture leaders***: capable of modelling desired behaviours that promote a safe, positive culture, and encourage them to be visible so they can lead by example.
• ***Appoint dedicated staff***: to lead work to tackle unprofessional behaviours, with skills in designing interventions and implementation and monitoring, to increase visibility of the work, gain traction and maximise staff engagement.

[60] University of Surrey, ibid, p. 8

Table 4: Key dynamics identified in review of interventions to address unprofessional behaviours (UB) in acute care[61]

• Interventions need to address ***systemic factors*** that contribute to UB not only individual behaviours
• ***Focusing on individual staff can have unintended consequences***[62] for psychological safety
• ***How and why an intervention is expected to work*** must be clear otherwise evaluations of interventions can be misleading
• Maintaining a focus on ***why it is important to reduce UB*** (e.g. patient safety) is key when designing an intervention
• ***Encouraging bystanders to intervene*** is important to culture change but can lead to moral injury[63]
• Identifying ***unintended consequences of anonymous reporting*** is essential
• Interventions ***must be perceived as authentic*** to foster trust in management
• ***One size does not fit all*** – tackling UB generally requires multiple and sustained interventions to address underlying conditions
• ***Addressing manager behaviour*** is essential for building trust in management
• ***Being inclusive and equitable*** is critical for effectiveness, sustainability and addressing inequalities
• There are ***trade-offs between fixed interventions and flexibility***
• There are ***trade-offs between a theory-first and practice first intervention*** design

[61] Maben et al 2023 Ibid.,Unprf Behav Review Interventions.pdf

[62] Ibid, p. 18, "When systems are implemented that seek to weed out 'bad apples', psychological safety is not improved, patient safety is unlikely to be positively impacted, and systemic issues remain unaddressed."

[63] Ibid, p. 18 "Creating an imperative to intervene can also lead to moral injury if staff do not subsequently intervene and feel guilty for not having done so. Further, intervening can place staff at risk of reprisal if performed in an unsafe organisational climate. Staff should be encouraged to intervene only when they feel safe and confident to do so."

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